Integrated Dermatology of Reno – Mortensen, PLLC
Aistheta Reno Medical Skin Care Center
6630 South McCarran Blvd., Suite A9
Reno, NV 89509

Date:

PATIENT NAME (LAST) (FIRST) (MIDDLE)			
PHYSICAL ADDRESS	CITY	STATE	ZIP
MAILING ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH	SOCIAL SECURITY NUMBER	SEX MALE FEMALE	MARITAL STATUS S M D W
PHONE NUMBER (CELL)	PHONE NUMBER (HOME)	PHONE NUMBER (WORK)	
IF A MINOR, PARENTS' NAMES (MOTHER) (FATHER)			
EMERGENCY CONTACT NAME	CELL PHONE	HOME PHONE	RELATIONSHIP
RACE:	PLEASE CIRCLE ONE: Hispanic/Latino or Non-Hispanic	LANGUAGE:	

EMPLOYMENT INFORMATION

PATIENT OCCUPATION	WORK PHONE		
PATIENT EMPLOYER			
EMPLOYER ADDRESS	CITY	STATE	ZIP
SPOUSE NAME	OCCUPATION		
EMPLOYER	WORK PHONE		

PRIMARY INSURANCE

NAME OF SUBSCRIBER	RELATIONSHIP TO PATIENT		
BIRTHDATE OF SUBSCRIBER	SOCIAL SECURITY NUMBER	OCCUPATION	
NAME OF EMPLOYER	WORK PHONE NUMBER		
EMPLOYER ADDRESS	CITY	STATE	ZIP
INSURANCE COMPANY			
POLICY NUMBER	GROUP NUMBER		

SECONDARY INSURANCE

NAME OF SUBSCRIBER	RELATIONSHIP TO PATIENT		
BIRTHDATE OF SUBSCRIBER	SOCIAL SECURITY NUMBER	OCCUPATION	
NAME OF EMPLOYER	WORK PHONE NUMBER		
EMPLOYER ADDRESS	CITY	STATE	ZIP
INSURANCE COMPANY			
POLICY NUMBER	GROUP NUMBER		

DO YOU HAVE A THIRD/TERTIARY INSURANCE?

I am consenting to be treated. By agreeing to receive care, I am consenting generally to other medical treatments such as laboratory tests and minor procedures that my physician may order. I understand that co-payments are due at the time of the visit. I authorize the release of any medical information necessary to process my medical claim. I realize that I am responsible for any co-insurance or deductible that my insurance company may apply.

Signature: Date:

I have no insurance and agree to pay my balance in full.

Signature: Date:

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Medical History Questionnaire

Your Name: _____ Date of birth: _____

Height: ____ft ____in Weight: ____lbs Preferred pharmacy & streets_____

Do you currently smoke? YES NO Have you ever smoked? YES NO

Reason for today's appointment: _____

How long have you had this problem? _____

Have you received treatment for this problem before today? YES NO

If yes, please describe (including any non-prescription medications / creams you have tried):

_____

_____

Do you have other skin problems you would like evaluated? _____
(*Note: These problems may require a second appointment. If you want more than one problem treated during this visit, your insurance company may refuse payment*).

Have you had a full body skin exam within the last year? ☐ Yes ☐ No

Please list your current medications (*Including over-the-counter and supplements*) _____

_____

Please list any allergies to medications: _____

_____

Do you have or have you ever had any of the following:

☐ ANEMIA	☐ BLOOD THINNERS	☐ GERD	☐ HIGH CHOLESTEROL	☐ RADIATION TREATMENT
☐ ANXIETY	☐ CANCER _____	☐ HEARING LOSS	☐ HYPERTHYROIDISM	☐ RENAL DISEASE
☐ ARTHRITIS	☐ COPD	☐ HEART DISEASE	☐ HYPOTHYROIDISM	☐ SEIZURES
☐ ASTHMA / HAYFEVER	☐ DEPRESSION	☐ HEPATITIS A, B, OR C	☐ KELOIDS	☐ SKIN CANCER
☐ ATRIAL FIBRILLATION	☐ DIABETES	☐ HIGH BLOOD PRES.	☐ MELANOMA	☐ STROKE
☐ BLEEDING DISORDERS	☐ ECZEMA	☐ HIV / AIDS	☐ PACE MAKER / ☐ DEFIBRILLATOR	☐ TRANSPLANT

FEMALES: ARE YOU CURRENTLY: PREGNANT Y / N TAKING: BIRTH CONTROL Y / N
DO YOU HAVE AN IRREGULAR MENSTRAL CYCLE Y / N

Have any blood relatives have or ever had any of the following:

☐ ARTHRITIS	☐ ASTHMA	☐ CANCER	☐ DIABETES	☐ ECZEMA
☐ HAIR LOSS	☐ HAY FEVER	☐ MELANOMA	☐ PSORIASIS	☐ SKIN CANCER

Is there anything else about your medical history which may be important for the doctor to know?

_____

Signature: _____ Date: _____

Aistheta
Reno Medical Skin Care Center

Integrated Dermatology of Reno-Mortensen, PLLC

Our Financial Policy

Here at Integrated Dermatology of Reno-Riley, PLLC dba Aistheta/Reno Medical Skin Care Center it is our mission to provide quality medical care in a professional and caring environment.

As a patient, the best action you can take to ensure that your billing is accurate is provide us with current contact and billing insurance information at each visit. With your cooperation, you should be able to receive all the benefits offered to you by your insurance plan(s), allowing our staff to do what they do best – concentrate on your skin care needs.

1. Payment is due at the time of service unless arrangements have been made in advance by your insurance carrier. We accept cash, check, Visa, MasterCard, AMEX and Discover.

2. Keep in mind that your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor – in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will send the bill to you for payment. If we later receive a payment from your insurer, we will refund any overpayment to you.

3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them. If your plan has assigned a copayment for your office visit we will collect that at the time of your visit.

4. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered" or "not medically necessary" and denies a submitted claim you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

5. If you do not show up for a scheduled appointment or do not provide 24 hours notice to cancel your appointment you will be charged $35 for each appointment that you "no show". If you "no show" a scheduled surgical appointment you will be charged $100. This must be paid prior to scheduling your next appointment.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____

Signature of patient (or responsible party) Date

_____

Please print the name of the patient

INTEGRATED DERMATOLOGY GROUP

William S. Mortensen, MD
Integrated Dermatology of Reno

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practice and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: _____
Printed Name – Patient or Representative

X _____ __/__/__
Signature Date

Relationship to Patient
(if other than patient): _____

Witness:

_____
Printed Name – Practice Representative

X _____ __/__/__
Signature Date

INTEGRATED DERMATOLOGY GROUP

William S. Mortensen, MD
Integrated Dermatology of XXXX

HIPPA Release of Information

Messages regarding office appointments may be left on my:

☐ Cell phone ☐ Home phone ☐work phone
☐ Email ☐ Sent as text to cell phone

Messages regarding information related to my care may be left on my:

☐ Cell phone ☐ Home phone ☐ Email

It is okay to discuss my health information with:

_____

_____

_____

This HIPPA Release of Information was signed by:

_____
Printed Name – Patient or Representative

_____ _____
Signature Date

Relationship to Patient
(if other than patient):_____

_____