Full Name: ________________________________ Date: _________________________

Mailing Address: ____

City / State: _______________________________ Zip Code: _____________________

Date of Birth: _______________ SSN: ______________________ Gender: Male Female

Cell Phone: ______________________ Home Phone: ___________________________

Is it okay for us to leave a detailed message at these phone numbers? Yes No

Email Address: ____________________________________

Emergency Contact: ________________________ Phone: _______________________

Are you a previous patient of Brooke Schmidt PA-C? Yes No

Authorization

Are we authorized to discuss your care with anyone over the phone? Yes No

If yes please list below:

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.

Patient Name: ______________________

Past Medical History

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

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation
- Bone Marrow Transplant
- Cancer (Type____________)
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD
- Hearing Loss
- Hepatitis
- Hypertension
- HIV / AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Radiation Treatment
- Seizures
- Stroke
- Transplant (Type______________)

Other medical conditions we should be aware of: _________________________________
____
____
____

Past Surgical History

Please list any previous surgeries:

____
____
____
____
____

Skin Disease History

Have you had any of the following?

- Severe Acne
- Actinic Keratoses
- Basal Cell Skin Cancer
- Eczema
- Melanoma
- “Precancerous” Moles
- Psoriasis
- Squamous Cell Skin Cancer
- 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?

Mother	Daughter	Grandmother	Niece
Father	Son	Grandfather	Nephew
Sister	Uncle	Grandson	Other ____________
Brother	Aunt	Granddaughter	

Medications: Please list all current medications & dosages 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 occasional smoker
Former smoker
Never smoker
Unknown if ever smoked

Started Smoking: ___________________
Quit Smoking: ______________________
# of Packs Per Day: _________________
Total Years Smoking: ________________

Alcohol Intake:

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 (parents, children):

____
____
____

Primary Care Provider: ____

Preferred Pharmacy: ____________________________ City: _________________________

PATIENT CONSENT AND FINANCIAL AGREEMENT

Welcome to Montana Sky Dermatology PC ("MSD"). Thank you for choosing us for your care and treatment. For purposes of convenience, this Agreement will refer to You as "You".

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.

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 Payer.

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 YOU 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 OR NON-COVERED BASIS, YOU 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. 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 (2) 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 AND (3) HAVE RECEIVED AND REVIEWED AND, IF NEEDED, COMPLETED THE FOLLOWING:

- **NOTICE OF PRIVACY PRACTICES**

____________________________ ____________________________

Print Name | Patient Signature | Date

____________________________ ____________________________

Authorized Representative or Account Guarantor | Relationship to Patient