

Today's Date: _____

Patient Information

Patient's Last Name	First Name (as it appears on insurance card or ID)	Middle Name
Nickname	Date of Birth (MM/DD/YYYY)	Sex
Preferred Language	Race	Ethnic Group
Mobile Phone	Home Phone	Work Phone
Email Address	Preferred Phone: ☐ Mobile ☐ Home ☐ Work	Preferred Method of Contact: ☐ Phone ☐ Email ☐ Patient Portal
Mailing Address (inc. Apt. #)		
City	State	Zip Code
Seasonal Mailing Address (inc. Apt. #)		Is Mail Forwarded? ☐ Yes ☐ No Dates: _____
Occupation	Employer/School	Employer/School Phone
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other: _____		
Spouse's Name	Phone	Spouse's Occupation/ Employer

Emergency Contact/Caretaker Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient
Caretaker Name	Phone ☐ Mobile ☐ Home ☐ Work	

Responsible Party / Guarantor (If other than patient):

Name	Date of Birth	Relation to Patient	
Address	City	State	Zip
Email	Phone ☐ Mobile ☐ Home ☐ Work		

Referral Information (Please check below to help us determine how you heard about our office)

☐ Physician ☐ Friend ☐ Relative ☐ Insurance ☐ One of Our Patient's ☐ Our Website ☐ Prior Patient ☐ Referral Service ☐ Internet(specify search engine): _____ Other: _____	
Referring Physician (Name, Address)	Phone Number
Primary Care Physician (Name, Address)	Phone Number
Preferred Pharmacy Name, Address include City & Zip)	Phone Number

Information Release

Do you give our office permission to discuss your medical information with family members, including but not limited to: biopsy results, blood / lab results, or other test results? ☐ Yes ☐ No

If YES:

Name	Relationship	Phone Number
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Do you give our office permission to leave detailed messages at your preferred phone number regarding any tests you may occur as a patient, including but not limited to: Biopsy results, Blood/lab results, or other test results? ☐ Yes ☐ No

Signature (Patient or Legal Representative)

Date



Full Name

Today's Date

Reason for Visit

DOB

Medical Alerts

Do you develop keloid scars? (firm, thick, scars) ☐ Yes ☐ No
Do you bleed easily? ☐ Yes ☐ No If yes, are you on blood thinners? ☐ Yes ☐ No
Do you have an artificial heart valve? ☐ Yes ☐ No
Have you had Artificial Joints in the last 2 years? ☐ Yes ☐ No
Do you have a Defibrillator or Pacemaker? ☐ Yes ☐ No
Do you have history of MRSA infection? ☐ Yes ☐ No
Do you require antibiotics prior to procedures? ☐ Yes ☐ No
Do you develop rapid heartbeat to epinephrine (e.g., EpiPen)? ☐ Yes ☐ No

Past Medical History

Have you ever had any of the following?

☐ NOT APPLICABLE ☐ Bone Marrow Transplant
☐ Anxiety ☐ Breast Cancer
☐ Arthritis ☐ Colon Cancer
☐ Asthma ☐ COPD
☐ Atrial Fibrillation ☐ Coronary Heart Disease
☐ BPH (Enlarged Prostate) ☐ Depression

☐ Diabetes ☐ HIV/ AIDS ☐ Leukemia
☐ End Stage Renal Disease ☐ High Blood Pressure ☐ Lung Cancer
☐ GERD (Acid Reflux) ☐ High Cholesterol ☐ Lymphoma
☐ Hearing Loss ☐ Hyperthyroidism ☐ Prostate Cancer
☐ Heart Valve Replacement ☐ Hypothyroidism ☐ Seizures
☐ Hepatitis ☐ Joint Replacement ☐ Stroke

Hospitalizations & Surgeries Use more space as needed (or attach list).

Reason	Date
_____	_____
_____	_____

Skin History

Have you ever had any of the following:

☐ Acne ☐ Dry Skin ☐ Poison Ivy
☐ Actinic Keratosis ☐ Eczema ☐ Precancerous Moles
☐ Asthma ☐ Flaky/Itchy Scalp ☐ Psoriasis
☐ Basal Cell Carcinoma ☐ Hay Fever/ Allergies ☐ Squamous Cell Carcinoma
☐ Blistering Sunburn ☐ Melanoma

If you have had skin cancer (basal cell, squamous cell, or melanoma), please provide additional details:

Year? _____ Body location? _____

How was it treated?

Do you have a family history of melanoma? ☐ Yes ☐ No

If yes, which relative? _____

Do you regularly apply sunblock to exposed areas? ☐ Yes ☐ No

If yes, which SPF? _____

Have you visited tanning salons or do you sunbathe? ☐ Yes ☐ No

Social & Other (REQUIRED)

Have you ever smoked/used tobacco?

☐ Yes ☐ No # of years _____

Do you smoke/use tobacco now?

☐ Yes ☐ No # packs/day _____

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

Have you ever received the pneumonia vaccine? ☐ 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

Women Only

Are you pregnant, breastfeeding, or planning to become pregnant?
☐ Yes ☐ No

Current Medications Use more space as needed (or attach list).

List all medications you are currently taking (including prescriptions, vitamins, herbals, over-the-counter, and birth control pills or devices).

If none, please check here: ☐

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

☐ Yes ☐ No

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies Use more space as needed (or attach list).

Are you allergic to any of the following? If none, please check here: ☐

☐ Adhesive Tape ☐ Aspirin ☐ Latex
☐ Codeine ☐ Sulfa ☐ Lidocaine
☐ Penicillin ☐ Cephalexin ☐ Clindamycin

Do you have any other medication allergies? If none, please check here: ☐

Name	Reaction
_____	_____
_____	_____

Family History

Has anyone in your family ever had any of the following conditions?

☐ Abnormal Moles ☐ Asthma ☐ Psoriasis
☐ Acne ☐ Cancer ☐ Skin Cancer (NOT Melanoma)
☐ Allergies ☐ Diabetes ☐ Other: _____
☐ Arthritis ☐ Eczema _____

Signature (Patient or Legal Representative)

OFFICE POLICIES

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 policies to create a productive relationship between you and our team of healthcare providers. Our team cares greatly about your health and wellness and will provide recommendations and treatment options to help. We expect that you will abide by those recommendations and follow instructions regarding medications, testing, follow-up visits, etc. In addition to the medical care provided, understanding your patient obligations and financial responsibilities are essential components in establishing and maintaining a strong patient/practice relationship. In order to achieve this, we have provided the following information regarding our office policies, which may be amended from time to time without prior notice.

Required Documentation

Photo Identification. To protect you against identity theft for services, we request and keep on file a copy of your photo identification issued by a local, state, or federal governmental agency (e.g., Driver's License, Passport, Military Identification, etc.). We also capture photograph(s) for record-keeping, treatment, health care operations, and other permitted uses in accordance with our Privacy Policies.

Insurance Card. We ask all patients to provide their insurance card (if applicable) at every visit. We keep on file a copy of your current insurance card to facilitate the submission and processing of your claim. **If you do not provide current proof of insurance, you may be billed as an uninsured/self-pay patient whose payment in full is required at time of service.** If you provide your insurance card(s) at a later time, we may be able to retroactively bill the services to your insurer depending on the insurance plan's requirements.

Annual Updates. At your first visit of the calendar year, our office will request that you review and update all required registration materials, including office, financial, privacy, and other applicable policies. Please also be prepared to provide your current photo identification, insurance card, and demographic information. Thank you in advance for your cooperation.

PATIENT RESPONSIBILITY

Patients or their legal representatives are ultimately responsible for all charges for services provided. We have a right to collect payment at the time of your visit for billable services rendered and any prior balances. Because insurance plans do not provide immediate information regarding patient responsibility, you will be required to securely authorize a credit card on file to settle your account and, if you have an outstanding deductible or coinsurance, you will also be asked to pay a deposit toward such amount when you check-in.

When you make a deposit, you are paying toward an estimated patient responsibility; when your insurance company notifies us of your patient responsibility, we will either send you a statement for the balance due or issue a refund. If we do not receive a payment within the specified time period, then we will charge your card on file in accordance with our Office Collections Acknowledgement & Authorization.

If you have a routine skin exam but need additional services, you will be billed accordingly for those additional services.

TYPES OF PAYMENTS

Co-payments. Insurance carriers require that we collect your co-payment at the time of your visit. If you are not prepared to pay such amount, please reschedule (subject to our cancellation policy).

Deductibles. Most insurance plans require you to pay a predetermined amount (the "deductible") before insurance will cover certain charges. Our system allows us to view the remaining deductible for certain plans, and we will collect a deposit toward deductible, calculated as *the lesser of* your remaining deductible or our standard deposit amounts for office visits and minor procedures, excisions, extended patch tests, Mohs Surgery, etc. Deposit amounts are subject to change at any time.

Co-insurance. Some insurance plans require that you pay a certain percentage (for example, 20%) of the allowable charge amount. Our system allows us to view only certain details of your insurance plan. If we can determine the expected out-of-pocket cost to you, we may ask that you pay your full co-insurance/out-of-pocket responsibility at the time of your visit. Otherwise, we will collect a deposit toward coinsurance,

calculated *as the lesser of* your remaining out-of-pocket maximum or our standard deposit amounts for office visits and minor procedures, excisions, extended patch tests, Mohs Surgery, etc. Deposit amounts are subject to change at any time. Your out-of-pocket responsibility will be detailed in the explanation of benefits provided by your insurance plan.

Uninsured Patients/Self-Pay. If you do not have insurance or if the services provided are not covered by your insurance, payment for all services is due at the time of your visit. When you check-in for your appointment, we may require an initial deposit or credit card authorization. Upon check-out, any deposits will be applied to your total balance and any outstanding balance will be due in full. Three options are available: (1) a prompt-pay discount is available if you pay in full at the time of service (no claim submission by us); (2) pay full-charge at time of service and request claim submission by us (limited benefit/indemnity plans only); or (3) you may pay a reasonable deposit and arrange to charge the remaining balance to your credit card on file in accordance with the terms of our payment plan, in which case you will not be eligible to receive the prompt-pay discount.

Out-of-Network/Non-Contracted. We participate with most major insurance plans. You should contact your insurance company to confirm if your provider is in network prior to making your appointment. If we do not participate with your insurance plan, you will be required to pay for your visit at the time of service. We are happy to provide you with a copy of your bill and appropriate information regarding your visit for you to submit to your insurance company. As of October 1, 2019, Colorado Center for Dermatology & Skin Surgery is not a participating provider with any Colorado Medicaid plans. Under Colorado law, Medicaid members cannot be billed for any service covered by Medicaid, even if the member agrees in advance to self-pay for the care. Unfortunately, this prevents us from providing medically-necessary care to any Medicaid patient. **We can see Medicaid patients only for non-medical/cosmetic treatments not covered by Medicaid.**

Non-Covered Services. It is your responsibility to contact your insurance plan to determine whether a particular service is covered. If we provide you non-covered services, you are expected to pay for the services at the time of your visit. If the total charge amount is not available at the time of check-out, you may be required to pay an estimated amount that will be applied to your charges.

If you are a Medicare patient, we will inform you of any non-covered services prior to your treatment. Your provider will review options with you and document your decision and acceptance of financial responsibility using the Centers for Medicare and Medicaid Services (CMS) Advance Beneficiary Notice (ABN) form.

Cosmetic Services. Patients are financially responsible for all cosmetic consults and treatments at the time of service. We do not bill insurance companies for cosmetic services.

Appointment Deposits. Upon scheduling certain appointment types, such as cosmetic and various medical services, we require an appointment deposit calculated based the appointment type (subject to change at any time). At your visit, any deposits will be applied to your total balance and any outstanding balance will be due in full. Please review our "Late Arrivals, Cancellations, and No-Shows" sections regarding rescheduling/cancellation and potential fees associated.

INSURANCE/PAYMENT

Your insurance is a contract between your insurer and you. It is your responsibility to know and understand the terms, guidelines and limitations of your plan, including your co-pay, deductible, and co-insurance obligations as well as any network or coverage limitations. It is also your responsibility to advise us of any changes in your insurance, your address, or your employer.

Claim Submission. If you are on traditional Medicare or are a member of a health plan we participate with, we will submit your claim to your insurance company. We will also file your secondary/supplemental insurance claims as a courtesy.

You are responsible for:

- Ensuring that you have active and in-network insurance coverage.
- Knowing if your insurance plan requires a referral. If so, please contact your primary doctor's office at least two (2) weeks prior to your appointment date. It takes most insurance companies at least one (1) week to receive the referral authorization. Please call our office at least three (3) business days prior to

your appointment to confirm that your referral has been received. If a referral is required and you do not have the appropriate referral or authorization, you may be billed as an uninsured patient.

- Checking with your insurance plan to determine if prescribed testing (lab, pathology, etc.) is covered under your insurance policy. (If you choose to have non-covered testing, we will require full payment at the time of your visit.)
- Checking with your insurance plan to review the schedule of benefits and whether a co-payment, deductible coinsurance, or other out-of-pocket responsibility applies.
- Filing any appeals with your insurance plan, if needed.
- Coordinating benefits if you have more than one insurance plan. You may be required to contact your insurance company to clarify which plan is primary or to correct any demographic or other issues. If your secondary insurance has not paid us within 30 days, the balance will become your responsibility.
- Arriving for appointments early/on-time with all required documentation.
- Paying the entire amount determined by your insurance to be the patient responsibility.

Insurance Verification. It is your responsibility to provide us with accurate and current insurance information, and it is also your responsibility to ensure you have active coverage. As a courtesy, we will attempt to verify your insurance eligibility two (2) business days prior to your visit. If we are unable to confirm active, in-network insurance coverage, we will attempt to notify you. If you are unable to present active insurance coverage prior to the visit, you will be required to either pay at the time of your visit or reschedule your appointment. For same day appointments, we will attempt to check eligibility when the appointment is made.

Outstanding Balances. After your visit and insurance adjudication, you will receive a statement notification via your activated patient portal, email, secure text, and/or mailing address on file. All outstanding balances are due upon receipt of the statement. If you come for another visit and have an outstanding balance, we will require payment for both the new visit and your outstanding balance. Your outstanding balances also can be viewed in your patient portal and paid conveniently online at coloradodermatology.com/onlinepayments.

We accept cash, check, and most major credit cards. In some circumstances, a payment plan may be arranged upon request and qualification. We do not accept Care Credit.

Delinquent Balances. Our office generally sends only **one statement**. You may also electronically access your statement(s) in your patient portal. You must ensure that your patient portal is activated and a valid email is associated in order to receive an electronic notification when your statement is available via your portal. Any outstanding balances greater than 30 days are considered delinquent. Delinquent balances greater than 90 days may be turned over to a collection agency, and our office reserves the right to discontinue services. If your account is assigned to a collection agency, you will be responsible for any fees charged by the collection agency along with any other collection costs, reasonable attorney's fees, and court costs. In addition, if you have unpaid delinquent accounts, we may discharge you as a patient and you may not be allowed to schedule any additional services.

Returned Payment Fee. Any checks, credit cards, auto debits returned/declined for any reason will incur an additional \$45 service fee in addition to the balance due. This outstanding balance total (including original amount and fee) will be due immediately and automatically processed on another valid payment method, or, if no such valid payment method is available, you are responsible for making a payment using a valid payment method (cash or card) within 7 days of notification.

Outside Lab/Pathology Fees. Our fees are for physician services only. When you have a biopsy, excision, or other necessitating factors, your provider may send the specimen to an outside lab for processing and interpretation or to another designated outside vendor. In those instances, you or your insurance company may receive a **separate bill** from the outside lab, pathology, or other diagnostic-related provider. It is your responsibility to notify your provider team, AT YOUR VISIT, if your insurance requires you to use a specific lab or vendor.

Benign Lesions. Patients are financially responsible for the removal or treatment of all benign skin lesions unless they have met certain clinical criteria, including, but not limited to change in quality or character, increase in size, pain, or bleeding. Billing insurance for a benign removal/treatment may constitute fraud.

LATE ARRIVALS, CANCELLATIONS, AND NO-SHOWS

Late arrivals. If you arrive late or have not fully completed required registration materials by your scheduled appointment time, you may be asked to reschedule your appointment or wait for an open appointment time on that day's schedule.

Rescheduling/Cancellations. If you are unable to keep a scheduled appointment, you must provide Advanced Notice to our office: at least ten (10) business days in advance for patch testing, two (2) business days in advance for surgical/procedural/cosmetic appointments, and one (1) business day in advance for other appointments. Such Advanced Notice must be communicated via telephone or in person during our regular business hours, and it your responsibility to ensure that our office has actually received your notice. Please note that any notices submitted less than one (1) business day in advance through our voicemail, email, electronic reminder system, or other recorded channels may not be received or reviewed in a timely manner. If you do not provide the required Advanced Notice, we may consider you a "no show." Any fees associated with a failure to provide sufficient Advanced Notice will not be applied towards your service or waived without management approval. We understand that special unavoidable circumstances may cause you to reschedule or cancel with less than our required Advanced Notice period, and you may request management review of your circumstances on a case-by-case basis. If you are on a medication that requires following-up during a specific window, please plan accordingly as rescheduling is subject to availability.

No-shows. If you do not show up for your appointment or did not provide sufficient Advanced Notice, you will be considered a no-show and the following fees may apply and are subject to change at any time: \$50 (office visits), \$125 (consults), \$200 (cosmetic treatments (including prepaid packages), excisions & patch testing), \$500 (Mohs), and/or \$1000 (CO2). Additionally, if you no-show, (i) the full amount of any prior deposits may be forfeited and (ii) future appointments may be subject to an appointment deposit at the time of scheduling. Any applicable fees will need to be paid prior to rescheduling. This fee cannot be billed to insurance. As permitted by state law, you may be discharged as a patient following two (2) or more no-shows in a 6-month period.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to our office at (303) 761-0906.

OTHER POLICIES

Prescription Refills. Please plan ahead for prescription refills. We ask that you **contact our office** at least **five (5) days prior** to running out of refills. All refill requests are subject to provider approval and may require an office visit and evaluation prior to approval. Generally, we will not refill prescriptions if you are outside the recommended follow-up window, and no refills will be given for patients who have not been seen in the practice during the past twelve months for that specific prescription. Please note, we will review prescription refill requests only during our normal business hours.

Medical Records. We urge you to access your medical records directly at any time from your patient portal. Medical records requests and/or completion of forms (e.g. disability, life insurance, cancer policies, etc.) may be subject to fees determined by state law, contractual agreements, and/or office policies. Medical records requests cannot be provided the same day requested and may take up to 30 days to be processed.

Minor Patients. All minors are required to have a parent/legal guardian present with them for each appointment. By law, we are required to have a parent/legal guardian consent to provide treatment to a minor. If a parent or guardian is unable to attend an appointment with the minor, then a signed and dated authorization to treat a minor is required prior to the appointment. If a minor comes to the office unattended and we do not have a signed and dated authorization from the parent/legal guardian for specific day(s) of treatment, we will be unable to see the patient at that time, and the appointment will have to be rescheduled (subject to our cancellation policy). The parent/legal guardian presenting the child for care is responsible for payment at the time of service. We can submit charges to an absent parent's insurance only with signed permission from the policyholder. Any patient over the age of 18 will be held financially responsible for all charges incurred.

Lab Results. If you have labs or test reports at our office and have activated your patient portal, your test results may be posted to your portal before your provider has reviewed them. Please note that these test

results could include sensitive information. If you are not comfortable seeing this information before you have discussed your results with your provider or a clinical team member, please wait to view the results.

After your provider reviews test results and recommends action, our office will then contact you to discuss. Please make sure to call if you have not heard from us within 2 weeks of your test. Please do not assume that your results are negative if you have not heard from us; it is possible that we have not received your results, or that we were unable to get into contact with you.

Exposures. If any exposure of blood or tissue occurs between patient and office personnel during the visit/treatment, a sample of patient's blood will be screened for infectious disease such as hepatitis and HIV. Under certain circumstances, associated screening costs may be billed to patient's insurance.

Routine Skin Cancer Screening Exams. To ensure the best dermatological care, we strongly encourage our patients to have a full-body screening exam at least annually (more frequently for patients with higher risk factors). If such exam cannot be performed at your initial visit due to the time needed to address your primary concerns, please make sure that you schedule an appointment as soon as possible. All screenings and follow-ups are subject to your insurance plans copay, deductible, and coinsurance requirements.

Product Purchases. All sales are final. No exchanges or refunds unless the product is defective upon sale. Please carefully review product recommendations and ask questions prior to completing a product purchase. If a product is found defective upon sale, please notify our office within 7 Days of the purchase date. Defective items may be eligible for replacement at the discretion of the practice. Refunds will not be issued. This policy applies to all in-office, phone, and online purchases and is strictly enforced.

Electronic Communications. Our practice may communicate electronically with patients through our patient portal, payment portal, website, practice email, Klara or other digital communications, individual team member or provider emails and or text messages. Take care when sending or reading messages that your device is secure and private. If you ask us to communicate electronically with you, we will assume that you check messages at reasonable intervals. We cannot guarantee that we will respond to your messages, and we understand that you cannot guarantee you will respond to ours. For important issues, telephone is best. Because electronic messages cannot be guaranteed 100% secure, please do not put sensitive matters in messages without considering this. You have the right to ask us to use either encrypted (secure) or unencrypted email (not secure) for your correspondence with us. Please be advised that unencrypted email has a higher risk of being intercepted and your private information obtained by an unauthorized party. We may use electronic messaging to inform you about things related to our practice that we believe would interest you. If you do not want to receive electronic messages from us, let us know. Please notify us as soon as possible if your email address or phone number changes. We will not give your email address or phone number to anyone who is not authorized. If you believe you have received or sent a message by mistake, or one that contains errors, please let us know. Delete any messages that are not intended for you. In addition to those above, electronic communications can have other risks and disadvantages that might cause inconvenience or harm. Everyone using electronic communications needs to use good judgment about these valuable technologies, and must remember that there are alternatives that would be better for some situations. PLEASE DO NOT USE ELECTRONIC COMMUNICATIONS FOR EMERGENCIES; CALL 911.

Thank you for helping us better serve our patients.



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)



NOTICE OF PRIVACY PRACTICES

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and information access, and we describe them in this notice. Please review carefully.

Ways in Which We May Use and Disclose Your Protected Health Information:

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

Treatment. We may use and disclose your protected health information, including full-face photographs, to provide, coordinate, or manage your health care and any related services. We may also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to another physician who we have requested to be involved in your care. For example – we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

Payment. We may use and disclose your protected health information to obtain payment for the health care services we provide you. For example – we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations. We may use and disclose your protected health information to support the business activities of our practice. For example – we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription-type services for our practice.

Appointment Reminders & Outreach. We may use and disclose your protected health information to contact you regarding a pending appointment, a missed appointment, an overdue appointment, a completed appointment, balances due/overdue, or any other healthcare-related function.

By supplying your email address, home phone number, and/or mobile phone number, and any other personal contact information, you authorize your healthcare provider and its employees, agents, and assignees to contact you via email, telephone, and/or text messaging, including using automated outreach and messaging systems. You may consent to allowing detailed messages being left on your voicemail, answering system, or with another individual, if you are unavailable at your provided number.

Treatment Alternatives. We may use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to you.

Others Involved in Your Care. When necessary and authorized, we may disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.

Education & Publication. We may use and disclose your protected health information for internal educational purposes and trainings. Unless it has been de-identified, we will not share your protected health information in outside publications or educational settings such as professional meetings, conferences, or outside lectures without your specific consent.

Research. We may use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.



As Required by Law. We may use and disclose your protected health information when required to by federal, state, or local law. You may request an accounting of such disclosures at any time (refer to An Accounting of Disclosures paragraph on the next page for details).

To Avert a Serious Threat to Public Health or Safety. We may use and disclose your protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability, and, with parental permission, proof of immunization to a school where required by law. If directed by a health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Worker's Compensation. We may use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness in accordance with state law.

Inmates. We may use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others, or for the safety and security of the correctional institution.

Your Health Information Rights

Although your health record is the physical property of the practice, the information belongs to you. You have the right to:

A Paper Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking a team member at your next visit or by calling and asking us to send you a copy. You may also print a copy from our website at www.ColoradoDermatology.com.

Inspect and Copy. You have the right to inspect and obtain a copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. You may request an electronic copy of your information in a form you specify; however, if we are not able to provide the information in the form requested, we must contact you to determine a suitable alternative. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. If you wish to inspect or copy your medical information, you must submit your request in writing to our practice administrator at Colorado Center for Dermatology, PLLC, 8008 E. Arapahoe Rd., Suite 200, Centennial, CO 80112. You may mail in your request or bring it to our office. We have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed an additional 30 days to respond but must inform you of this delay in writing.

Request Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice administrator, stating exactly what information is incomplete or inaccurate and your reasoning that supports your request. We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if: (i) the information was not created by us, or the person who created it is no longer available to make the amendment; (ii) the information is not part of the record which you are permitted to inspect and copy; (iii) the information is not part of the designated record set kept by this practice; or (iv) if it is the opinion of the health care provider that the information is accurate and complete.

Request Restrictions. You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operations. For example, you could request that we not disclose information to your insurance carrier about a treatment that you paid for in full out of pocket. Your request must be made in writing to our practice administrator. Other than the example above, we are not required to agree to your request if we feel it is in your best interest to use or disclose that information.



However, if we do agree, we will comply with your request unless that information is needed for emergency treatment.

An Accounting of Disclosures. You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for the purposes of treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may request information about disclosures for any dates within the six years prior to the date of your request (our legal obligation to retain information). Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a reasonable cost-based fee for providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. Our practice may communicate electronically with patients through our patient portal, payment portal, website, telephone, practice email, individual team member or provider emails, and or text messages. You have the right to request how we communicate with you to preserve your privacy. For example – you may request that we call you only at your work number, or contact you by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests, and all such requests are valid until revoked in writing.

File a Complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice administrator or directly to the Secretary of Health and Human Services. To file a complaint with our administrator, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it attention to Privacy Officer, Colorado Center for Dermatology, PLLC. There cannot be retaliation for your filing a complaint.

Uses or Disclosures Not Covered

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. For example, if you request that we transfer your medical records to another provider, we will ask you to sign an authorization for us to do so. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

Facility Safeguards

Any non-patient or non-employee/affiliate who visits our office and enters any area, other than our main waiting room, must sign-in and wear a name tag to clearly identify themselves. Certain facilities may have security cameras and/or alarm systems in place, as necessary and appropriate.

For More Information

If you have questions or would like additional information, you may contact our practice administrator at (303) 761-0906.



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 form¹ 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, deposit² 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 refund³ 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)

REQUIRED⁴: 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 Payment⁵: _____ 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.