Thomas Dermatology
General, Surgical, Cosmetic

# New Patient Packet

Welcome to Thomas Dermatology! Please fill out all information as accurately as possible. If you are filling this out at home, please bring all attached pages. All answers are confidential. Thank you!

## Patient Information

Name: _____ Date of Birth (MM/DD/YYYY): _____

Age: _____ Gender: _____ Marital Status: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Mobile Ph: _____ Home Ph: _____ Email:_____

Height: _____ Weight: _____ Race: _____ Ethnicity: _____ Language: _____

**Seasonal Address (Temporary address that is only valid for a specific period of the year)**

Address: _____ City: _____ State: _____ Zip: _____

## If Patient is a Minor

Parent/Guardian: _____ Date of Birth: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Mobile Ph: _____ Home Ph: _____ Email:_____

## Emergency Contact

Name: _____ Relationship:_____

Phone: _____ Email:_____

## Primary Insurance

Name: _____ Policy #: _____ Group #: _____

Phone:_____ Address: _____ City: _____ State: _____ Zip:_____

Policy Holder: _____ Relationship:_____ DOB:_____

## Secondary Insurance

Name: _____ Policy #: _____ Group #: _____

Phone:_____ Address: _____ City: _____ State: _____ Zip:_____

Policy Holder: _____ Relationship:_____ DOB:_____

## Primary Care

Primary Provider: _____ Referring Provider: _____

## Pharmacy

Name: _____ Phone: _____

Address: _____ City: _____ State: _____

Zip: _____ Major Cross Streets: _____

Sign (Patient/Parent/Guardian): _____ Date: _____

## Review of Systems

☐ Easy Bruising ☐ Easy Scarring ☐ Excessive Bleeding ☐ Joint Pain ☐ Rash ☐ Immunocompromised

## Medical History

☐ Internal Cancer
Type/Year:_____
☐ COVID-19
☐ Asthma
☐ Seasonal Allergies
☐ Food Allergies
☐ Anxiety/Depression

☐ Hepatitis B
☐ Hepatitis C
☐ Tuberculosis
☐ HIV/AIDS
☐ Diabetes
☐ COPD

☐ Arthritis
☐ Thyroid Disorder
☐ Lupus
☐ Other Autoimmune Disease
Type:_____
☐ High Blood Pressure
☐ Heart Disease
Type:_____

☐ Alzheimer's
☐ Parkinson's
☐ Multiple Sclerosis
☐ Are you pregnant?
☐ Are you nursing?
☐ Other: _____
_____

## Surgical History

☐ Organ Transplant: Organ: _____ Year:_____
☐ Joint Replacement: Joint: _____ Year: _____
☐ Artificial Heart Valve: Type: _____ Year: _____
☐ Bone Marrow/Stem Cell Transplant: Year: _____

☐ Mohs Surgery or Skin Cancer Surgery
☐ Hysterectomy
☐ Pacemaker/Defibrillator
☐ Other: _____

## Skin History

☐ Acne
☐ Actinic Keratosis
☐ Basal Cell Carcinoma
☐ Have you had a blistering sunburn?
☐ Have you ever used a tanning bed?

☐ Dry Skin/Eczema
☐ Hair Loss
☐ Melanoma
☐ Do you use sunscreen? Y/N
☐ Do you work: Indoors/Outdoors

☐ Abnormal Moles
☐ Psoriasis
☐ Squamous Cell Carcinoma
☐ Other: _____

## Family History

☐ Melanoma ☐ Basal/Squamous Cell ☐ Asthma ☐ Allergies/Hayfever ☐ Eczema ☐ Psoriasis

### Medications/Supplements

_____
_____
_____
_____
_____
_____

### Allergies to Medications/Products

_____
_____
_____
_____
_____
_____

## Social History

Alcohol: Frequency: _____ Smoker: Frequency: _____

**Do you have an advance directive? (e.g., living will, healthcare power of attorney) Yes / No**

**Is this form being filled out by someone other than the patient? Yes / No Reason if Yes:** _____

Sign (Patient/Parent/Guardian): _____ Date: _____

# Understanding Your Visit, Insurance and Out of Pocket Costs

We know that insurance plans, billing terms, and medical costs **can be confusing and frustrating;** you're not alone. While it's ultimately your responsibility to know your coverage, our goal is to guide and support you as much as possible.

***Reading this will help avoid surprises and ensure the best possible experience during your visit.***

## Health Insurance Basics

- **Copay:** A set fee you pay when you check in (e.g., $25–$50).
- **Deductible:** The amount you pay out-of-pocket each year before insurance starts paying.
- **Coinsurance:** After meeting your deductible, you may still owe a percentage of the bill (e.g., 20%).

***These costs are set by your insurance company — not by us.***

## Why Your Visit May Include Extra Charges

Many dermatology visits involve procedures (treatments, biopsies, removals), which are billed separately from your office visit. We try to take care of issues the same day so you don't have to come back. When that happens, your insurance may apply your deductible and coinsurance, resulting in a higher bill — especially if you haven't met your deductible. This can lead to higher out-of-pocket costs than you may have expected when you check out after your appointment has concluded.

## How Dermatology Differs From Your Primary Care Provider

- Dermatology visits often include procedures, even during routine exams. Insurance treats these as separate, billable services.
- Unlike primary care, you may owe more than just your copay.

***We bill strictly based on what was done during the visit, per insurance rules.***

## Why We Don't Bill As Preventive Care

Dermatology visits are billed as specialist office visits, not preventive or "annual" wellness visits. Even if your appointment is for a routine skin check, insurance will process it under your specialist benefits and standard copay/deductible rules. Preventive visit coverage through your insurance generally applies only to your primary care provider.

## What a Typical Visit Might Look Like

**This is a general example of what a dermatology visit may look like—from check-in to follow-up—and how your insurance plan may determine what you owe.**

1. You arrive and pay your copay at check-in, which covers the office visit/exam.
2. During the visit, the provider finds a suspicious lesion and performs a biopsy, and may also freeze a few growths. These are separate procedures, billed in addition to the office visit.
3. At checkout, our front desk works with our clinical team to estimate your out-of-pocket cost based on your insurance plan.
4. If you have a deductible remaining or coinsurance, we may collect a portion of that amount before you leave.
5. The biopsy is sent to an outside lab, which may send you a separate bill based on your plan's benefits.
6. After insurance processes your claim, you may receive a bill from us for any remaining balance applied to your deductible or coinsurance.

**I acknowledge that I have read and reviewed the information above regarding my visit, insurance billing, financial responsibility, and how charges may be applied based on my insurance plan. I understand that the details provided are intended to help me better navigate my care and avoid unexpected costs.**

Sign (Patient/Parent/Guardian): _____ Date: _____

# Financial Policy | Assignment of Benefits

Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which you are required to read and sign prior to treatment.

- ALL FORMS MUST BE COMPLETED AND SIGNED PRIOR TO SEEING A PROVIDER.
- PLEASE PRESENT YOUR CURRENT INSURANCE CARD AND PHOTO ID AT EACH VISIT. IF YOUR COVERAGE CANNOT BE VERIFIED OR YOUR PLAN IS NOT ACCEPTED, OUR STAFF WILL REVIEW AVAILABLE OPTIONS WITH YOU BEFORE SERVICES ARE PROVIDED. SELF-PAY OPTIONS ARE SUBJECT TO APPLICABLE INSURANCE AND PROGRAM REQUIREMENTS.
- FULL PAYMENT IS DUE AT THE TIME OF SERVICE FOR CASH PATIENTS, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.
- CO-PAYS, CO-INSURANCE, AND DEDUCTIBLE PAYMENTS ARE DUE AT TIME OF CHECK-IN.
- WE ACCEPT CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER.
- ANY BALANCE OWED FROM PRIOR VISITS MUST BE PAID PRIOR TO ANY SUBSEQUENT VISIT.
- ALL ACCOUNTS 90 DAYS PAST DUE WILL BE AUTOMATICALLY ASSIGNED TO A COLLECTION AGENCY UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.
- IF YOUR ACCOUNT IS REFERRED TO A COLLECTION AGENCY, A COLLECTION FEE EQUAL TO 5% OF THE OUTSTANDING PRINCIPAL BALANCE WILL BE ADDED.
- APPOINTMENTS HAVE A 15-MINUTE GRACE PERIOD. BEYOND THAT TIME, YOU MAY BE REQUIRED TO RESCHEDULE.

## No-Show, Reschedule, and Cancelation Fees

- **Medical Office Visits:** Patients who no-show, or who fail to cancel or reschedule at least 24 hours in advance, will be charged a $50 fee.
- **Aesthetician Services:** Patients who no-show, or who fail to cancel or reschedule at least 24 hours in advance, will be charged a $50 fee.
- **Surgical Appointments:** Patients who no-show, or who fail to cancel or reschedule at least 24 hours in advance, will be charged a $100 fee.
- **Cosmetic Consultations:** Patients who no-show, or who fail to cancel or reschedule at least 24 hours in advance, will forfeit their consultation fee.
- **Cosmetic Packages:** Patients who no-show, or who fail to cancel or reschedule any services that are part of a package at least 24 hours in advance, will be charged a $100 no-show/cancellation fee.
- **Major Cosmetic Procedures (at least 20% deposit to schedule):** For larger cosmetic procedures requiring at least a 20% deposit, patients who no-show, or who fail to cancel or reschedule at least 7 days in advance, will forfeit their deposit.
- **Minor Cosmetic Procedures (deposit varies):** For smaller cosmetic procedures requiring a deposit, patients who no-show, or who fail to cancel or reschedule at least 24 hours in advance, will forfeit their deposit.
- **Payment Authorization:** Thomas Dermatology reserves the right to charge the credit or debit card on file for any applicable no-show fees, forfeited deposits, or missed appointment penalties as described above.

## Insurance Coverage

It is your responsibility to obtain any necessary referral or prior authorization information from your primary care physician prior to your appointment and bring a copy with you to your visit. If you do not have a referral or authorization number and your insurance company requires it, your appointment will be cancelled.

You hereby assign or otherwise authorize payment of medical benefits to us for the Services provided to you or your Covered Family Member. You authorize the release of any medical or other information necessary to process any claims for the Services provided. You further understand and accept your financial responsibility for any portion of the bill not covered by your health insurer or health plan. Submission of charges does not waive our right to seek payment directly from you.

I, the undersigned, do hereby authorize my insurance carrier(s) to pay directly to Thomas Dermatology the insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for any charges not covered by said insurance carrier(s), including copay and/or deductible amounts. I, the undersigned, do hereby also give my permission to Thomas Dermatology to furnish my insurance carrier(s) any and all information pertaining to my medical records.

**I have read the Financial Policy, Assignment of Benefits, and Insurance Coverage described above, and understand and agree to all provisions.**

Sign (Patient/Parent/Guardian): _____ Date: _____

# HIPAA Notice of Privacy Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

**Introduction**

At Thomas Dermatology, we are committed to treating and using protected health information about you responsibly. This notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective, and applies to all protected health information as defined by federal regulations.

**For More Information or to Report a Problem**

If you have questions and would like additional information, you may contact the practice's Privacy Officer, Mary Ann Lopez at 702-430-5333 Ext. 121. If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Building, Washington, D.C. 20201.

**Acknowledgment of Receipt of Privacy Notice**

At my request, I will be presented with a copy of Thomas Dermatology's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

_____

I have read the HIPAA Notice of Privacy Practices described above and understand and agree to all of its provisions.

Sign (Patient/Guardian): _____ Date: _____

Please allow access to my Protected Health Information (PHI) to my:

Spouse / Child / Parent / Guardian / Other

Name: _____

Sign (Patient/Guardian): _____ Date: _____

## Terms of Service and Patient Authorizations

By signing below, you acknowledge your understanding and agreement to our policies regarding medical records, communication, billing, and laboratory services, ensuring clarity and transparency throughout your care.

**Please initial and sign:**

____ I authorize Thomas Dermatology to receive, mail, fax and/or email my medical records to another physician or medical facility during the course of my diagnosis and treatment.

____ I authorize Thomas Dermatology to access my pharmaceutical records and history.

____ I understand that it is my responsibility to notify Thomas Dermatology of any changes to my information including mailing address, phone numbers, insurance policies, or any other information needed to contact me, collect payments, or carry out my treatment. All information presented today is accurate and current.

____ I authorize Thomas Dermatology to contact me by any method that I provide contact information for. I understand that if I do not want Thomas Dermatology to contact me using a specific method, I will not provide that applicable method.

____ I authorize Thomas Dermatology to send any specimen obtained through the course of my treatment to an outside laboratory. These lab's services are separate from those received from Thomas Dermatology and will be billed separately by that lab. Thomas Dermatology will make every effort to send the specimen to a lab within the insurance network, but it is my responsibility to inform Thomas Dermatology of a lab that is contracted with my insurance.

____ I understand that all co-pays, deductibles, and coinsurance are due at the time of service.

____ I understand that depending on my insurance plan (coinsurance, copay, and deductible), there may be additional costs beyond what I paid at check-in if a procedure was done today in-office. If I am unsure of what my out-of-pocket costs are, Thomas Dermatology will provide me with the proper CPT codes on request and reschedule my procedure for another day.

____ I authorize Thomas Dermatology to act on my behalf with my health insurance plan, pharmacy benefit manager, or pharmacy to request prior authorizations, coverage determinations, and to submit appeals and any required supporting documentation related to medications prescribed by my provider, including in the event that coverage for a medication is denied, delayed, or restricted by my insurance plan.

____ I understand that new minor patients must be accompanied by a parent or legal guardian for their initial appointment. Legal guardians must provide documentation of guardianship. After the initial visit, a parent or legal guardian may complete a Minor Consent Form authorizing the minor to attend future appointments alone or with an approved adult.

Print Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

# Medical Record Release

**Please only fill out the highlighted area**

**Please initial and sign:**

____ I, the undersigned, do hereby give permission to my physician's office identified below to furnish Thomas Dermatology with any and all information pertaining to my medical records.

____ I, the undersigned, do hereby give permission to Thomas Dermatology to furnish my physician's office identified below with any and all information pertaining to my medical records.

Physician Name: _____

Office: _____

Attn:_____

Address: _____

Phone: _____

Fax: _____

Requested Records: _____

____ I, the undersigned, do hereby request a copy of my protected health information from Thomas Dermatology. I understand that according to NRS 629.061, a copy of my medical records will be furnished within 30 days after the date or receipt of this request and that there may be a fee of $0.60 per page. I also understand that I may be required to pay the fee in full before a copy of my records will be released.

**Please address any medical records requests to:**

| Lake Havasu City | Kingman | Bullhead City |
|---|---|---|
| 1801 Mesquite Ave, | 1815 N Stockton Hill Rd, | 2350 Miracle Mile, 600A |
| Lake Havasu City, AZ 86403 | Kingman, AZ 86401 | Bullhead City, AZ 86442 |
| Phone: 928-377-4540 | Phone: 928-377-4540 | Phone: 928-377-4540 |
| Fax: 928-216-4165 | Fax: 928-216-4165 | Fax: 928-216-4165 |

Print Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____