Academic Dermatology of Nevada
The smart approach to skin disorders.

Curt Samlaska, MD, FACP, FAAD
Kristine Herlevi, PA-C
2839 St. Rose Parkway, Suite 100
Henderson, NV 89052
(702) 837-8988, Fax (702) 990-5269

New Patient Information

Patient Name: _____ Ethnicity:_____ Age: _____ Sex: **M** **F**

Address: _____ Language: _____ Date of Birth: _____

City: _____ State:_____ Zip: _____ SSN _____-____-_____

Telephone: (H)_____ (W)_____ (C)_____ Occupation: _____

Employer: _____ Address:_____

Primary Insurance

Insurance Co. Name: _____ Phone: _____ Policy # _____

Insurance Co. Address: _____
Street/P.O. Box City State Zip

Insured's Name: _____ SSN: _____ DOB: _____Relation:_____

Insured's Employer: _____ Employer's Phone # _____

Secondary Insurance

Insurance Co. Name: _____ Phone: _____ Policy # _____

Insurance Co. Address: _____
Street/P.O. Box City State Zip

Insured's Name: _____ SSN: _____ DOB: _____Relation:_____

Insured's Employer: _____ Employer's Phone # _____

EMERGENCY CONTACT- Name: _____ Phone # _____

Address: _____ Relationship: _____

Physician /Person who referred you: _____ Phone # _____

Address: _____

Treatment and Financial Responsibility Statement

A. I hereby request treatment by Academic Dermatology of Nevada. Such treatment may include testing and/or surgical procedures.

B. I, (Guarantor/Patient) _____, accept responsibility to pay for all services rendered to me or (Patient/Minor) _____.

C. In consideration of my relationship to the patient and of Academic Dermatology of Nevada, rendering medical services to said patient, I, _____ undertake to be financially responsible for and agree to pay, upon request, for all services rendered to the patient. I agree the obligation of the undersigned is an original, direct, independent, and positive promise to pay based on the executive credit of the undersigned and is not a collateral or contingent promise to answer the debt of another. In the event of default on payment due, I agree to pay all costs of collections including any attorneys fees and court costs.

Insurance Assignment

A. This will authorize the filing of insurance claims on my behalf and assign payment directly to Curt Samlaska, M.D. for any and all amounts due for services provided in accordance with my insurance policy/policies.

B. I understand that my insurance policy is a contract between me and my insurance company and that I am financially responsible to Curt Samlaska, M.D. for any fees not covered by my insurance policy.

C. I hereby authorize the release of information acquired in the course of the examination and/or treatment to my insurance carrier and/or my primary care physician as needed or required.

Signature of Guarantor/Responsible Party: _____

Date: _____ **Email Address:** _____

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Medical History Form

Date of Visit: _____ **Date of Birth:** _____ **Age:** _____ **Gender: M F**

Reason for dermatology visit? _____

Medical Conditions

☐ **None OR Write "P" for Past and "C" for Current Problem (Use other* if problem not listed).**

____ Gout
____ Osteoarthritis
____ Rheumatoid Arthritis
____ Osteoporosis
____ Scoliosis
____ Fracture / Broken Bone
____ Cerebral Palsy
____ Dementia
____ Neuropathy
____ Seizure Disorder

____ Heart Disease
____ High Blood Pressure
____ High Cholesterol
____ Stroke
____ Blood Clots / DVT
____ Pulmonary Embolism
____ Asthma
____ Chronic Bronchitis
____ COPD
____ Anemia

____ Bleeding Disorder
____ Sickle Cell Trait / Disease
____ Diabetes
____ Thyroid Disorder
____ Liver Disease
____ Hepatitis
____ Ulcers / Reflux
____ Kidney Disease
____ Pregnant
____ Breastfeeding

____ Cancer Hx (history):
Type: _____

Psychological Disorders:
____ Depression
____ Drug Abuse
____ Alcohol Abuse
Other: _____
____ HIV / AIDS
____ Hx Hepatitis: A B C
Other: _____

List Drug Allergies & Reactions	**Current Medications,** **None:** ☐		**List Past Surgery & Dates,** **None:** ☐

☐ **None**

Family History

☐ **Unknown/Adopted OR indicate if any of your blood relatives have had any of the following conditions**

____ Skin Cancer
____ Melanoma
____ Hay Fever / Allergy
____ Atopic Dermatitis
____ Psoriasis

____ Eczema
____ Rheumatoid Arthritis
____ Osteoporosis
____ Muscle Disorders
____ Heart Disease

____ High Blood Pressure
____ Respiratory Disease
____ Blood Disease
____ Bleeding Disorder
____ Diabetes

____ Kidney Disease
____ Depression
____ Cancer:
Type: _____
Other: _____

Social History

Tobacco Use: **Non Smoker:** ☐
____ Former Smoker
Year Quit _____
____ Current smoker, # Pack/day _____
Years _____

Alcohol Use: **Never:** ☐
____ Rarely
____ Weekly
____ Daily
How much daily: _____

Marital Status: **Other:**
____ Single
____ Married
____ Divorced
____ Widowed

Do you have an advance directive? ……no yes
Are you a victim of violence or abuse? ……..no yes
Have you had a flu shot this year? ……..…..no yes
Have you had a pneumonia shot? ……no yes
Have you been hospitalized for any reason? ……....no yes

Name of Primary Care Provider if applicable: _____

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Review Of Symptoms

Patient Name: _____ **Date:** _____

Name of Primary Care Provider (PCP): _____ **Send letter to PCP?** **No** **Yes**

PLEASE INDICATE BELOW. ARE YOU *CURRENTLY* EXPERIENCING ANY OF THESE SYMPTOMS:

General, constitutional **None:** ☐
Chills
Fatigue
Fever
Night sweats
Weight loss

Eyes and vision **None:** ☐
Difficulties/Vision
Blurry or double vision
Eye disease
Glaucoma

Ears, nose, throat **None:** ☐
Nasal or mouth sores
Nasal or mouth dryness
Nose bleeds
Hearing loss
Ringing in ears
Loss of smell
Mouth and or gum disease
Sore Throat

Heart and Cardiovascular **None:** ☐
Heart trouble or murmur
Chest pains
Sudden heartbeat changes
Swelling of feet, ankles, hands

Respiratory **None:** ☐
Coughing or shortness of breath
Sputum production
Wheezing
Coughing up blood

Gastrointestinal **None:** ☐
Nausea or vomiting
Black or tarry stools
Blood in stools
Abdominal pain
Change in bowel movements
Constipation
Diarrhea

Endocrine **None:** ☐
Hormonal problems
Heat or cold intolerance
Dry skin
Swollen glands
Excessive thirst
Excessive urination
Thyroid disease

Musculoskeletal **None:** ☐

Muscle pain or cramps	no	yes
Back pain	no	yes
Cold extremities	no	yes
Joint aches	no	yes
Difficulty walking	no	yes
Decreased joint range of motion	no	yes
Muscle pain or cramps	no	yes

Additional Skin History **None:** ☐

Acne	no	yes
Dry lips	no	yes
Hair and nail changes	no	yes
Change in skin color	no	yes
Rash or itching	no	yes
Varicosities	no	yes
Breast lump, pain or discharge	no	yes

Neurologic **None:** ☐

Frequent or recurrent headaches	no	yes
Light headed or dizzy	no	yes
Convulsions or seizures	no	yes
Numbness or tingling sensations	no	yes
Tremors	no	yes
Paralysis	no	yes
Stroke	no	yes
Head injury	no	yes

Psychiatric **None:** ☐

Think of suicide	no	yes
Anxiety	no	yes
Depression	no	yes
Memory loss	no	yes

Hematology

Unusual bruising	no	yes
Blood clots	no	yes
Anemia	no	yes
Swollen glands	no	yes
Delayed healing	no	yes
Hepatitis exposure	no	yes
Bleeding problems	no	yes

Allergy history **None:** ☐

Hay fever history	no	yes
Asthma	no	yes
Nasal congestion	no	yes
Food allergy	no	yes
Itching	no	yes

Patient sign here: _____

Date: _____

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Practice Policies & SIGNATURE ON FILE

I hereby consent to and authorize all treatment that may be advisable or necessary. I will inform this office of any changes in my medical history, insurance coverage, telephone number an/or address as they occur. I certify this information is true and correct to the best of my knowledge.

I UNDERSTAND AND ACCEPT THAT I AM UNLTIMATELY FINANCIALLY RESPONSIBLE FOR ALL EXPENSES AND CHARGES INCURRED FOR SERVICES PROVIDED (REGARDLESS OF MY INSURANCE STATUS) AT ACADEMIC DERMATOLOGY OF NEVADA, 2839 St. ROSE PARKWAY, SUITE 100, HENDERSON, NV 89052.

PLEASE NOTE PAYMENT IS EXPECTED AND DUE AT THE TIME OF SERVICE FOR "YOUR PORTION" OF CHARGES; that includes and co-pays, co-insurance, any remaining deductible or certain cosmetic services. If you do not know the amount of your co-pay, 20% of the total charges will be collected at the time of service. For your convenience, we accept cash, personal checks with a check guarantee card (and driver's license) and VISA, MASTER CHARGE or DISCOVERY.

As a courtesy to our patients, we will bill your insurance company. In order to do so, we must have updated and accurate insurance information. If a completed claim form is required to accompany our bill, we must have that completed form at the time of your office visit. Please be aware that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Your account with this office is your responsibility whether or not your insurance company pays.

We are preferred providers for most managed care organization; which means we have agreed to accept reduced reimbursement for our professional service. However, some insurers may use a variety of tactics to avoid, delay or inappropriately pay for our services, in addition to the already reduced ("contracted") fee schedule that we have agreed to. As your advocate, we will make every effort to obtain appropriate payment from your insurance company. However , if your insurance company has not paid your account in full or made any kind of satisfactory arrangement for payment or otherwise within 60 days of your first bill, (or we are unable to locate/notify you of your account status despite reasonable effort) you will be turned over to our collection agency. If your account is referred to a Collection Agency, you will be responsible for all Collection costs (40% or more of the amount owed), Attorney fees, Court costs, Service Fees & associated Miscellaneous Fees and Costs. An adult accompanying a minor patient (the "responsible party") is responsible for full payment of the minor patient's account.

Because of the quality of care that we provide for each of our patient, our practice is extremely busy. Please help us to better serve you by keeping all scheduled appointments. If you respectively (i.e. twice or more) fail to show for your appointments or cancel with less than 24 hours advanced notice, our policy is to charge $25.00 for such missed appointments. There will be a $25.00 charge for returned checks. Refunds of $5.00 or less will not be refunded unless requested by the patient by phone or in writing.

I herein authorize payment of medical benefits to Curt Samlaska, MD, FACP, FAAD & Associates, LLC, when an assigned claim is filed. Further my signature authorizes Curt Samlaska & Associates, LLC to release any medical information necessary to process my insurance claims or as needed by my insurances (if any).

I authorize the use of this form on my insurance submissions, if needed. I permit a copy (of fax) of this authorization to be used in place of this original.

Please let us know if you have any questions or concerns. Our strict adherence to these policies serves to enhance our physician/patient relationship. My signature below indicates that I understand and accept these policies and obligations.

PRINT NAME: _____ **SSN:** _____

_____ **Date:** _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A DETAILED DESCRIPTION OF THIS PRIVACY PRACTICES NOTICE MAY BE FOUND IN THE MAGAZINES DRAWERS OF THIS WAITING ROOM.

This describes the type of information we gather about you, with whom that information may be shared and the safeguards we have put in place to protect it. You have the right to the confidentiality of your medical information and the right to approve or refuse the release of specific information except when the release is required by law, or permitted by law without your authorization. This notice describes practices of all of the persons and entities of Academic Dermatology of Nevada, regarding the use of your medical records.

1. Any health care professional of Academic Dermatology of Nevada, and all employees, staff and other personnel who may need access .
2. Keep confidential any medical information that concerns your condition/treatment, how your care is paid for and demo graphic information.
3. Give you this notice of our policies and procedures regarding privacy practices with respect to medical information about you.
4. Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, training doctors, or other health care professionals who are involved in taking care of you.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party.

For Health Care Operations Purposes. We may use or disclose medical information about you for health care operations purposes. This is to make sure that all of our patients receive quality care.

Appointment Reminders. We may use and disclose information to contact you as a reminder that you have an appointment for treatment or medical care.

Individuals Involved in Your Care or Payment for Your Care. We may release information about you to a friend or family member who is involved in your care, with your permission. We may also give information to someone who helps pay for your care.

As Required by Law. We will disclose information about you when required to do so by federal, state or local law.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Academic Dermatology of Nevada. All complaints must be submitted in writing only. You will not be penalized for filing a complaint. Please address you complaint to the office address listed above.

I hereby acknowledge that I have received and/or reviewed a copy of the Privacy Practices Notice.

Date: _____ **Printed Name of Patient:** _____

Signature of Patient: _____

I also authorize the following individuals to have access to my records:

Name	Relationship
_____	_____
_____	_____
_____	_____