

Kallgren Dermatology Clinic, P.C.  
3434 47<sup>th</sup> Street, Suite #200  
Boulder, CO 80301  
303-444-8100  
Email: [kallgrenderm@comcast.net](mailto:kallgrenderm@comcast.net)  
Web Site: [kallgrenderm.com](http://kallgrenderm.com)

**FINANCIAL DISCLOSURE  
FOR NON-MEDICARE PATIENTS**

As a contracted provider with my insurance company which is \_\_\_\_\_ at the present time, Diane L. Kallgren has agreed to file a claim for services rendered. Moreover, I understand that some or all of the services which are to be provided may not be deemed “covered” services under my particular plan. I will be responsible to pay Diane L. Kallgren, M.D. for any co-payment as instructed by my insurance company, and unsatisfied deductible or termination of coverage, any amount considered non-covered by my insurance company deems my responsibility, and any amount considered non-covered by my insurance company. Should my insurance company or any benefits provided by that insurance company change I will immediately notify Diane L. Kallgren, M.D. of that change.

In addition, I am aware that said co-payment, unsatisfied deductible, and 100% deemed my responsibility for all physician charges should the above criteria not be met.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION PROVIDED TO ME AND AGREE TO BE FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED BY DIANE L. KALLGREN, M.D.

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Patient’s Name \_\_\_\_\_ Signature \_\_\_\_\_

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Subscriber’s Name \_\_\_\_\_ Signature \_\_\_\_\_

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Witness \_\_\_\_\_ 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.

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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.

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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 IDENTIFYABLE 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

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 (Novocain)?  YES  NO Any adverse reaction?  YES  NO

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

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

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

<b>Lungs:</b>	<b>YES</b>	<b>NO</b>	<b>Other Systemic:</b>	<b>Yes</b>	<b>No</b>
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"/>
<b>Cardiovascular:</b>	<b>YES</b>	<b>NO</b>	☯☹☺◆✦✧✨		<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"/>
<b>Pacemaker</b>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infection		
Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>	when taking antibiotics	<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 life: \_\_\_\_\_

**Skin:** Have you ever had skin cancer?  YES  NO What  
type? \_\_\_\_\_

Has anyone in your family had skin cancer?  YES  NO Was it  
melanoma? \_\_\_\_\_

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

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?  
\_\_\_\_\_

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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 \_\_\_\_\_

Initials

\_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_

Signed by Patient

Date

\_\_\_\_\_

Reviewed by

Date

SSN: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

Street

Zip Code \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

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# \_\_\_\_\_

### INSURANCE

NAME OF INSURANCE \_\_\_\_\_ PHONE# \_\_\_\_\_ GROUP #: \_\_\_\_\_

SOCIAL SECURITY OR ID# \_\_\_\_\_ NAME OF INSURED \_\_\_\_\_

ADDRESS OF INSURANCE COMPANY: \_\_\_\_\_

Street City State Zip Code

IF STUDENT  FULL TIME  PART TIME NAME OF SCHOOL \_\_\_\_\_

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.

PPO PATIENTS: I understand that if my insurance company refuses to pay for services rendered because they feel the services are not medically necessary or is pre-existing, that I am responsible to pay the balance in full promptly.

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 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