COLORADO CENTER for DERMATOLOGY & SKIN SURGERY

Annual Information Update*

**Please review facesheet at check-in to note changes to address, phone, email, marital status, emergency contact, PCP, preferred pharmacy, etc. Thank you.*

Patient's Name | DOB (MM/DD/YYYY)

Occupation

Responsible Party /Guarantor (if other than patient)

Guarantor Name | DOB | Relation to Patient

Mailing Address (inc Apt #) | City | State | Zip

Email | Phone ☐ Mobile ☐ Home ☐ Work

Detailed Messages

Do you give our office permission to leave detailed messages at your preferred phone number regarding any tests that you may incur as a patient, including but not limited to: biopsy results, blood / lab results, or other test results? ☐ **Yes** ☐ **No**

Medications & History Use more space if needed or attach list

List all new medications you are currently taking that you **have not previously reported to our office** (including prescriptions, over-the- counter, vitamins, herbals, and birth control pills or devices).

If no changes, please check here: ☐

Name | Dosage | Frequency

Name | Dosage | Frequency

Name | Dosage | Frequency

Name | Dosage | Frequency

I consent to having my medication history digitally imported from my pharmacy, health plans, and other healthcare providers.

☐ Yes ☐ No

Allergies

Since your last visit, do you have any **new** medication, adhesive tape, or latex **allergies**?

If no changes, please check here: ☐

Name | Reaction

Name | Reaction

Name | Reaction

Women Only (REQUIRED)

Are you pregnant, breastfeeding, or planning to become pregnant?

☐ Yes ☐ No

Since your last visit, any changes to your medical history (conditions, surgeries, hospitalizations)? Please describe below.

If no changes, please check here: ☐

Social & Other (REQUIRED)

Have you ever smoked/used tobacco?

☐ Yes ☐ No # of years

Do you smoke/use tobacco now?

☐ Yes ☐ No # packs/day

Have you ever received the pneumonia vaccine? ☐ Yes ☐ No

Do you have a **Healthcare Proxy** in the event you cannot make your own medical decisions? ☐ Yes ☐ No

Do you have a **Living Will**? ☐ Yes ☐ No

If Age 12-14:

Have you had 2 HPV (Human papillomavirus) vaccines? ☐ Yes ☐ No

Have you had your TDap (Tetanus, Diphtheria, Pertussis) vaccine? ☐ Yes ☐ No

Have you received your Meningococcal vaccine? ☐ Yes ☐ No

POLICIES & ACKNOWLEDGMENTS

☐ I acknowledge and will comply with the information contained within the practice's **Office Policies**. I understand that these policies are subject to change without prior notice and that I may request a copy of the current policies at any time.

☐ I acknowledge and consent to the information contained within the practice's **Notice of Privacy Practices**. I understand that these policies are subject to change without prior notice and that I may request a copy of the current policies at any time.

Signature Patient or Legal Representative

Date

Print Name of Signer

COLORADO CENTER for DERMATOLOGY & SKIN SURGERY

AGREEMENT TO OFFICE POLICIES

My signature below indicates that I have read, understand and will comply with the information contained within the practice's Office Policies (last revised January 1, 2026). I understand that these policies are subject to change without prior notice and that I may request a copy of the current policies at any time.

_____ _____

Signature of Patient (or Legal Representative) Date

_____ _____

Print Name of Patient Print Name of Legal Representative (if applicable)

ACKNOWLEDGMENT OF RECEIPT & CONSENT TO NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have reviewed, acknowledge, and consent to the information contained within the practice's Notice of Privacy Practices (last revised January 1, 2026). I understand that these policies are subject to change without prior notice and that I may request a copy of the current policies at any time.

_____ _____

Signature of Patient (or Legal Representative) Date

_____ _____

Print Name of Patient Print Name of Legal Representative (if applicable)

OFFICE COLLECTIONS ACKNOWLEDGMENT & AUTHORIZATION

Thank you for choosing Colorado Center for Dermatology & Skin Surgery for your healthcare needs. To help us fulfill our mission to provide personalized and exceptional care to each of our patients, we have developed office collections policies to create a productive relationship between you and our team of providers.

This form[1] outlines our office & financial procedures for patients:

- If you are insured, please provide us with your most current plan information, including any secondary, supplemental, or additional coverage. Please bring your insurance card and photo ID with you to each visit, we are required to confirm your identity when you check-in.
- As a courtesy, our office will verify your insurance network, eligibility, and benefits prior to your scheduled appointment; however, it is ultimately your responsibility to confirm that your coverage is active and in-network and that services provided by our office are covered by your insurance plan.
- If you are not insured, or if we are not in-network with your insurance, payment in full for services provided are due at the time of service. We are NOT in-network with Medicaid. **By signing this form, you attest that you are not covered in any way by Medicaid, whether, primary, secondary, or other**.
- **Please review your insurance benefits and coverage prior to each visit so that you understand your financial obligations for specialist encounters**. Because there is no guarantee of reimbursement or payment from any insurance company or payer, you agree to pay all charges for your treatment not paid by your insurer or any other payer source. **Pursuant to our contractual terms with your insurance payer(s), we will collect any applicable copayment, deposit[2] toward deductible and/or coinsurance, and outstanding balance at each visit**, and any remaining charges are due and payable upon receipt of the bill.
- Once your insurance company processes the claim for your visit and determines your financial responsibility based on your benefit coverage ("Patient Responsibility"), your insurance company will send you an explanation of benefits (EoB). Our office will apply any applicable payments and/or deposits toward your financial responsibility. If a balance remains, you will receive a statement notification via your activated patient portal, email, secure text, and/or mailing address on file. You will receive an account credit or refund[3] for any overages paid at the time of service.
- You may pay your outstanding balance **within 25 days of the date on your initial statement** ("Statement Date") with your preferred payment method. If you do not pay your balance in full within 25 days of the Statement Date or directly contact our billing department to request alternate payment arrangements, then, pursuant to the credit card authorization below, we will automatically process your outstanding balance and send a receipt to your email on file. If your payment is returned/declined for any reason, a $45 service fee will be assessed, and the outstanding balance (including service fee) will be due in full immediately.

My signature below indicates that I have read, understand, and will comply with the information contained in this Office Collections Acknowledgment & Authorization.

_____ _____

Signature of Patient (or Legal Representative) Date

_____ _____

Print Name of Patient Print Name of Legal Representative (if applicable)

REQUIRED[4]: I hereby authorize Colorado Center for Dermatology & Skin Surgery to charge any outstanding account balances not paid within 25 days of the initial Statement Date per the terms above.

Card Type (check one): ☐ Visa ☐ Mastercard ☐ AMEX ☐ Discover ☐ Other: _____

Last 4 digits of Actual Card Presented/Used for Payment[5]: _____ Exp. Date: _____

Last 4 digits of Electronic Card Scramble (if applicable): _____ ☐ Apple/Google/Samsung ☐ Other: _____

Name on card (please print): _____

Cardholder Signature _____ Date _____

For Administrative Use Only: Date S.S. (initials): _____

[1] This form incorporates by reference our Office Policies and replaces any previously signed Office Collections Acknowledgment & Consent or Authorization forms.
[2] Deposit amounts are set forth in our Office Policies and are subject to change as our office deems necessary and appropriate.
[3] Any credit balance will first be applied to any outstanding or upcoming balance. If the remaining credit balance is less than $5.00, our office will mail a refund check only upon request within 180 days of your date of service.
[4] This card authorization is valid until revoked in writing and is required for all patients. It is your responsibility to notify us of any changes to your account and to ensure we have your current address and email address on file. If you do not provide a valid payment authorization, we may (i) require full payment at time of service based on your estimated or potential out-of-pocket responsibility or (ii) refuse to provide service.
[5] For your security, only the last 4 digits of your card are documented on this form. Please BRING/PRESENT/USE THE ACTUAL CARD so that it can be entered directly into our secure payment processing system. If the actual card is not available, you may be asked to complete a new form authorizing a card that is available.