

Kallgren Dermatology Clinic, P.C.
3434 47th Street, Suite #200
Boulder, CO 80301
303-444-8100
Email: kallgrenderm@comcast.net
Web Site: kallgrenderm.com

**FINANCIAL DISCLOSURE
FOR MEDICARE PATIENTS**

We are Medicare participating providers. We will bill Medicare and Medigap carriers. You as a Medicare patient will be responsible for payment of the following at the time of service:

- A. The annual deductible
- B. Co-Insurance (the 20% that Medicare allows but does not pay, see below)
- C. Co-payments of secondary insurance
- D. Charges for non-covered or cosmetic services

You will be required to sign a waiver of liability form in the event that a service is provided which is not covered by Medicare.

If you have Medicare as well as secondary coverage with a commercial plan that is not Medigap or is an insurance company with which we have no contract, we will collect the deductible, 20% and/or co-payment at the time the service is rendered.

Medigap is a Medicare supplemental policy offered by private insurance carriers to supplement "covered" services through Medicare. Medicare will "crossover" insurance claims to private insurers when the Medigap policy is in force. *NOTE* Not all secondary insurance policies are Medigap. Please check with the receptionist if you have a question regarding your secondary insurance.

Presently we are contracted with several HMO/PPO companies. Please check with the receptionist if you have a secondary plan. If it is one we are contracted with we will file your claim as a courtesy to you. However, if no payment is received from your secondary supplemental policy within 60 days of filing your claim you will be mailed a bill and be responsible to remit your balance due. If you do not have a secondary plan listed above we will collect the 20% of allowed charges and the deductible if applicable. You will then receive a receipt to send to your secondary insurance policy with your explanation of benefits when received.

Your signature below signifies that you have read and understand our financial policy and your responsibility regarding charges incurred in this office.

Patient Signature

Date

I request authorized Medigap benefits be made on my behalf for any services rendered to me. I authorize any holder of medical information to release to the Medigap carrier any information needed to determine benefits payable for related services.

Patient Signature

Date

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**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM**

KALLGREN DERMATOLOGY CLINIC

I. _____ have read a copy of Kallgren Dermatology Clinic's
Notice of Patient Privacy Practices.

Signature of Patient or Parent/Legal Guardian

Date

If you would like this office to be able to discuss your information with another person or family member please authorize this request below.

Name of person we can discuss your information with

Relationship

The above authorization can be revoked in writing at any time.

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NOTICE OF PRIVACY PRACTICES AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

EFFECTIVE DATE OF THIS NOTICE: May 15, 2008

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF KALLGREN DERMATOLOGY CLINIC) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (PHI). In conducting our business we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By Federal and State law we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws can be complicated but are required to provide you with the following information:

- 1) How we may use and disclose your PHI.
- 2) Your privacy rights in your PHI.
- 3) Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that we may create or maintain in the future. Our practice will post a copy of our current Notice on our website and in our office in a visible location at all times, and you as our patient may request a copy of our current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT:

The practice manager at your location of treatment or Kevin Maguire, Privacy Official for Kallgren Dermatology Clinic, P.C.- telephone number 303-444-8100.

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:

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The following categories describe the ways in which we may use and disclose your PHI:

1. Treatment. The information in your medical records will be used to determine which treatment option best addresses your health needs. The treatment selected will be documented in your medical records so that other health care professionals can make informed decisions about your care. For example, we may request you have laboratory tests and we may use the results of those test to reach a diagnosis. Many of the people who work for our practice, including but not limited to our healthcare providers and staff, may use or disclose your PHI in order to treat you or assist others in your treatment. Additionally, we may disclose your PHI to other who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other healthcare providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services, treatments, and products you may receive form us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We may also use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services, treatments and items. We may disclose your PHI to other healthcare providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other healthcare providers and entities to assist in their healthcare operations.

4. Appointments and Reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment or as a follow up on treatment or services performed. This contact may be via telephone, in writing either by letter or post card, email, or by leaving a message on your answering machine, or otherwise which could (potentially) be picked up by others.

5. Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options and alternatives. We may treat you in an open treatment area and some incidental PHI may be overheard by other patients being treated at the same time.

6. Health Related Benefits and Services. Our practice may use and disclose your PHI to inform you of health related benefits or services that may be of interest to you. For example, we may send you newsletters that may include information about our practice, health related issues, and products and services.

7. Release of Information to family/Friends. Our practice may release your PHI to a friend or family member that is involved in your care or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to the child's medical information.

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8. Disclosure Required by the Law. Our practice will use and disclose your PHI when we are required to do so by Federal, State or Local Law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- A. maintaining vital records, such as births and deaths;
- B. reporting child abuse or neglect;
- C. preventing or controlling disease, injury, or disability;
- D. notifying a person regarding potential exposure to a communicable disease.

Medical History Form

Patient: _____ Date of Birth: ____/____/____ Today's Date: ____/____/____

Reason for today's visit: _____

Are you allergic to any medications? YES NO If yes, list below:

1. _____ 2. _____

Have you ever had dental anesthesia (Novocaine)? YES NO Any adverse reaction? YES NO

List all medications you are currently taking (including prescriptions, over-the-counter medications, vitamins, and herbals):

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs	YES	NO	Other Systemic:	YES	NO
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular	YES	NO	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	What Type? _____		
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Yeast Infection	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	when taking antibiotics		
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
			Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

List any other major surgeries in your lifetime: _____

Skin: Have you ever had skin cancer? YES NO

Has anyone in your family had skin cancer? YES NO

Do you have a history of any specific skin diseases? YES NO If yes what? _____

Do you have problems with healing YES NO

Do you develop keloids (scars) after surgery YES NO

Do you bleed easily? YES NO

Do you develop skin rashes in reaction to Medications Food Environment Bandages Topical Neosporin

(Other _____)

Social History:

Do you drink alcohol? YES NO If YES _____ drinks per day

Do you use IV drugs? YES NO If YES, what? _____ How often? _____

Do you smoke? YES NO If YES, how much: _____

Have you had or have you been exposed to HIV (AIDS) ? YES NO

Please answer the following questions: **(Women) Are you pregnant?** YES NO Due Date: ____/____/____

What is your occupation? _____ Hobbies? _____

Completed by: Patient _____ / ____ / ____ Medical Assistant _____

Signed by Patient Date _____ / ____ / ____

Reviewed by

Date

SSN: _____ BIRTHDATE: _____ AGE: _____ SEX: _____

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____ HOME PHONE: _____

Street

WORK PHONE: _____

Zip Code

City

State

CELL PHONE: _____

MARITAL STATUS ___S___M___W___DP SPOUSE NAME: _____ BIRTHDATE: _____

EMPLOYER (IF MINOR, PARENTS): _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____ PHONE #: _____

Street

City

State

Zip Code

EMERGENCY CONTACT: _____ PHONE #: _____ RELATIONSHIP: _____

PERSON RESPONSIBLE FOR PAYMENT: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE #: _____

Street

City

State

Zip Code

METHOD OF PAYMENT: ___CASH___CHECK___CREDIT CARD **REFERRED BY:** _____

Physician, Friend Relative, Other

PRIMARY CARE DOCTOR: _____

ADDRESS: _____ PHONE #: _____

Street

City

State

Zip Code

OTHER PHYSICIAN SPECIALISTS: _____ **PHARMACY:** _____ **PHARM PH#:** _____

MEDICARE PATIENTS

PLEASE PRESENT INSURANCE CARDS AND PHOTO ID TO THE RECEPTIONIST SO COPIES CAN BE MADE.

Have you met your Medicare yearly deductible? ___Yes___ No Secondary yearly deductible? ___Yes___ No

Have you recently joined an HMO? If yes, identify: _____

Are you covered by an HMO/PPP which makes Medicare your secondary insurance? ___Yes___ No

Primary Insurance Name: _____ Secondary Insurance Name: _____

Medicare ID#: _____ Secondary Insurance ID#: _____

(Medicare patients are fully responsible for their yearly deductible and 100% of the allowable Medicare Fee. Medicare pays 80% of this fee. You, the patient, are responsible for the full 20% Medicare does not pay. This includes any amount of the 20%the coinsurance does not pay.)

INSURED RESPONSIBILITY: It is understood that services rendered by the doctor are to the patient, not to the insurance company, and that the patient and the undersigned are responsible for the payment of such services. It is not the responsibility of the doctor to collect from the insurance company. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. All returned checks (NSF, Account Closed, Refer to Maker, or Uncollected Funds) are subject to a \$40 service charge and cost of collection fee. In consideration of any services rendered by Dr. Diane L. Kallgren, or associated health care provider, I agree to be responsible for the payment of all services notwithstanding any insurance coverage I may have. If it is necessary for Dr. Kallgren to employ anyone, including attorneys, to collect such payments, then I shall be responsible to pay reasonable fees and costs, as well as a \$25 surcharge, in addition to said payment.

I certify that the information given by me in applying for payment under Title IVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to any referring physician, consultants as needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to Dr. Diane Kallgren.

Do we have your permission to:

- 1) leave a message on your answering machine at home? ___Yes___ No
- 2) discuss your medical condition with any member of your family? If yes whom? _____ Relationship: _____

PATIENT SIGNATURE/LEGAL GUARDIAN

DATE