Dear Patient,

Welcome to Spectrum Dermatology! Thank you for choosing us for your skin care and dermatology needs. We believe in delivering highly personalized, quality dermatology care to all of our patients. For our new patients, we would like to provide you with some information to make your visit with us a more smooth and enjoyable experience. Please call us at 480-948-8400 or visit our website at www.SpectrumDermatology.com, if you have any questions.

Directions to Scottsdale Office: 9500 East Ironwood Square Drive, Suite 110. From the 101 Fwy, exit Shea and go East. Make a right on 96th and then a right on Ironwood Square Drive.

Directions to Camelback Office: 4350 East Camelback Road, Suite A-200. We are located at the North West corner of 44th Street and Camelback. The parking lot entrance is located on Camelback just West of 44th Street.

Directions to Desert Ridge Office: 20950 North Tatum Boulevard, Suite 250. From the 101 Fwy, exit Tatum and go north. We are located at the South West corner of Tatum Boulevard and Rose Garden Lane.

Directions to Chandler Office: 312 N. Alma School Road, Suite 5. We are located on the west side of Alma School Road just North of Chandler Blvd. in the Medical Arts Plaza.

New Patients: Please arrive 30 minutes prior to your appointment time to ensure your paperwork is completed. We can email or mail your paperwork prior to your appointment. Please complete and bring it with you or to expedite the check in process, you can mail, fax (480-948-8401) or email [info@SpectrumDermatology.com] your paperwork. Alternately, you may download your forms on-line at our website www.SpectrumDermatology.com under the Patient Forms tab.

Photo ID/Insurance Cards: Please bring your Photo ID as well as your Insurance card to your visit. We will need to make copies of these and keep them on file.

Late for Appointments: If you arrive 15 minutes or more after your schedule visit time, we reserve the right to reschedule your appointment.

Cancellations and No Shows: Please provide 24 hours or more advance notice, if you wish to reschedule or cancel your appointment. Repeated missed appointments may lead to dismissal from the practice. We also reserve the right to bill you a $25.00 fee if you fail to provide advance notice of any appointment cancellation. We will give you a confirmation call 2-3 days prior to any appointment you have scheduled with us, however, do not rely upon this reminder system to cancel your appointment.

Wi-Fi: We do provide complimentary Wi-Fi for our patients in the office.

Payment: We accept Cash, Checks, Visa, Mastercard, American Express, Discover.
Copays: Copays are due at the time of patient check-in

Deductible/Co-Insurance: We will collect your estimated deductible/co-insurance prior to the procedure. If there are any adjustments after the procedure, we will refund you the difference.

Self Pay: All services must be paid in full at the time of service. This includes payment for all services considered cosmetic.

Returned Checks: A $30.00 fee will be charged for every returned check. Payment after a returned check will only be accepted via cash or credit card.

Collections: Once an account has been placed in collection status, all prior balances must be paid in full before an appointment will be scheduled. All future copays, deductibles/co-insurance will be due at the time of your visit or you will be asked to reschedule. Any balance assigned to a collection agency will be assessed a 30-40% collection fee.

Biopsy/Pathology or Lab Samples: These may be sent to labs outside of our office and will be billed independently of Spectrum Dermatology. You may receive a bill from the outside lab and will be responsible for payment to that facility.

Medical Records Requests: $30.00 fee + a signed Medical Release form will be required prior to the release of any medical records. The fee can be avoided by using the Patient Portal to access your records. We will release the records within 7 business days. Please notify us, if you need the records transfer expedited, we will make every effort to do so. This is not required for transfer of records to physicians who participate in your care, reports you require for your personal records or insurance companies to complete payment of an open claim.

Patient survey: We are committed to providing excellent dermatologic care in a warm and caring environment. We hope you will help us to better serve you, by taking the time to fill out our patient surveys. These will be available in the office and on the internet. They can be dropped anonymously (or with your contact information, if you would like us to contact you) in patient survey boxes in the office or mailed or emailed back to us at info@SpectrumDermatology.com.

Thank you for making us your provider for your dermatology and skin care needs.

Sincerely,

Nancy H. Kim, MD
**PATIENT INFORMATION**

**PATIENT NAME:**
- **LAST**
- **FIRST**
- **M.I.**
- **SOCIAL SECURITY NUMBER**

**MAILING ADDRESS**
- **STREET OR PO BOX**
- **APT, STE OR UNIT #**
- **DATE OF BIRTH**

**SEX (CIRCLE)**
- **FEMALE**
- **MALE**

**E-MAIL**

**CITY**
- **STATE**
- **ZIP**

**HOME PHONE NO**
- **CELL PHONE NO**
- **WORK PHONE NO.**

**PHARMACY NAME**
- **PHARMACY PHONE**
- **PHARMACY CROSS STREETS**

**HOW DID YOU HEAR ABOUT US?**
- [ ] WEB SEARCH
- [ ] ZOC DOC
- [ ] YELP
- [ ] GOOGLE
- [ ] PHYSICIAN
- [ ] INSURANCE
- [ ] WORD OF MOUTH
- [ ] OTHER:

**MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR VOICE MAIL?**
- [ ] YES
- [ ] NO / HOME
- [ ] CELL

**PERSON RESPONSIBLE FOR CHARGES**

If person responsible for payment is different from patient, then complete below.
If patient is child please indicate if parents are: [ ] Married [ ] Separated [ ] Divorced

**FULL NAME**
- **SOCIAL SECURITY NUMBER**

**MAILING ADDRESS**
- **STREET OR PO BOX**
- **APT, STE OR UNIT #**
- **DATE OF BIRTH**

**CITY**
- **STATE**
- **ZIP**

**PREFERRED PHONE NUMBER TO CONTACT YOU ON:**

**PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY:**
- [ ] SPOUSE
- [ ] CHILD
- [ ] OTHER

**PHYSICIAN:**

**PATIENT INFORMATION**

**INSURANCE INFORMATION**

**PRIMARY INSURANCE**
- **INSURANCE NAME:**
- **POLICY/ID#:**
- **GROUP/ACCOUNT#:**
- **CADDHOLDERS NAME:**
- **DOB:**
- **SSA#**
- **RELATION TO PATIENT:**

**SECONDARY INSURANCE**
- **INSURANCE NAME:**
- **POLICY/ID#:**
- **GROUP/ACCOUNT#:**
- **CADDHOLDERS NAME:**
- **DOB:**
- **SSA#**
- **RELATION TO PATIENT:**

I hereby certify the above information is true and correct to the best of my knowledge. I understand that while Spectrum Dermatology’s physicians contract with many insurance companies, it is MY responsibility to verify with my plan that the physician I am seeing is a participating provider. It is also my responsibility to find out what my coverage options are with my insurance plan. I further understand that Spectrum Dermatology will assist me in obtaining authorization from my primary care physician or insurance company if necessary. If however, authorization is not obtained, I may be financially responsible for services rendered. I hereby authorize Spectrum Dermatology to submit insurance claim forms along with medical records necessary to obtain payment from my insurance Company. I understand that I am responsible for all charges regardless of insurance coverage. I acknowledge that photo IDs taken are used to assist in patient recognition per HIPPA guidelines. I authorize the Doctor to release any medical information including diagnosis, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information. I authorize payment of medical benefits to Spectrum Dermatology.

**PATIENT OR RESPONSIBLE PARTY SIGNATURE:**

**DATE:**

SP14-102 REV. 4/15
Thank you for choosing Spectrum Dermatology for your Dermatology and Skin care needs. We are committed to providing you with quality and affordable health care. Our Medical and Business Office staff members will work very hard to make sure that your paperwork is filed accurately and promptly.

INSURANCE: We participate in many insurance plans, including Medicare. We will attempt to bill whichever insurance you have advised us of as a courtesy. Because most of the data we have relative to you comes from you, please help us maintain accurate records by filling out forms legibly, and letting us know whenever important data changes (like your address, telephone number[s], any changes in your name, your medical insurance, etc.).

KNOW YOUR BENEFITS: Each and every insurance company and plan, including Medicare, has different plans, each with different benefits. Because your health insurance is an arrangement between you and your insurer, you should understand what services are covered under your specific plan. Your insurer can assist you with any questions you have relative to your own benefits with them. Many insurance plans have their own specific criteria for which services they will cover and how frequently they will cover them. Consequently it is impossible to know all of the many different employer group benefits from one employer to the next. Therefore, Spectrum Dermatology cannot be held responsible for informing patients whether a particular service is “covered” or not. However, our staff will make every effort to try to assist you in understanding your health benefits or supply you with other health plan related resources.

PROOF OF INSURANCE/ID: All patients must complete our patient information form. We must also obtain a copy of your driver’s license and current, valid insurance card. If you are unable to present an insurance card at the time of service, or if you are covered by an insurance company with which we are not contracted, we require that you pay in full for services in advance.

COPAYMENTS, COINSURANCE AND DEDUCTIBLES: All copayments, coinsurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure to do so may be considered a breach of your contract with your health plan. We may decline to see patients for non-emergent visits if co-payments are not made at the time of the visit.

CLAIMS SUBMISSION: Our office will submit your claims for the insurance companies we are contracted with and assist you in any way we reasonably can to help you get your claim paid. Your insurance may need you to supply certain information directly to them. It is your responsibility to comply with their request in a timely manner.

NONPAYMENT: In the event that your insurance does not pay your claim to us in sixty (60) days, we will transfer the remaining balance to you and will send you a statement. If the account becomes 60 days past due, then the unpaid balance may be turned over to a collection agency. Please be aware that all collection fees and/or legal fees will be owed in addition to the remaining balance. Patients sent to collections will be discharged from the practice after 30 days unless the balance is paid in full. Patients will be notified by regular or certified mail that they have 30 days to establish alternative medical care. During that interim 30 day period, you will only be able to be treated at Spectrum Dermatology on an emergency basis.

NON-COVERED SERVICES: Your Spectrum Dermatology provider may provide services that may not be covered as a benefit of your specific plan with your insurer. Patients or Guarantors are financially responsible for any and all services provided that may not be covered by your insurance plan. It is your responsibility to know and understand your specific insurance plan and what benefits are provided.

PRIVATE PAY/SELF PAY: Payment in full is due at the time of visit, without exceptions.

“NO SHOW” POLICY: Any patient that does not show for their scheduled office visit appointment and does not call within 24 hours to cancel will receive a $25 charge. Any patient that does not show for their scheduled surgery appointment and does not call within 48 hours to cancel will receive a $300 charge.

OUTSIDE PATHOLOGY, LAB FEES: Biopsy, Pathology and Lab samples sent outside of our office are billed independently of Spectrum Dermatology. You may receive a bill from the outside lab and will be responsible for payment to that facility.

RETURNED CHECKS: $30.00 Fee for returned checks. If your check is returned from the bank, we may NOT ACCEPT an additional check as payment on your account. Future payments must be made with cash, money order or credit card.

I have read and agree with the above Patient Financial Policy. I understand the terms and conditions outlined herein as confirmed by my signature below.

Patient or Responsible Party’s signature _________________________________ Date Signed __________________

Patient’s Printed Name: ______________________________________________

Responsible Party’s Printed Name (if applicable): __________________________
To Our Patients:

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is swiped and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster and more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held encrypted until your insurances have paid their portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card. No employees of Spectrum Dermatology will have access to your credit card information.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company’s determination of payment.

Co-pays due at the time of visit will, of course, still be due at the time of the visit.

If you have any questions about this payment method, do not hesitate to ask.

I authorize Spectrum Dermatology to charge outstanding balances on my account to the following credit card which has been given (please circle):

AMEX     Visa     MasterCard     Discover

Signature:___________________________  Date ___________________
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _________________________________________ acknowledge that I have received
(Name of Patient)
a copy of SPECTRUM DERMATOLOGY’s ‘Notice of Privacy Practices’. This Notice
describes how SPECTRUM DERMATOLOGY may use and disclose my protected health
information, certain restrictions on the use and disclosure of my healthcare information, and
rights I may have regarding my protected health information.

________________________________________________________________________
(Signature of Patient, or Personal Representative) (Date)

________________________________________________________________________
(Relationship to Patient)

**Personal Representative** (Family members, attorney, etc.): I hereby authorize Spectrum
Dermatology and its employees to discuss, send and/or receive medical information to/with
the following.

Please provide their names and phone numbers below:

1. Name ___________________________________ Relationship ___________________
   Phone # ______________________________

2. Name ___________________________________ Relationship ___________________
   Phone # ______________________________

3. Name ___________________________________ Relationship ___________________
   Phone # ______________________________

HIPAA-ACK2 5/16
**HISTORY AND INTAKE FORM**

**PHYSICIAN:** ____________________________

### PATIENT NAME

<table>
<thead>
<tr>
<th>.pb</th>
<th>DOB</th>
<th>AGE</th>
</tr>
</thead>
</table>

### Past Medical History - Select any of the following medical conditions you currently have (please check all that apply)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>COPD</td>
<td>Hypertension</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Coronary Artery Disease</td>
<td>HIV/AIDS</td>
</tr>
<tr>
<td>Asthma</td>
<td>Depression</td>
<td>Hypercholesterolemia</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>Diabetes</td>
<td>Hyperthyroidism</td>
</tr>
<tr>
<td>Bone Marrow Transplant</td>
<td>End Stage Renal Disease</td>
<td>Hypothyroidism</td>
</tr>
<tr>
<td>BPH</td>
<td>GERD</td>
<td>Leukemia</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>Hearing Loss</td>
<td>Lung Cancer</td>
</tr>
<tr>
<td>Colon Cancer</td>
<td>Hepatitis</td>
<td>Lymphoma</td>
</tr>
<tr>
<td>OTHER</td>
<td>OTHER</td>
<td>OTHER</td>
</tr>
</tbody>
</table>

### Past Surgical History - Have you had any surgeries on the following organs? (please check all that apply)

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Surgery</th>
<th>Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix Removed</td>
<td>Joint Replacement, Hip</td>
<td>Prostate: Prostate Cancer</td>
</tr>
<tr>
<td>Bladder Removed</td>
<td>Joint Replacement, Knee</td>
<td>Prostate: Prostate TUR</td>
</tr>
<tr>
<td>Breast: Mastectomy right left bilateral</td>
<td>Kidney: Nephrectomy</td>
<td>Rectum: APR</td>
</tr>
<tr>
<td>Kidney Stone Removal</td>
<td>Kidney Transplant</td>
<td>Rectum: Low Anterior Resection</td>
</tr>
<tr>
<td>Kidney Stones Removed</td>
<td>Kidney: Skin Biopsy</td>
<td>Skin: Basal Cell Cancer</td>
</tr>
<tr>
<td>Colectomy: Colon Cancer Resection</td>
<td>Kidney: Hepatectomy</td>
<td>Skin: Melanoma</td>
</tr>
<tr>
<td>Colectomy: Diverticulitis</td>
<td>Liver: Liver Transplant</td>
<td>Skin: Squamous Cell Carcinoma</td>
</tr>
<tr>
<td>Colectomy: Inflammatory Bowel Disease</td>
<td>Liver: Shunt</td>
<td>Spleen Removed</td>
</tr>
<tr>
<td>Colon: Colectomy</td>
<td>Ovaries Removed: Endometriosis</td>
<td>Testicles Removed right left bilateral</td>
</tr>
<tr>
<td>Gallbladder Removed</td>
<td>Ovaries Removed: ovarian cancer</td>
<td>Uterus: Cervical Cancer</td>
</tr>
<tr>
<td>Heart: Mechanical Valve Replacement</td>
<td>Ovaries Removed: tubal ligation</td>
<td>Uterus: Hysterectomy-Fibroids</td>
</tr>
<tr>
<td>Heart: PTCA</td>
<td>Prostate: pancreas: Pancreatectomy</td>
<td>Uterus: Hysterectomy-Uterine Cancer</td>
</tr>
<tr>
<td>OTHER</td>
<td>OTHER</td>
<td>OTHER</td>
</tr>
</tbody>
</table>

### Skin Disease History - Have you had any of the following skin conditions? (please check all that apply)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne</td>
<td>Dry Skin</td>
<td>Poison Ivy</td>
</tr>
<tr>
<td>Actinic Keratoses</td>
<td>Eczema</td>
<td>Precancerous Moles</td>
</tr>
<tr>
<td>Asthma</td>
<td>Flaking or Itchy Scalp</td>
<td>Psoriasis</td>
</tr>
<tr>
<td>Basal Cell Skin Cancer</td>
<td>Hay Fever/Allergies</td>
<td>Squamous cell skin cancer</td>
</tr>
<tr>
<td>Blistering Sunburns</td>
<td>Melanoma</td>
<td>NONE</td>
</tr>
<tr>
<td>OTHER</td>
<td>OTHER</td>
<td>OTHER</td>
</tr>
</tbody>
</table>

Do you wear Sunscreen?  YES  NO If yes, what SPF? _____________

Do you tan in a tanning salon?  YES  NO

Do you have a family history of MELANOMA (NOT the same as basal cell or squamous cell carcinoma)?  YES  NO

If yes, which relatives?

- Mother
- Father
- Sister
- Brother
- Daughter
- Son
- Uncle
- Aunt
- Niece
- Grandmother
- Nephew
- Grandfather

Is there any other family history of cancer (breast, ovarian, pancreatic or prostate)? ____________________________

### PRESENT MEDICATIONS

List any medications you are taking at this time. Include such items as aspirin, vitamins, laxatives, etc.

<table>
<thead>
<tr>
<th>NAME OF MEDICATION</th>
<th>DOSE (Include strength &amp; # per day)</th>
<th>NAME OF MEDICATION</th>
<th>DOSE (Include strength and # per day)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>5.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td>6.</td>
<td></td>
</tr>
</tbody>
</table>

(Continued on next page)
### History and Intake Form

**Patient Name**

**DOB**

**Age**

### Allergies

(Please list ALL allergies.)

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Social History

(please check all that apply)

- [ ] Currently smokes – daily
- [ ] Currently smokes – not daily
- [ ] Has Never smoked
- [ ] Has smoked in the past
- [ ] Drug use
- [ ] None
- [ ] Started Smoking (MM/DD/YYYY):
- [ ] Quit Smoking (MM/DD/YYYY):
- [ ] Number of packs per day:
- [ ] Total years Smoking:
- [ ] Not sexually active
- [ ] EtoH none
- [ ] Patient feels safe at home
- [ ] Has smoked in the past
- [ ] Drug use
- [ ] EtoH less than 1 drink per day
- [ ] Patient feels unsafe at home
- [ ] Sexually active with one partner
- [ ] EtoH 1-2 drinks per day
- [ ] Other:
- [ ] Sexually active with more than one partner
- [ ] EtoH 3 or more drinks per day
- [ ] IV drug use
- [ ] None
- [ ] Never smoked
- [ ] Started Smoking (MM/DD/YYYY):
- [ ] Quit Smoking (MM/DD/YYYY):
- [ ] Number of packs per day:
- [ ] Total years Smoking:

### Driving Status

- [ ] Drives in the Daytime
- [ ] Drives at Night
- [ ] How often do you exercise?

### What is your caffeine use?

### Occupation and Workplace:

### Place of Residence:

### Review of Systems: Are you CURRENTLY experiencing any of the following? (please check yes or no for the following)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems with bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems with healing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems with scarring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imunosuppression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changing Mole</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rash</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bloody stool</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Alerts (please check any that you have experienced)

- [ ] Pacemaker
- [ ] Defibrillator
- [ ] Artificial joints within past 2 years
- [ ] Artificial heart valve
- [ ] Premedication prior to procedures
- [ ] Allergy to adhesive
- [ ] Allergy to topical antibiotic ointments
- [ ] Blood thinners
- [ ] Pregnancy or planning a pregnancy
- [ ] Allergy to lidocaine
- [ ] Rapid Heart Beat with epinephrine
- [ ] Yeast infections with antibiotics
- [ ] GI upset with antibiotics
- [ ] Other:

### West Africa: Travel or contact

- [ ] Ebola Risk: Fever >= 100.4 degrees
- [ ] Ebola Risk: Resided or Traveled to
- [ ] Country-wide spread Ebola transmission in last 21 days

### Reason for Seeing the Doctor Today

Briefly describe the reason you are here today.

### I hereby certify that the above information is true and correct to the best of my knowledge.

**Patient/Representative Name (print):** ____________________________

**Signature:** ______________________________________

**Date:** __________