Dermatology and Laser Institute of Colorado, P.C.
9695 S. Yosemite Street, Suite 175
Lone Tree CO 80124

INSTRUCTIONS FOR PAPERWORK

Welcome to **Dermatology and Laser Institute of Colorado** and **nV DermSpa**! And welcome to an innovative, yet traditional approach to practicing medicine! Whether you are a new or long-time patient, we are thrilled that you have entrusted your care to us. We plan to exceed your expectations!

We are a **direct pay (cash pay) practice** which means that we do **not** participate with any insurance or government healthcare program, including Medicare, Medicaid, and ANY commercial insurance plan. Dr. Ort is an **out-of-network** provider for ALL insurance plans. Patients pay a reasonable fee for their care, in full, at the time of service. We do not work for insurance companies or the government. **We work for you.**

Our streamlined registration process eliminates the need for insurance cards, prior authorizations, and referrals. The following are the forms that you will be asked to complete. Thank you.

1. REGISTRATION (2 pages)

2. FINANCIAL and HIPAA POLICY (2 pages)

3. MEDICARE and MEDICAID FORM (1 page)

4. MEDICAL HISTORY (1 page)

Please note: For HIPAA and patient identification purposes, we will request a photo ID to be scanned and stored according to our Privacy Policy.

About Your Doctor

Dr. Richard J. Ort, M.D. is a Board-Certified Dermatologist who founded the practice in 2001. Dr. Ort has extensive training in medical, surgical, and cosmetic dermatology.

Highlights of Dr. Ort's training include:

- **Princeton University** Undergraduate Degree
- **Columbia University** Medical Degree
- **University of Pennsylvania** Internship in Internal Medicine
- **Emory University** Residency in Dermatology
- **Harvard University** Fellowship in Laser, Cosmetic, and Skin Cancer Surgery

· 20+ years experience in dermatology
· Recognized expert in laser surgery with 10 state-of-the-art lasers
· Expert injector of botulinum toxin and fillers for facial and body rejuvenation
· 15+ years as volunteer faculty member teaching surgery at the Denver VA Medical Center
· 20+ years providing dermatology instruction to medical students and residents
· Broad experience as an expert in medical malpractice and peer review cases

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REGISTRATION (PAGE 1)

Today's Date _____/_____/_____

Name _____
(Last) (First) (Middle Initial)

Mailing Address_____
(Street)

_____
(City) (State) (Zip)

Home Phone (_____)_____ Date of Birth _____/_____/_____ Age _____

Cell Phone (_____)_____ Social Security Number _____

Sex M / F Marital Status S / M / D / W
(Circle One)

FINANCIALLY RESPONSIBLE PARTY

□ Same as patient □ Other than patient, relationship _____

Name _____
(Last) (First) (Middle Initial)

Mailing Address_____
(Street) (City) (State) (Zip)

Home Phone (_____)_____ Cell Phone (_____)_____

EMERGENCY CONTACT

In case of an emergency, who may we contact?

Name _____ Relationship _____ Phone (_____)_____

Mailing Address_____
(Street) (City) (State) (Zip)

REFERRAL AND PHYSICIAN INFORMATION

How did you hear about us? □ Website □ Online Search □ RealSelf □ Mailer □ Printed Ad

□ Patient Referral (Name) _____ □ Doctor Referral (Name) _____

□ Other _____

Your Primary Care Physician_____

Other family members that are patients_____

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REGISTRATION (PAGE 2)

Patient Name: _____

PREFERRED PHARMACY

Pharmacy Name_____ Phone_____

Location or Cross Streets_____

APPOINTMENT CONFIRMATIONS

Our office will text or email you with appointment reminders. Please provide the following:

Phone (_____)_____ Email _____@_____

I would like to receive promotions or other information from the practice via email: □ Yes □ No

CONFIDENTIAL COMMUNICATION

Email: To protect your privacy, we do not generally use email to communicate with you. If you wish to send us email, we will provide instructions on how to send end-to-end encrypted email. If you send an email which is not end-to-end encrypted, you assume all security and privacy risks.

Lab Tests: You may require a skin biopsy or other lab test. Results are typically available in one week or less. Do not assume that results are negative if you have not heard from the office. Please call our office if you have not received your results within two weeks of the biopsy or test.

Please fill in as appropriate:

I authorize to be notified of medical results at this phone number: (_____)_____

I authorize messages with medical results to be left at this number: (_____)_____

I authorize messages with medical results to be left with certain individuals at these phone numbers:

Name _____ Relationship _____ (_____)_____

Name _____ Relationship _____ (_____)_____

By signing this form, you consent to allow our office to communicate with you by the means designated above. This consent will remain in effect unless revoked by you.

x_____ **_____/_____/_____**
Patient or Guardian Signature **Date**

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FINANCIAL POLICY (PAGE 1)

Patient Name: _____

1. **Out-of-Network.** We do NOT participate with ANY commercial insurance or government healthcare plan. This includes Medicare, Medicaid, Medigap, Tricare and any other health insurance plan. **Dr. Ort is an OUT-OF-NETWORK provider for ALL insurance plans.** Dermatology and Laser Institute of Colorado is NOT an in-network facility with any insurance plan.

2. **Payment. Payment in full is required for all services before you leave our office**. We accept cash, check, credit cards, and debit cards, including HSA cards for qualified services. A deposit or prepayment may be required prior to scheduling some procedures.

3. **Pricing.** The fee for your visit is based on time spent with Dr. Ort. There are three different pricing levels depending on procedures performed. Our fee schedule is posted on our website.

4. **Telemedicine.** The fee for a telemedicine or video visit is the same as for a regular visit.

5. **Cosmetic.** Cosmetic services are billed under a separate fee schedule.

6. **No Emergency Services.** We are not an emergency facility and do not provide emergency services.

7. **No Surprise Billing.** Federal law (No Surprises Act) provides consumers with rights and protections against surprise medical bills. When you get emergency services or get treated by an out-of-network provider at an in-network facility, you are protected from surprise billing or balance billing. Please refer to the notice entitled “Your Rights and Protections Against Surprise Medical Bills.”

8. **Insurance Reimbursement.** Your insurance company may reimburse you under out-of-network coverage, depending on your specific benefits. If you would like to file for reimbursement, for a nominal fee we will provide a form with the CPT and ICD-10 codes that you can submit to your insurance carrier. Please note that it is your responsibility to understand your plan’s out-of-network coverage. We do not make any promises that your claim will be reimbursed partially or in full. If you have questions, please contact your insurance company or benefits manager.

9. **Medicare.** Medicare rules require that all patients sign a one-page private contract with Dr. Ort acknowledging that medical services will not be covered and that a claim will not be submitted to Medicare. This applies both to traditional Medicare as well as Medicare Advantage plans. Please note that any prescriptions or tests from Dr. Ort will still be covered by Medicare.

10. **Medicaid.** Under Colorado law, Medicaid patients cannot be billed for any medical service covered by Medicaid, even if the patient agrees in advance to self-pay for the care. We can treat Medicaid patients only for cosmetic services that are not covered by Medicaid.

11. **FSA/HSA.** Flexible Spending Accounts (FSA) or Health Savings Accounts (HSA) can be used to pay for non-cosmetic services.

12. **Labs.** If you need any biopsy tests or lab work, you will receive a separate bill from the lab. If you have insurance, you may choose to have these services billed to your insurance. We have negotiated discounted lab fees for our self-pay patients.

13. **Prior Authorizations.** There is a $25 charge to complete a medication prior authorization.

14. **Forms.** There is a $25 charge to complete FMLA forms, cancer policy forms, etc.

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FINANCIAL POLICY (PAGE 2)

Patient Name: _____

15. **Skin Care Products.** All product sales are final. No refunds will be issued.

16. **Legal.** Any legal documents for Guardianship or Power of Attorney must be presented at the time of service. All legal documents must be original copies.

17. **Children.** All children under 18 years of age must be accompanied by a parent or legal guardian on the first visit as per Colorado law. The parent or legal guardian must sign an authorization form if the child is to be seen alone during routine follow-up visits.

18. **Cancellations.** If you need to cancel an appointment, please provide at least two business days notice. If you are scheduled for a procedure and fail to provide the above notice, or fail to show up, you will be assessed a minimum cancellation fee of $100.00. You will be unable to schedule any new appointments until the fee is paid.

19. **Fees.** There is a $50.00 fee for any check returned by our bank or for any credit card transaction that is returned by our merchant banker. There is a $50.00 fee if your account is sent to a collections agency.

    I attest that I have read and understand the above information and that any questions have been explained to my satisfaction. **I agree to comply with the terms of this financial policy and to pay in full for all services rendered at the time of my visit.**

x_____ _____/_____/_____
Patient or Guardian Signature **Date**

HIPAA POLICY

Our practice is dedicated to maintaining the privacy of your Protected Health Information (PHI). We are required by law to maintain the confidentiality of this PHI under the Heath Insurance Portability and Accountability Act (HIPAA). We cannot release or discuss PHI with spouses, parents of dependents who are 18 or older, or parents acting as caretakers for disabled or aged adults unless express legal documentation has been provided. Patients who would like us to discuss or disclose PHI to a designated family member, friend, or caretaker must sign a release form permitting such disclosure.

Your signature below signifies that you have been notified and offered a copy of our Notice of Privacy Practices.

x_____ _____/_____/_____
Patient or Guardian Signature **Date**

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MEDICARE & MEDICAID

Patient Name: _____

Please answer Questions 1 and 2 and sign below.

1. Do you have MEDICARE?

All patients must initial on ONE of the following lines.

_____ **INITIAL** No. I (or my dependent) **AM NOT** currently enrolled in Medicare, including Original Medicare, a Medicare Advantage Plan, or any other Medicare plan, whether as a primary, secondary, or tertiary plan.

OR

_____ **INTIAL** Yes. I (or my dependent) **AM** enrolled in Medicare or a Medicare plan, whether as a primary, secondary, or tertiary plan. I understand that Dr. Ort has opted out of Medicare. I understand that Medicare rules require that I sign a one-page private contract with Dr. Ort indicating that medical services will not be covered by Medicare.

2. Do you have MEDICAID?

All patients must initial on ONE of the following lines.

_____ **INITIAL** No. I (or my dependent) **AM NOT** currently enrolled in Medicaid or any Medicaid plan, whether as a primary, secondary, or tertiary plan.

OR

_____ **INITIAL** Yes. I (or my dependent) **AM** currently enrolled in Medicaid or a Medicaid plan, whether as a primary, secondary, or tertiary plan. I understand that, in compliance with Colorado law, this office does not treat Medicaid patients for medically-necessary care. I am seeking purely **COSMETIC** services which are not medically necessary.

I hereby attest to the above.

x_____ _____/_____/_____
Patient or Guardian Signature **Date**

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MEDICAL HISTORY

Patient: _____ D.O.B.: _____ Date: _____

What is the primary reason for your visit? _____

Please list all medications that you are currently taking: _____

_____

_____

Are you allergic to any medications? ☐ **Yes** ☐ **No** ***This is important;*** **i**f Yes, please list on the line below:

_____

Do you now have, or have you ever had, diseases or conditions of:

Lungs	**Yes**	**No**	**Other**	**Yes**	**No**		**Yes**	**No**
Emphysema	☐	☐	Excessive Bleeding	☐	☐	Cold Sores	☐	☐
Asthma	☐	☐	Excessive Clotting	☐	☐	Keloids	☐	☐
Pulmonary Embolus	☐	☐	Diabetes	☐	☐	Abnormal Healing	☐	☐
On Supplemental Oxygen	☐	☐	Thyroid	☐	☐	Cancer	☐	☐
Cardiovascular	**Yes**	**No**	Kidney	☐	☐	"type"		
High Blood Pressure	☐	☐	Bladder	☐	☐	Radiation Treatment	☐	☐
Chest Pain	☐	☐	Stomach or Bowel	☐	☐	Depression	☐	☐
Heart Attack	☐	☐	Liver or Hepatitis	☐	☐	Psychiatric Problem	☐	☐
Artificial Valves	☐	☐	Artificial Joints	☐	☐	Do You Smoke	☐	☐
Heart Murmurs	☐	☐	Arthritis	☐	☐	Drink Excess Alcohol	☐	☐
Mitral Valve Prolapse	☐	☐	HIV / AIDS	☐	☐	Do You Use Drugs	☐	☐
Rheumatic Fever	☐	☐	Stroke	☐	☐	Do You Sunbathe	☐	☐
Atrial Fibrillation	☐	☐	Seizures / Epilepsy	☐	☐	Use Tanning Beds	☐	☐
Pacemaker	☐	☐	Fainting	☐	☐	Use Sun Screen	☐	☐
Internal Defibrillator	☐	☐	Auto-Immune Disease	☐	☐	**Females –** (Only)	**Yes**	**No**
Irregular Heart Beat	☐	☐	Ever Taken Accutane®	☐	☐	Pregnant	☐	☐
						Trying To Get Pregnant	☐	☐

Please list any other disease or condition: _____

Skin: Have you ever had skin cancer? ☐ Yes ☐ No If Yes, please list type and location (if known)
(For example, TYPE for skin cancers are: basal cell cancer, squamous cell cancer, malignant melanoma)

Type: _____ Location: _____

Has anyone in your family had skin cancer? ☐ Yes ☐ No If Yes, please list type and location (if known)
Type: _____ Location: _____

Do you have a history of specific skin diseases? ☐ Yes ☐ No If Yes, please list details

_____

On a scale of 1 to 10 how would you rate the appearance of your skin? (circle one) 1 2 3 4 5 6 7 8 9 10
Need Help **Average** **Very Good**

What is your occupation? _____
What are your hobbies? _____

Are you interested in learning more about our Cosmetic Services and / or nV Skin Care products? ☐ Yes ☐ No

_____ _____
Reviewed and signed by provider Date

Information above corrected and re-reviewed

Provider Initial/Date	Provider Initial/Date	Provider Initial/Date	Provider Initial/Date	Provider Initial/Date	Provider Initial/Date