**FLATIRONS DERMATOLOGY ANNUAL PAPERWORK**

(To be completed yearly by **ALL** patients)

**PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME OF YOUR PRIMARY CARE PHYSICIAN** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY CARE PHYSICIAN PHONE NUMBER** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHARMACY NAME, PHONE NUMBER, & CITY**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the preferred phone number(s) to call you regarding any financial, insurance, or medical information:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** May we leave a voice message? **[ ] YES [ ] NO**

Are there any family member(s) we can speak to regarding your medical information? **[ ] YES [ ] NO**

If **YES**, please give name(s) and relationship to the patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT CLINICAL DIAGNOSIS AND TREATMENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby give consent to the clinical staff of **Flatirons Dermatology** to examine, treat, and counsel me. I understand there are certain hazards and risks connected with all forms of treatment and my consent is given with this knowledge.

**INITIAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HEALTH INFORMATION CONSENT AND PATIENT PORTAL**

**My Authorization (PLEASE CHECK ONE)**

 [ ] You may disclose non-urgent and benign medical results to me via the secure online medical records portal.

 [ ] You may **NOT** disclose non-urgent and benign medical results to me via the secure online medical records portal.

I may revoke this authorization in writing. If I revoke this authorization, it does not affect any actions taken by **Flatirons Dermatology** based upon this authorization.

**INITIAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have reviewed a copy of **Flatirons Dermatology** Notice of Privacy Practice Information Form. I also acknowledge that if I would like a copy of the Notice of Privacy Practice Information Form that I will request one from Flatirons Dermatology Front Desk Team.

**INITIAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT FINANCIAL RESPONSIBILITES**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have reviewed **Flatirons Dermatology Patient Financial Responsibilities** Policy and agree to all terms. I also acknowledge that if I would like a copy of the Patient Financial Responsibilities that I will request one from Flatirons Dermatology Front Desk Team.  I hereby authorize Flatirons Dermatology and its employees, agents, and assignees to contact me via e-mail and text messaging, and to my cellular devices.

**INITIAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



Christopher M. Smith, MD

Chante K. Aksut, MD

Wendy R. Ortiz, PA-C

Ben R. Kochman, PA-C

**\*FOR OFFICE USE ONLY\***

PATIENT INFORMATION

Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_
Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION TO / FROM FLATIRONS DERMATOLOGY

(This release expires 1 year from the date of signature or upon written notification)

I hereby authorize the release of information from my medical records as indicated below.

Records released TO / FROM

Physician/Clinic Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Records released TO / FROM

Flatirons Dermatology

13605 Xavier Lane, Suite B

Broomfield, CO 80023

Phone: (303) 404-3376

Fax: (303) 468-8793

THE TYPE OF INFORMATION TO BE DISCLOSED AS FOLLOWS:

\_\_\_\_\_\_\_All Information in chart \_\_\_\_\_\_\_Laboratory Reports

\_\_\_\_\_\_\_Financial Information \_\_\_\_\_\_\_Pathology and associated Procedure Reports

\_\_\_\_\_\_\_Medical Information \_\_\_\_\_\_\_Substance abuse if any

I request and authorize the release of information to/from the organization, agency, or individual name above. I understand that the information to be released may include the following condition(s). Drug abuse/alcohol abuse (Fed. Reg.42 C.F.R, Part 20). Psychological or psychiatric conditions/HIV antibody test which causes AIDS. An AIDS diagnosis and/or and AIDS related condition/third party source receive treatment from Flatirons Dermatology. I understand that any disclosure of information carries with it the potential for and unauthorized re-disclosure of information may not be protected by federal confidential rules. I have a right to revoke the authorization in writing to Flatirons Dermatology.

I UNDERSTAND THERE MAY BE A CHARGE FOR THIS SERVICE ACCORDING TO COLORADO STATUTE (6CCR 1101-1, RULE XIV). $18.00 for the first 10 pages, $0.85 pages 11-39 and $0.57 for pages 41 and above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient / Agent / Guardian Signature Date