Colorado Skin Care
Beauty Through Science

Patient Information

Name____Birthdate_______/_______/_______

Address______________________________Apt______City_____________State_____ZIP_________

Cell Phone__________________Home Phone_____________________E-Mail____________________

Employer______________________________Primary Dr.____________________________________

Primary Insurance___________________________ ID ____________________Group______________

Policy Holder Or Party Responsible For Patient’s Balance (Parent Or Guardian If A Minor)

Name_________________________________ Relationship _______________Phone________________

Address ____Employer______________________

Emergency Contact Information

Name__________________________________ Relationship______________ Phone_______________

What services are you interested in? (Check all that apply)

- ☐ CoolSculpting / Body Contouring
- ☐ Fine lines and Wrinkle Reduction
- ☐ Skin Tightening / Stretch Marks
- ☐ Facial Redness / Veins
- ☐ Botox / Newtox (Jeuveau)
- ☐ Filler / Facial Contouring
- ☐ Minimize Appearance of Scar
- ☐ Tattoo Removal
- ☐ Laser Hair Removal
- ☐ Brown Spot Removal
- ☐ Chemical Peels
- ☐ Laser Facial (Genesis)
- ☐ Microdermabrasion
- ☐ Derm Consultation
- ☐ Skin Exam / Spot Check
- ☐ Skin Tag Removal

Other:_______________________

Do you give us permission to contact you via phone, email, and mail to leave you detailed messages regarding any tests or results? (Please circle one) YES NO

Do you have any environmental allergies or allergies to medications? YES NO (If yes please list)

____

Are you taking or have you taken any of the following in the last month? (Circle all that apply)

Blood Thinner
Advil, Aleve
Aspirin
Vitamin E

Antibiotics
Antivirals
Topical Steroids
St. John’s Wart

Gold Therapy
Garlic/Gingko/Ginger
Birth Control
Accutane (Last used ___/___/___)

Please List ALL Current Medications____

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Preferred Pharmacy______________________________ **Phone number** _________________________

How did you hear about us? Friend/Referral______________________________**($50 for anyone YOU refer)**

- ☐ Google/ Internet
- ☐ Building/Sign
- ☐ Facebook
- ☐ Instagram
- ☐ YouTube
- ☐ Insurance______________

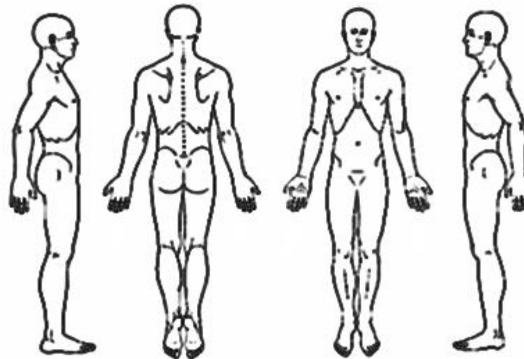
Have you ever had or been diagnosed with any of the following? (circle all that apply)

Skin Cancer
Rosacea
Psoriasis
Collagen Disorder
Vitiligo
Anemia
HIV
Auto-immune Disorder

Cystic Acne
Eczema
Melasma
Suspicious Skin Lesions
Heart Condition
Bleeding/Clotting Disorder
Neurologic Disorder
Arthritis

Cold Sores
Deep Sun Burns
Allergic Skin Reactions
Keloid/Hypertrophic Scarring
Diabetes
Hepatitis – A B C
Marfans/Lupus
Cancer

Please indicate the area(s) of concern on the following diagram:



Do you currently have any of the following (Check all that apply) or circle NONE APPLY

Skin

- ☐ Mole Changes
- ☐ Change in Hair/Nails
- ☐ New Lesion
- ☐ Itching
- ☐ Dryness
- ☐ Rash

Eyes

- ☐ Cataracts
- ☐ Vision Change
- ☐ Glaucoma
- ☐ Redness
- ☐ Pain

Ear Nose Throat

- ☐ Voice Change
- ☐ Dentures
- ☐ Hoarseness
- ☐ Sinusitis
- ☐ Tinnitus
- ☐ Canker Sores

Respiratory

- ☐ Asthma
- ☐ Bronchitis
- ☐ Cough
- ☐ Breathing Problem
- ☐ Shortness of Breath

Cardiovascular

- ☐ Chest Pain
- ☐ Coronary Artery Disease
- ☐ Ankle Swelling
- ☐ Hypertension
- ☐ Palpitations
- ☐ Cold Extremities

Gastrointestinal

- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heart Burn
- ☐ Hemorrhoids
- ☐ Nausea/Vomiting

Genitourinary

- ☐ Change Stream
- ☐ Hernia
- ☐ Hesitancy
- ☐ Impotence
- ☐ Frequent Urination
- ☐ Lesions
- ☐ STD's
- ☐ Urgency

Musculoskeletal

- ☐ Arthritis
- ☐ Decreased Motion
- ☐ Gout
- ☐ Injuries
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Swelling

Psychiatric

- ☐ Anxiety/Depression
- ☐ Agitation

Female Reprod.

- ☐ Vaginal Discharge
- ☐ Vaginal Dryness
- ☐ Painful Intercourse
- ☐ Irregular Periods
- ☐ Menopause
- ☐ Breast Pain
- ☐ Breast Lumps
- ☐ Breast Discharge
- ☐ Pelvic Fullness/ Discomfort

Endocrine

- ☐ Hot/Cold Intolerance
- ☐ Neck Enlargement
- ☐ Temperature/Chills
- ☐ Decreased Sex Drive

Neurologic

- ☐ Decrease in Concentration
- ☐ Decrease in Memory
- ☐ Dizziness
- ☐ Headache
- ☐ Numbness
- ☐ Seizures
- ☐ Tremor

General

- ☐ Weight Gain
- ☐ Weakness
- ☐ Fatigue

HIPAA Notice of Privacy Practices

This notice describes how healthcare information about you may be used and disclosed and how you can access this information. Our commitment at Colorado Skin Care is to serve our patients with professionalism and care to protect the privacy and security of all Protected Health Information. If you would like a copy of our complete Notice of Privacy Practices, please ask any staff member.

During the course of serving your interests it may be necessary to share information with other healthcare providers and/or business associates. The following are examples where information may be shared.

- Medical information may be used to show that a patient needs certain care, treatment, and services (such as lab tests, prescriptions, treatment plans, and research study requirements).
- We may disclose Protected Health Information to another provider for treatment (such as, referring doctors, or specialists)
- We may send claims to your insurance company containing medical information. We might also contact their utilization review department to receive precertification (approval for treatment in advance).
- We may use your photographs for patient/provider education. (see below)
- We may share your health information with a person whom is involved in your medical care of payment for your care, such as your family member or a close friend. We may also notify your family regarding your location and health condition.

If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law.

Consent to Use Photos/Release Information

I, ____________________________________ DOB: _____/_____/_____, hereby give David Verebelyi MD and/or his staff, permission to use my photographs and protected health information in the following manner. **Please note that all identifying information will be removed from photos**. (Please initial all that apply):

__________ I only want my photos used in the medical chart and nowhere else

__________ My photos may be used in the physician's office to show other patients "before/after" pictures

__________ My photos may be used for medical education/lectures to other physicians

__________ My photos may be used in professional writing which may include textbooks, journals, etc.

__________ I authorize unrestricted use of photographs, (privacy will be maintained)

__________ I authorize the release of information to healthcare providers and other organizations to facilitate care

If you are not available at the time of call, please list individuals (designees) which we may discuss your care and medical information. This person (designee) will also be able to contact our office regarding your information.

Designee____Relationship_______________Phone____________

Patient or Guardian Signature:____ Date:_______________

Clinic Policies

Late/No Show Policy

Please be advised that you are expected to arrive 10 minutes prior to your appointment time to allow for check-in and registration.

If you arrive later than your scheduled appointment time, you may be asked to re-schedule or be seen as a walk-in if there is a provider available.

If you are unable to make your appointment, please call and re-schedule so that other patients can be accommodated. If you do not show up for your appointment and do not call during business hours to cancel at least 48 hours prior to your appointment, you will be considered a No Show. There will be a $50.00 No Show fee charged to your credit card. **We require a credit card on file and will charge a $50 NO Show fee if you miss your appointment.**

Deposits and Packages

Initial________

Consultation fees are eligible to be applied toward any treatment in the office for up to **one year** from the consultation date.

Some procedures may require a $500.00 deposit which is due when surgery is scheduled. Payment in full is required one week prior to your scheduled surgery date**. All deposits and packages are non-refundable**. Under certain circumstances the deposit may be applied to other services **ONLY** if the original procedure is cancelled or rescheduled more than one week prior to the surgery date.

All deposits will be forfeited if not applied to a specific treatment one year from the date of payment.

For vascular procedures billed through insurance, a credit card will be held on file. If your appointment is for a surgical procedure you may be charged up to 20% of the TOTAL cost. YOU MUST cancel 7 business days prior to the surgery to avoid this fee.

Membership Payments

Initial_____

If you sign up for our membership and place a card on file, you are authorizing Colorado Skin and Vein to charge a monthly membership fee on a reoccurring basis. The charge will be placed monthly on the day you originally signed up for the membership. The membership can be cancelled at any time but once the monthly fee has been paid it will not be refunded, we will cancel future reoccurring payments.

Co-payments and Deductibles

Your co-payment is required as part of a contractual agreement between you and your insurance company and will be collected prior to seeing the provider at time of service. If you have not met your deductible and are having an in office surgical procedure, we will collect the deductible amount required prior to your surgery. (Note: the deductible is the out of pocket amount required before insurance will pay out any insurance claims.)

You agree that if the insurance company denies benefits for any reason, you are responsible for the full amount owed for services provided.

________________________________ ______________________________________ ___________________

Patient Name Responsible Party Signature Date