**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? **YOUR REFERRING PHYSCIAN: ­­­**

**Circle**  If yes: within the past 3 months, 6 months, 12 months or longer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YES OR NO** Have you been treated for or diagnosed with high blood pressure? Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YES OR NO** Are you a current smoker or tobacco user? **YOUR** **PRIMARY CARE PHYSICIAN:**

**YES OR NO** Are you a former smoker or tobacco user? Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YES OR NO** Do you drink alcohol? Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 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  **YOUR PHARMACY FOR PRESCRIPTIONS:**

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

**YES OR NO** If over 50 have you had your pneumonia shot? Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YES OR NO** Do you have a history of melanoma, melanoma in situ, or lentigo maligna? Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Do you have or have you had in the past:**

**YES OR NO** Problems with bleeding **YES OR NO** A defibrillator or Pacemaker

**YES OR NO** Problems with scarring (hypertrophic or keloid) **YES OR NO** Artificial Joints within the past 2 years

**YES OR NO** Immune suppression (including medication caused) **YES OR NO** Allergy to adhesive or topical antibiotics

**YES OR NO** Fever blisters/ cold sores **YES OR NO** Allergy to lidocaine or rapid heartbeat with lidocaine

**YES OR NO** Chest pain **YES OR NO** Blood Thinners (including aspirin)

**YES OR NO** Fever or chills or night sweats  **YES OR NO** History of Staph infection/ MRSA

**YES OR NO** Unintentional weight loss **YES OR NO** Hepatitis B, or Hepatitis C or HIV

**YES OR NO** Thyroid problems  **YES OR NO** Poor Kidney or Liver Function

**YES OR NO** Abdominal Pain **YES OR NO** Are you pregnant or planning a pregnancy?

**YES OR NO** Joint Aches **YES OR NO** Anxiety or depression

**YES OR NO** Muscle Weakness **YES OR NO** Vision or hearing problems

**YES OR NO** Headaches (out of the ordinary for you) **YES OR NO** Lymph node enlargement

**YES OR NO** Seizures **YES OR NO** A need for antibiotics before routine dental cleaning

**YES OR NO** Cough or shortness of breath **YES OR NO** Artificial Heart Valve

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Please Check Medical Problems**

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

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please List your medications with dosages**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_**

**Please list any allergies below**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Please Check Past Surgeries­­­­­­­­­­­­­­­­­­­­**

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