



Full Name: _____ Date: _____

Mailing Address: _____

City / State: _____ Zip Code: _____

Date of Birth: _____ SSN: _____ Gender: Male Female

Cell Phone: _____ Home Phone: _____

Okay to leave a message? Yes No Email Address: _____

Emergency Contact: _____ Phone: _____

Preferred Language: _____ Ethnicity: _____

Previous patient of Brooke Schmidt PA-C? Yes No

Primary Care Provider: _____

Preferred Pharmacy: _____ City: _____

Past Medical History

Select any of the following medical conditions you have now or previously have had:

<input type="checkbox"/> Anxiety <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Bone Marrow Transplant <input type="checkbox"/> Cancer (type _____) <input type="checkbox"/> COPD <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> GERD	<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hypertension <input type="checkbox"/> HIV / AIDS <input type="checkbox"/> Hypercholesterolemia <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Radiation Treatment <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Transplant (Type _____)
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Other: _____

Past Surgical History

Please list any previous surgeries:

Skin Disease History

Have you had any of the following?

- | | |
|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Flaking or Itchy Scalp |
| <input type="checkbox"/> Actinic Keratoses | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> "Precancerous" Moles |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> None |

Other: _____

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? Yes No

If yes, which relative?

- | | | |
|----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Daughter | <input type="checkbox"/> Grandmother |
| <input type="checkbox"/> Father | <input type="checkbox"/> Son | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> Sister | <input type="checkbox"/> Uncle | <input type="checkbox"/> Grandson |
| <input type="checkbox"/> Brother | <input type="checkbox"/> Aunt | <input type="checkbox"/> Granddaughter |
| | <input type="checkbox"/> Nephew | |
| | <input type="checkbox"/> Niece | |

Other: _____

Medications: Please list all current medications or supply us with a list

Allergies: Please list all allergies and reactions if known:

Social History

Smoking Status (please choose one):

- Current every day smoker
- Current someday smoker
- Former smoker
- Never smoker
- Unknown if ever smoked

Started Smoking

- mm/dd/yyyy _____

Quit Smoking

- mm/dd/yyyy _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one): None 1 or less per day 1-2 per day 3 or more per day

Occupation: _____ Workplace: _____

Family History

Please include relevant information about first-degree relatives only:

Authorization

Are we authorized to discuss your care with anyone over the phone?

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Signature

Date

By signing above I authorize the people listed to discuss all aspects of my care with the staff at Montana Sky Dermatology PC. Further consent will be needed for disclosures of a non-verbal nature.



Acknowledgement of Receipt of Notice of Privacy Practices

Montana Sky Dermatology PC
1600 Whitefish Stage Road, Suite 1
Kalispell, MT 59901

Privacy Official: Lacie Hardy (406) 314-4477

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices.

Print Name Patient Signature Date

Authorized Representative Signature Relationship to Patient

If not signed by the patient, please indicate your relationship to the patient:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

For Office Use Only

Acknowledgment refused:

Efforts to obtain:

Reasons for refusal:



PATIENT CONSENT AND FINANCIAL AGREEMENT

Welcome to Montana Sky Dermatology PC ("MSD"). Thank you for choosing us for your care and treatment.

Please review this Agreement carefully. Except in cases of emergency care, we must have a signed and dated Patient Consent and Financial Agreement before Healthcare Services (defined below) can be provided to You. If You have any questions about this Agreement, our staff will be happy to answer your questions before you sign.

If, at a later date, you have additional questions about your medical bills or need to make corrections to the information you have provided to us, please contact our staff at (406) 314-4477 or in person at 1600 Whitefish Stage Rd, Suite 1, Kalispell, MT 59901. For billing questions please contact Clinic Service at 303-755-2900.

For purposes of convenience, this Agreement will refer to You as "You".

CONSENT FOR TREATMENT AND CARE

You hereby consent to any healthcare services provided by Montana Sky Dermatology PC. You acknowledge that no guarantees have been made regarding the outcome of these Healthcare Services. If You are not able to sign this Agreement personally, then the consent for Your care and treatment: (1) may be given by Your representative(s) who are legally authorized to make decisions and sign this Agreement on Your behalf, or (2) shall be implied in cases of emergency.

FINANCIAL AGREEMENT

Agreement to Pay Charges and Billing Statements– In consideration of the Healthcare Services provided to You, You and/or any individuals who are directly responsible for Your medical bills, such as a parent or guardian, (collectively, "Guarantors") agree to pay MSD's billed charges related to those Healthcare Services ("Charges"), minus any contractual reductions from the Charges agreed to by Montana Sky Dermatology PC with Your Health Plan Payor.

You understand and agree that: (1) the terms of this Agreement prevail over any conflicting terms and conditions in any other contract or plan to which You claim to be a party or a beneficiary; (3) it is possible that Your Health Plan will determine that Healthcare Services provided to You are not Covered Services and that You will be responsible for paying for those Healthcare Services; and (4) the terms of this Agreement are governed by the laws of the State of Montana.

OUT-OF-NETWORK PATIENTS- YOU UNDERSTAND AND AGREE THAT, EXCEPT WHEN PROHIBITED BY APPLICABLE LAW, MSD MAY COLLECT ITS CHARGES FROM GUARANTORS WHEN MONTANA SKY DERMATOLOGY PC DOES NOT HAVE A WRITTEN CONTRACTUAL RELATIONSHIP WITH AN INSURANCE COMPANY OR OTHER HEALTH PLAN PAYOR REGARDING AN AGREED UPON RATE OF PAYMENT FOR THE HEALTHCARE SERVICES PROVIDED TO YOU (called "OUT-OF-NETWORK"). YOU UNDERSTAND AND AGREE THAT WHEN RECEIVING HEALTHCARE SERVICES FROM MONTANA SKY DERMATOLOGY PC ON AN OUT-OF-NETWORK BASIS, GUARANTORS MAY ALSO BE REQUIRED TO MAKE PAYMENT AT THE TIME SERVICES ARE PROVIDED.

Payment – Guarantors may make payment to MSD: (1) at the time Healthcare Services are provided to You; (2) in accordance with billing statements received from MSD; or (3) in accordance with a payment schedule that is agreed upon by both MSD and Guarantor(s). If Guarantors fail to make any scheduled payment when due, You understand and agree that: (1) MSD may declare the entire balance to be immediately due and payable, and (2) Guarantors will be responsible for all costs associated with collection of the owed Charges, including reasonable attorney's fees. No partial payment of the amount owed by Guarantors to MSD (whether the payment says it is in full payment or not) will be treated as full payment without a specific separate written agreement between Guarantors and MSD that is signed by both parties. MSD may also assign past due accounts to third party collection agencies.

Third Party Liability – In the event that any third party is or could be liable for part or all of the Charges for the Healthcare Services provided to You (such as due to an automobile accident), You acknowledge that Guarantors

remain responsible for the portion of the Charges that You are responsible to pay, but MSD is also legally authorized to bill for and recover from that third party the full Charges for the Healthcare Services provided to You. MSD may do this whether or not MSD has also submitted a bill for the services to any federal, state, or private healthcare insurance/health benefits plans (collectively a "Health Plan Payor") covering You. Guarantors will not be responsible for any amounts in excess of the portion of the Charges that You are responsible to pay, but MSD may recover from the third party an amount that permits MSD to receive up to the full Charges for the Healthcare Services provided to You. Guarantors also acknowledge that MSD may submit a Healthcare Provider/Facility Lien, as allowed by Montana Code Annotated Title 71, Chapter 3, Part 11, to the third party.

Refunds – Please let us know if Your address changes so that we can contact You in the event that Your account is overpaid and You are entitled to a refund. If we cannot locate You over a period of five (5) years after Your right to a refund has been identified, then Montana law requires us to send Your refund to the Montana Department of Revenue. Montana law permits us to impose a charge against Your refund during the time it remains unclaimed. MSD's annual charge is Ten U.S. Dollars (\$10.00) and will be imposed at the beginning of each annual period.

AUTHORIZATION

Without waiver or limitation of the above Financial Agreement, You hereby: (1) authorize MSD, on Your behalf, to submit a claim for and to accept, negotiate and deposit payment from any Health Plan Payor and other responsible third party providing coverage for, or who may be otherwise liable for, payment of any of the Charges for the Healthcare Services provided to You ("Responsible Third Parties"); and (2) direct those Health Plan Payers and Responsible Third Parties to which MSD submits a claim for payment to make payment(s) directly to MSD. You understand and agree that MSD: (1) is not required to submit a claim for payment to anyone other than Guarantors; but (2) may choose to submit a claim to one or more of Your Health Plan Payers and Responsible Third Parties. This authorization is limited only to the rights, on Your behalf, to submit a claim for and to accept, negotiate and deposit payment from any Health Plan Payor and Responsible Third Parties. It does not entitle MSD to any other rights or bind MSD to any responsibilities that You may have under any Health Plan Payor agreements, third party liability agreements or policies or any other theories of coverage or liability. You hereby consent also to MSD providing notice of this authorization to Your Health Plan Payers and other Responsible Third Parties.

INSURANCE BENEFITS DISCLAIMER

If You are covered by a Health Plan Payor agreement that requires pre-authorization for Healthcare Services, it is Your responsibility to obtain the pre-authorization from Your Health Plan Payor. You understand and agree that You are responsible for any Charges incurred should Your Health Plan Payor deny all or any portion of Your MSD Healthcare Services or otherwise fail to make payment for the Charges.

RELEASE OF INFORMATION

You acknowledge that MSD is authorized by law to release medical and account information necessary for the purposes of treatment, payment, and healthcare operations. This information may be released to Health Plan Payers, liability insurance companies, billing companies, collection agencies, attending/consulting healthcare providers, governmental programs or medical review organizations and otherwise as permitted or required by law.

CONSENT TO CONTACT

You agree that, in order for MSD to request Your feedback about the Healthcare Services provided to You, to service Your account, or to collect any amounts You may owe, MSD, including without limitation any independent contractors, account management companies or collection agencies may contact You by telephone, SMS text message or email at any cellular or residential telephone number or email address provided during Your registration process. These methods of contact may include auto-dialed, prerecorded and/or artificial voice message calls or texts as permitted by law.

BY SIGNING BELOW, YOU CONFIRM THAT YOU: (1) UNDERSTAND AND AGREE TO THE TERMS OF THIS AGREEMENT, (2) HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THIS AGREEMENT.

Print Name

Patient Signature

Date

Authorized Representative or Account Guarantor

Relationship to Patient