Mark E. Hinkson, D.O.
Rob Willis, PA-C

3425 S. Merlin Dr.
Idaho Falls, ID 83404
(208) 528-6653

Thank you for choosing Mountain West Dermatology for your skin care needs. We look forward to seeing you in our office. In order for us to best serve you, please come prepared with the following:

Completed Documents

- New Patient Information
- Financial Policy
- Medical History
- Protected Health Information Authorization.

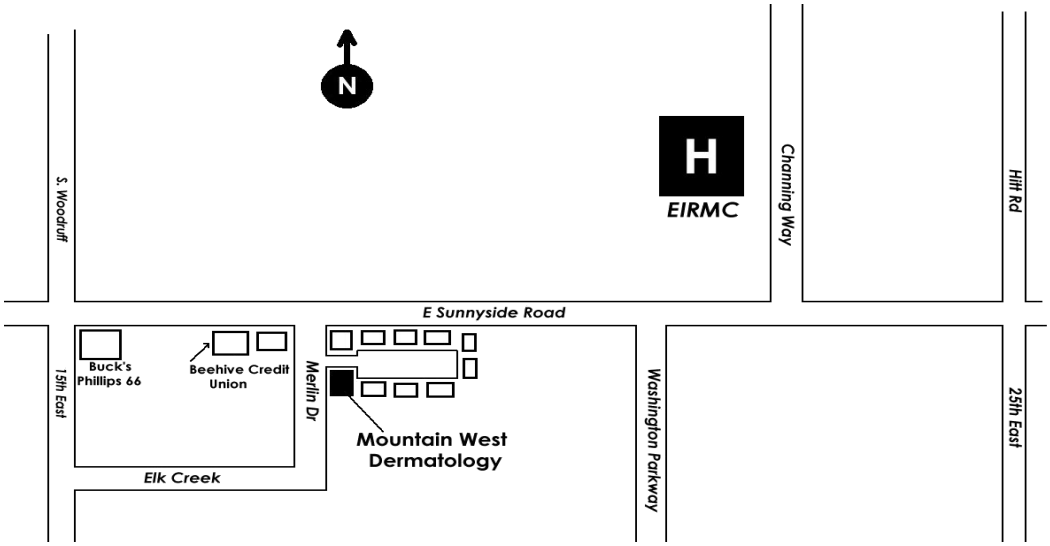
Identification

- We are under Federal Trade Commission law regarding identity theft prevention. You will be required to provide identification at your appointment. This includes:
  - State or Federal issued photo ID card **(i.e. drivers license or military card);**
  - Current health insurance card.
  - If no photo ID is available, utility bills or other correspondence showing name and current residence will be required.
  - If the patient is a minor child, the parent or guardian should provide the information listed above.

Please plan for adequate time when coming to our office so will be able to address your concerns. We make every effort to stay on schedule through out the day. Kindly give 24 hours notice if you are unable to keep your appointment.

Directions to Mountain West Dermatology 3425 S Merlin Dr. Suite 200

From the intersection of Sunnyside and Woodruff (St. Clair). Travel east on Sunnyside. Take the first right just past the Beehive Credit Union (Merlin Dr.) Turn Left into Chantilly Professional Park. Mountain West Dermatology is the 1st building to the right as you enter. Please feel free to call (208)528-6653 if you need further information.



Welcome to our Office

Patient Information

Last	First	Middle	
Name:			SSN - -
Address		Apt #	Date of Birth / /
Zip Code	City	State	Gender
Home Phone ( )	Cell Phone ( )		Marital Status
Employer			Work Phone ( )

Preferred Language: ☐ Decline to specify

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline to specify

Race: ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ Other Race ☐ Decline to Specify

Responsible Party

Last	First	Middle	
Name:			SSN - -
Address		Apt #	Date of Birth / /
Zip Code	City	State	Home Phone ( )
Employer			Work Phone ( )

Insurance Information

If you provide us a copy of your card, please complete the fields marked **.

Primary Insurance Company **	**Policyholder Name** **	**Date of Birth** ** / /
Subscriber ID	**Group Number**	SSN - -
Employed By	Relation to Patient **	Copay $

Secondary Insurance Company **	**Policyholder Name** **	**Date of Birth** ** / /
Subscriber ID	**Group Number**	SSN - -
Employed By	Relation to Patient **	Copay $

Primary Care Physician		**Referring Physician**	

Emergency Contact (not living with you) **Name** **Relationship** **Phone ( )**

How did you hear about us? Physician Family Member Friend Website/Internet Email Insurance Co. Phone book Other:

Office Policy: Your co-pays, deductibles or percentages are due at the time of service. We file insurance claims in your behalf. However, you are responsible for all deductibles and charges not covered by insurance. Please keep us informed of all changes to your coverage. Your account may be charged interest for unpaid balances. All collection costs and attorney fees are your responsibility if not paid as agreed.

Authorization: By signing this, I authorize release of any/all medical records regarding my care to another physician/facility. I understand that this medical information may be used for diagnostic, insurance, legal and other reasons as deemed necessary by Mountain West Dermatology to ensure the best medical care on my behalf.

I have read the above and accept financial responsibility for this account.

Signature _____ Date _____

Minor Patients only

I authorize Mountain West Dermatology to treat this minor patient when **NOT** accompanied by parent or legal guardian.

Signature _____ Date _____

Mountain West Dermatology
Patient Financial Policy

The following information outlines the patient financial policy of Mountain West Dermatology.

Cancellation and No Shows – Please be courteous and provide at least 24 hours' notice when you need to cancel an appointment. If you do not cancel and fail to come to your appointment ("no show"), you will be charged a $25 "no show" fee. This fee must be paid before additional appointments can be scheduled.

☐ **Initial – I understand the cancellation and no show policy**.

Self Pay/Services not billed to insurance – All patients who do not carry health insurance or who choose not to have services billed to their insurance company are required to pay 100% of office visit charges at the time of service. We accept cash, personal checks, credit and debit cards. Additional charges incurred during the visit with the provider, such as a procedure or laboratory services, may be balance billed. We offer a 10% discount to all charges paid in full at time of service.

Insurance – Expenses incurred in our clinic are submitted to your insurance carrier as a courtesy. It is the responsibility of the patient and/or the responsible party to understand their insurance policy. Insurance copays should be paid at the time of service. After your insurance has determined benefits, any coinsurance amounts or non-covered services are the responsibility of the patient or responsible party. We will submit claims for primary and secondary insurance.

Medicaid – All Medicaid recipients must present their Medicaid card at time of service. Any Medicaid recipient who participates in the Healthy Connections program must have a referral from their Healthy Connections provider.

Outside Services – Patients will receive separate statements for laboratory and pathology services.

- Laboratory services provided by Express Lab.
- Pathology services provided by Pinkus Dermatology of Michigan and Pathology Associates of Idaho Falls.

Any billing questions should be directed to the correct service provider.

Outstanding Balance and Past Due accounts – Patients who do not pay the balance due in full are subject to the following payment guidelines:

- After a claim has been processed by insurance, patients will have a 90 day grace period to pay their account without penalty or finance charges.
- Finance charges begin accruing on all unpaid balances at 90 days past due. The finance charge annual percentage rate (APR) is 18%, with a minimum finance charge of $5.00.
- **For all account balances older than 90 days, patients are REQUIRED to participate in AutoPay, our automated payment program, with either a credit or debit card.**
- After the 90 day grace period, if a patient account is not paid in full AND the patient does not participate in AutoPay, the account will be sent to our collection agency, Medical Recovery Services (MRS). Payment arrangements can be made with them. A collection fee (33% of the balance due) will be added to the account.

I have read and agree to the above outlined financial policy of Mountain West Dermatology. I agree that I am ultimately responsible for any charges incurred at Mountain West Dermatology.

Patient Name: _____ Date of Birth: _____

Patient/Responsible Party: Printed Name: _____

Signature: _____ Date: _____

MOUNTAIN WEST
DERMATOLOGY AND ESTHETICS

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

HIPAA Privacy and Acknowledgment

I understand that my medical information is protected under HIPPA law and that this office is under obligation to keep my Protected Health Information (PHI) confidential. I acknowledge that I have been provided a copy of the Notice of Privacy practices and that I may ask for a copy this notice at any time to read the specific applications in which my PHI may be used.

_____ _____
Patient/Parent/Guardian Signature Date

Mountain West Dermatology reserves the right to change the Notice of Privacy Practices at any time. Current information will be available on our website and in office. You are also able to request that your PHI is restricted beyond our policies, but we are not obligated to agree to any additional restrictions.

Patient Communication

It is the policy of Mountain West Dermatology not to release confidential medical information regarding your treatment to family members or friends, except for (I) parent/legal guardian, (II) other persons authorized by the patient, (III) as we may reasonably infer from circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (IV) in emergency situations, or (V) other as otherwise permitted by HIPAA.

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you.

If you do not want information shared, check "no".

Spouse: _____	Yes ____	No ____
Parent: _____	Yes ____	No ____
Other: _____	Yes ____	No ____
_____	Yes ____	No ____

I understand that I may revoke this authorization at any time by giving a written notice to the Privacy Officer at this office. However, I understand that I may not revoke this authorization for any action taken before receipt of my written notice to revoke this authorization.

Alternative Communications. You are entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only: _____
_____

By signing below, I give my authorization to use or disclose my protected health information as described.

Patient/Parent/Guardian Signature: _____ Date: _____

Medical History

Past Medical History: (please circle all that apply)

Anxiety	Depression	Hypothyroid
Arthritis	Diabetes	Leukemia
Asthma	End Stage Renal Disease	Lung Cancer
Atrial fibrillation	GERD	Lymphoma
Bone Marrow Transplantation	Hearing Loss	Prostate Cancer
BPH	Hepatitis	Radiation Treatment
Breast Cancer	High Blood pressure	Seizures
Colon Cancer	HIV/AIDS	Stroke
COPD	High Cholesterol	
Coronary Artery Disease	Hyperthyroid	**NONE**

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Colectomy: Colostomy
Gallbladder Removed
Heart: Coronary Artery Bypass
Heart: PTCA / Stent
Heart: Mechanical Valve Replacement
Heart: Biological Valve Replacement
Heart: Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Liver: Shunt
Liver: Transplant
Liver: Hepatectomy
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Ovaries: Tubal ligation
Pancreatectomy
Prostate Removed: Prostate Cancer
Prostate Biopsy
Rectum: APR
Rectum: Low Anterior Resection
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Hysterectomy: Cervical Cancer

NONE

Other _____

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	**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(s)? _____

Medications: (Please enter all current medications) If you have more than 4, ask for an additional page.

Name	Strength:	Dosage:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: (Please enter all allergies)

_____

_____

Social History: (Please circle all that apply)

Cigarette Smoking:

Never smoked
Currently Smokes
Former Smoker

Alcohol Use:

None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Family Medical History (Only first degree relatives)

Examples: High blood pressure, high cholesterol, stroke, heart attack, diabetes, cancer, or healthy.

Father _____
Mother _____
Siblings _____
Children _____

Review of Systems: Are you currently experiencing any of the following?
(Please circle all that apply)

Problems with bleeding	Unintentional weight loss	Neck Stiffness
Problems with healing	Thyroid problems	Headaches
Problems with scarring	Sore throat	Seizures
Rash	Blurry vision	Cough
Immunosupression	Abdominal pain	Shortness of breath
Hay Fever	Bloody stool	Wheezing
Chest Pain	Bloody urine	Anxiety
Fever or chills	Joint aches	Depression
Night sweats	Muscle weakness	

ALERTS: (please circle all that apply)

Allergy to Adhesive	Artificial joint replacement	Pacemaker
Allergy to lidocaine	Blood thinners	Require antibiotics prior to surgical procedure
Allergy to topical antibiotics	Defibrillator	
Artificial heart valve	MRSA	Rapid heartbeat with Epinephrine

Are you pregnant or currently trying to get pregnant? Y N

Preferred Pharmacy: _____ Phone Number: _____
City or Zip code: _____