Date: _____

Patient Name: _____ **Date of Birth**: _____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Primary Phone Number: (_____) _____ Type: Home | Cell | Work

Secondary Phone Number: (_____) _____ Type: Home | Cell | Work

SSN: _____ **Email Address**: _____

How would you like to receive your appointment reminders? By Text or Phone

Preferred Language: English or other: _____ **Gender**: Male or Female

Race: White/ Caucasian Native American/ Alaskan Native African American Asian

Native Hawaiian/ Pacific Islander or Other_____

Marital Status: Married Divorced Widowed Single

Emergency Contact Name: _____ Relationship: _____

Primary Phone Number: (_____) _____

Secondary Phone Number: (_____) _____

Patients Employer Name: _____

Patients Employer Phone Number: (_____) _____

Receipt of Notice of Privacy Practices Written Acknowledgement Form & Nondiscrimination statement

Dr. Susannah L. Collier M.D.

I am a patient of Dr. Susannah L. Collier M.D.; I hereby acknowledge receipt of Dr. Susannah L. Collier's Notice of Privacy Practices & nondiscrimination statement.

Name: _____ **or Guardian/ POA Name:** _____

Signature:_____ **Date**: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Dr. Susannah L. Collier M.D.

With my consent, Susannah L. Collier M.D., PLLC may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment, and Healthcare Operations (TPO). Please refer to Dr. Susannah L. Collier M.D. PLLC's waiting area and upon request we will give you a copy of our Notice of Privacy Practices.

Dr. Susannah L. Collier M.D. PLLC or an authorized representative of her office has permission to discuss my medical condition, information, test results, and or laboratory findings with the following non-medical persons:

Name & Phone: _____

Name & Phone_____

Name & Phone_____

Patient Signature: _____

Assignment of Benefit Statement, Financial Options for Payment Arrangements and Financial Agreement

As a courtesy, we will be happy to file an insurance claim on your behalf. However there are several administrative steps that are required prior to your surgery and/or appointment:

*if your insurance requires a written referral from your primary care physician or authorization, it is your responsibility to obtain it

* If you have a biopsy or excision done (NOT Mohs), it will be sent to a pathologist for diagnosis (usually Craig Abbott, MD or Clay Cockerell, MD) unless you notify our office that you need it to be sent to a specific lab. This is a separate charge and any billing questions regarding the pathology need to be addressed with the pathologist's Office

*Our office may not be contracted with all insurance companies; If this is the case, your 'out of network" benefits, if you have them, will apply.

*After the insurance claim is processed, we will bill you for the balance on your account and this balance is due immediately

* If your insurance company does not pay your claim within 90 days of the date of service you will be responsible for the full balance.

*Co-pays, coinsurance, and/or deductibles will be your responsibility whether in or out of your insurance network

Dr. Collier does offer a payment plan. These arrangements need to be discussed with our billing department before your first appointment. By signing here you are acknowledging you understand the above and you are giving us permission to submit your claim to your insurance company.

Patients Signature: _____ Date: _____

Payment Options: You can choose from: *Cash, Check, Visa, MasterCard, or Discover Card*.
Please note: Dr. Susannah L. Collier M.D. requires your copayment and/or a portion of your deductible and/or coinsurance be collected at the time of any consultation and / or treatment if you are insured. Any balance your insurance puts to your responsibility is due immediately following your first statement. If you are self-pay, then the total is due at the time of your appointment. ******Dr. Susannah L. Collier M.D. Charges $35.00 for returned checks****

I, _____, understand that Susannah L Collier, MD, on a needs based basis, offers a 6 month interest free payment plan if I am not able to pay by balance after my insurance has paid their portion. I understand that this six months starts the month of the first statement sent by Collier Skin Cancer Center (CSCC). I understand that it is my responsibility to call CSCC and speak with the billing department to qualify for this payment plan. I understand that my total balance is divided over 6 months and this amount (1/6 of total balance) is due each month whether I receive a statement from CSCC or not. I understand that I am welcome to make a month payment that is larger to the month payment amount but each month my payment of 1/6 of my total balance has to be received by the last day of the month to keep my account in good standing. I understand that a partial or missed payment will result in being sent to collections. Any account sent to collections regardless of whether a payment plan is in place or not will result in additional fees. I understand that by signing this I am not agreeing to a payment plan, I have to call CSCC once I receive my first statement to activate this payment plan option.

Patients Signature: _____ Date: _____

I hereby authorize payment directly to Dr. Susannah L. Collier M.D., PLLC, of all surgical and/ or medical benefits otherwise payable to me for services (but not in excess of Dr. Susannah L. Collier's charges). Any unpaid deductibles and / or co-pays not payable by my insurance company on the day of evaluation and/ or surgery I am responsible for. I understand that charges not payable by my insurance company (i.e. co-insurance, and/or deductible) are my responsibility and are due in full within 90 days from the date of service regardless of any insurance pending. I understand that I have options to assist me in paying for the services provided by Dr. Susannah L. Collier MD, if I am unable to pay the full balance.By signing this, you agree and understand the above terms and conditions.

Patients Name: _____ D.O.B. _____

Patients Signature: _____ Date: _____

Parent or guardian (if patient is under 18) _____ Date: _____

Patient Portal Information: (This is a website, drcollier.ema.md, where you can securely access and update your information with Dr. Collier and access summaries of your visits with Dr. Collier. We will set up an account for you. When you log in, you can change your password but not your user name.) The password must be seven characters, one numeric character, and one upper case character

User Name: _____Password: _____

Patient Name: _____Date: _____

YES OR NO Have you ever been seen by Dr. Susannah L. Collier in the past?

Circle If yes: within the past 3 months, 6 months, 12 months or longer

YES OR NO Have you been treated for or diagnosed with high blood pressure?

YES OR NO Are you a current smoker or tobacco user?

YES OR NO Are you a former smoker or tobacco user?

YES OR NO Do you drink alcohol?

- No alcohol
- Occasionally
- Less than 1 drink a day of alcohol
- 1-2 drinks a day of alcohol
- 3 or more drinks a day of alcohol

YES OR NO If over 50 have you had your flu shot? (flu season: Sept- Feb)

YES OR NO If over 50 have you had your pneumonia shot?

YES OR NO Do you have a history of melanoma, melanoma in situ, or lentigo maligna?

YES OR NO Do you have any new or changing moles?

YOUR REFERRING PHYSCIAN:

Name: _____

Phone: _____

YOUR PRIMARY CARE PHYSICIAN:

Name: _____

Phone: _____

YOUR PHARMACY FOR PRESCRIPTIONS:

Name:_____

Location: _____

Phone: _____

Do you have or have you had in the past:

YES OR NO Problems with bleeding

YES OR NO Problems with scarring (hypertrophic or keloid)

YES OR NO Immune suppression (including medication caused)

YES OR NO Fever blisters/ cold sores

YES OR NO Chest pain

YES OR NO Fever or chills or night sweats

YES OR NO Unintentional weight loss

YES OR NO Thyroid problems

YES OR NO Abdominal Pain

YES OR NO Joint Aches

YES OR NO Muscle Weakness

YES OR NO Headaches (out of the ordinary for you)

YES OR NO Seizures

YES OR NO Cough or shortness of breath

YES OR NO A defibrillator or Pacemaker

YES OR NO Artificial Joints within the past 2 years

YES OR NO Allergy to adhesive or topical antibiotics

YES OR NO Allergy to lidocaine or rapid heartbeat with lidocaine

YES OR NO Blood Thinners (including aspirin)

YES OR NO History of Staph infection/ MRSA

YES OR NO Hepatitis B, or Hepatitis C or HIV

YES OR NO Poor Kidney or Liver Function

YES OR NO Are you pregnant or planning a pregnancy?

YES OR NO Anxiety or depression

YES OR NO Vision or hearing problems

YES OR NO Lymph node enlargement

YES OR NO A need for antibiotics before routine dental cleaning

YES OR NO Artificial Heart Valve

Patient Name: _____ **Date: _____**

Please Check Medical Problems

- o Anxiety/ Panic Attacks
- o Arthritis
- o Asthma
- o Irregular heartbeat / A-Fib
- o Bone Marrow Transplant
- o Enlarged Prostate
- o Breast Cancer
- o Colon Cancer
- o Lung Disease/ COPD/ Asthma
- o Heart Attack/ Coronary Disease
- o Depression
- o Diabetes/ High Blood Sugar
- o Kidney Disease/ Dialysis
- o Heart Burn/ Reflux
- o Hearing Loss/ Deaf
- o Liver Disease/ Hepatitis
- o High Blood Pressure
- o HIV/ AIDS
- o High Cholesterol
- o High Thyroid/ Hyperthyroid
- o Low Thyroid/ Hypothyroid
- o Cancer of the blood/ Leukemia
- o Prostate Cancer
- o Lung Cancer
- o Radiation Treatment
- o Seizures/Epilepsy
- o Stoke/TIA

Please List your medications with dosages

_____
_____
_____
_____
_____
_____
_____

Please list any allergies below

_____
_____
_____
_____
_____

Please Check Past Surgeries

- o Appendix
- o Bladder
- o Kidney Removal/ Nephrectomy
- o Kidney Biopsy
- o Kidney Treatment
- o Kidney Stone
- o Breast: Right Mastectomy
- o Breast: Left Mastectomy
- o Breast: Bilateral Mastectomy
- o Breast: Right Lumpectomy
- o Breast: Left Lumpectomy
- o Breast: Bilateral Lumpectomy
- o Breast Biopsy
- o Breast Reduction
- o Breast Implants
- o Ovaries Removed : Endometriosis
- o Ovaries Removed: Cyst
- o Ovaries Removed: Cancer
- o Hysterectomy: Cancer
- o Hysterectomy: Fibroids
- o Prostate Removed: Cancer
- o Prostate Biopsy
- o Prostate Removed or TURP
- o Hip Replacement (Left) Year _____
- o Hip Replacement (Right) Year _____
- o Hip Replacement (Both) Year _____
- o Colon Cancer Surgery
- o Diverticulitis Surgery
- o Inflammatory Bowel Surgery
- o Gallbladder (Cholecystectomy)
- o Spleen
- o Testicles
- o Skin: Biopsy
- o Skin: Basal Cell Carcinoma
- o Skin: Squamous Cell Carcinoma
- o Skin: Melanoma
- o Heart: Bypass
- o Heart: Stent/ Angioplasty
- o Heart: Mechanical Valve
- o Heart: Pig/ Cow/ Tissue Valve
- o Knee Replacement (Right) Year_____
- o Knee Replacement (Left) Year _____
- o Knee Replacement (Both) Year _____