Tareen Dermatology
MEDICAL | SURGICAL | COSMETIC

• ROSEVILLE • FARIBAULT
• MONTICELLO • EAGAN
• MAPLEWOOD • HUDSON
651.633.6883
tareendermatology.com

NEW PATIENT INTAKE FORM

Legal Name: ____ ____________________
(First) (Middle Initial) (Last) (Prefer to be called)

Date of Birth _____/______/_________ Age:________________ Sex: _________________

Marital Status: ☐Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Mailing Address:____
(Street) (City) (State) (Zip)

Home Phone:___________________☐OK to leave message Cell Phone:___________________☐OK to leave message

Occupation: _____________________________ Work Phone: __________________Ext: ______☐OK to leave message

Email Address: ____

Emergency Contact:______________________________Relationship:_______________Phone #:___________________

Primary Care Physician and Clinic Name:____

Primary Language: ☐English ☐Spanish ☐Somali ☐Other:_____________________________________

Race: ☐Caucasian ☐Asian ☐African American ☐Other:_________________________ ☐ Prefer not to Say

Ethnicity: ☐Hispanic ☐Latino ☐Not Hispanic or Latino ☐ Prefer not to Say

Responsible Party (if different from patient)

Name:____
(First) (Middle Initial) (Last)

Date of Birth:____/____/_______ Relationship to Patient: ____

Address:____
(Street) (City) (State) (Zip)

Home Phone: (   )_____________ Cell Phone: (   )_____________ Work Phone: (   )_____________ Ext:_____

Referral (how did you hear about Tareen Dermatology)

Physician and Clinic Name: ____

Family Member: ____

Other: ____

Have you had or currently have any of the following medical conditions:

☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Bone Marrow Transplant
☐ Breast Cancer
☐ Colon Cancer
☐ COPD
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ End Stage Renal
☐ Hearing Loss
☐ Hepatitis
☐ Hypertension
☐ HIV/AIDS
☐ Hypercholesterolemia
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Immunosuppression
☐Leukemia
☐ Lung Cancer
☐ Lymphoma
☐ MRSA
☐ Pacemaker
☐ Prostate Cancer
☐ Radiation Treatment
☐ Seizures
☐ Stroke
☐ Valve Replacement
☐ Other:______________________
☐ None

Are you currently: Pregnant ☐ Yes ☐ No Planning Pregnancy ☐ Yes ☐No Breast Feeding ☐Yes ☐No

Have you had any surgeries? (Including joint replacement and heart valve surgeries):

____
____
____

Medications: (including over-the-counter)

____
____
____

Drug Allergies:

____
____

Do you have or have had any of the following skin conditions?

☐ Acne
☐ Actinic Keratosis
☐ Basal Cell Skin Cancer
☐ Blistering Sunburns
☐ Dry Skin
☐ Eczema
☐ Flaking or Itchy Scalp
☐ Hay Fever/Allergies
☐ Melanoma Skin Cancer
☐ Poison Ivy
☐ Precancerous Moles
☐ Psoriasis
☐ Squamous Cell Skin Cancer
☐ Other:________________________
☐ None

Do you have a family history of melanoma or other skin cancers? ☐ Yes ☐ No ☐ Unknown:_________________
If yes, which relative? What type of skin cancer? ____

Smoking Status:

☐ Current Everyday Smoker
☐ Current Some Day Smoker
☐ Former Smoker
☐ Never Smoked

Alcohol Consumption:

☐ None
☐ Socially
☐ Moderate
☐ Daily

Pharmacy Name: ____ City/State: _____________________________________

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CONSENT TO COMMUNICATIONS

Patient's Name (please print) ______________________ Patient's Date of Birth ______________

Please check all that apply:

☐ I authorize Tareen Dermatology, P.A. ("Tareen Dermatology") to deliver my detailed health information, including but not limited to my detailed biopsy results, to me via the following methods:

☐ Email: ______________________
Email Address

☐ Voicemail: ______________________
Telephone Number

☐ I authorize Tareen Dermatology to release my detailed health information, including but not limited to my detailed biopsy results, and to discuss this information with the following individual(s):

Name ______________________ Relationship to patient ______________________

Name ______________________ Relationship to patient ______________________

Please provide an alternate contact, listed person(s) will only be contacted by Tareen Dermatology, P.A. ("Tareen Dermatology") in the event of an Emergency or if we are urgently needing to contact you.

Alternate Contact Name (please print) ______________________ Relationship to Patient ______________________

Telephone Number ______________________ ☐ Okay to leave voicemail

☐ I would like Tareen Dermatology's Cosmetic Specials and Newsletter emailed to me at the following

Email Address: ______________________

I acknowledge Tareen Dermatology will confirm appointments by automated text message, phone calls and email. These reminders will be sent to the phone number and email address provided at intake. If I wish to discontinue these reminders, I may do so by following the opt-out process contained within such messages or by notifying Tareen Dermatology at: 651-633-6883.

I have fully read, understand and agree to the information contained in this Consent to Communications ("Form"). I have had the chance to ask questions about the information contained in this Form, and all my questions have been answered to my satisfaction. I understand and agree that this Form will remain in effect until I revoke it by sending a written request to Tareen Dermatology's Privacy Officer, which I may do at any time. I understand that any such revocation shall have no effect on any actions taken in reliance on this Form before to my revocation.

Patient's Signature (or Patient Representative's Signature) ______________________ Today's Date ______________

If patient is under the age 18 or unable to provide informed consent:

Representative's Name (please print) ______________________ Relationship to Patient ______________

CONSENT AND AUTHORIZATION FORM

I. CONSENT AND AUTHORIZATION FOR THE RELEASE OF INFORMATION.

a. Release of Information. I consent to the release by Tareen Dermatology, P.A. ("Tareen Dermatology") of health records and information about me, to the extent permitted by law, to the following individuals and entities:

i. To a health care provider being advised of or consulted in connection with my treatment or care.

ii. To a health plan, insurer, third-party payor, third party administrator or other organization providing me with health benefits, for the purposes of claims payment and benefit determinations, fraud investigations, or quality of care studies or reviews.

iii. To a person or organization in connection with Tareen Dermatology's health care operations. These operations may include, but are not limited to, interdisciplinary care conferences, quality improvement activities, performance evaluations, business management, and other related activities.

iv. To a person or organization providing services in connection with Tareen Dermatology's patient health record portal or the person or organization hosting or providing the portal service.

v. To a health information exchange where my information may be shared with and accessed by other health care providers and health care related entities for purposes of treatment, payment, and the health care operations of the participating organizations.

vi. To the individuals that I included on my Consent to Communications from Tareen Dermatology form.

b. Record Locator and Patient Information Services. I consent to Tareen Dermatology searching for, accessing, and/or receiving health information about me and the location of my health records through a record locator service and/or patient information service.

c. Revocation. I understand and agree that this consent and authorization is valid until I revoke it, which I may do at any time by giving written notice to Tareen Dermatology. I further understand and agree that revocation will not apply to information that has already been disclosed pursuant to this Consent and Authorization Form.

II. PAYMENT RESPONSIBILITY AND AUTHORIZATION.

a. Payment Responsibility. I agree that I am financially responsible and shall pay for all services furnished to me by Tareen Dermatology and any providers performing services on my behalf at the request of Tareen Dermatology including, but not limited to, charges that are not paid in full by my insurance, government program benefits or other third-party payors (each a "Third-Party Payor" and collectively, "Third-Party Payors"). I shall make these payments upon receipt of a statement. I understand and agree that Tareen Dermatology is not responsible for collecting payments from Third-Party Payors or negotiating disputed settlements on my behalf. I agree to pay or reimburse Tareen Dermatology for all costs it may incur in collecting amounts owed to it for the services provided to me, including, but not limited to, attorneys' fees and collection agency fees.

b. Payment Authorization. I shall inform Tareen Dermatology of all Third-Party Payors through which I may have benefits covering the services provided to me by or on behalf of Tareen Dermatology. I authorize Tareen Dermatology to directly bill my Third-Party Payors for such services but acknowledge that Tareen Dermatology is not obligated to submit claims to a Third-Party Payor(s) on my behalf unless required by law or by its contract with a Third-Party Payor. I also authorize any Third-Party Payor through which I may have benefits to make payment directly to Tareen Dermatology for such services, and to release any medical information about me needed to determine the benefits payable for such services. If I have a Medicare Supplement Insurance (Medigap) policy, I request that payment of authorized Medigap benefits be made to Tareen Dermatology directly on my behalf by my Medigap insurer.

c. **Payment of Medicare Benefits to Tareen Dermatology.** I request payment of authorized Medicare benefits to be made either to me on my behalf to Tareen Dermatology for services furnished to me by Tareen Dermatology. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

d. **Referrals and Prior Authorizations.** I understand and agree that it is my responsibility to know and abide by the terms of my Third-Party Payor coverage, including referral or authorization requirements and other types of benefit limitation. I understand that I am responsible for obtaining any required referrals for specialized care before making appointments. I agree to obtain a required authorization for services or to provide all information needed by Tareen Dermatology to obtain a required authorization in advance of my visit. If my Third-Party Payor refuses to cover the services I receive, based on the lack of a required referral or authorization or otherwise, I understand I am financially responsible and agree that I will pay for the services provided by Tareen Dermatology, except to the extent such obligation is limited by applicable law or contractual obligations of Tareen Dermatology applicable to payment for those services.

e. **Full Body Skin Cancer Screenings.** I understand and agree that routine full body skin cancer screenings are not covered in full as a preventative service under most health plans, including Medicare. If my Third-Party Payor requires the payment of a copay for these screenings (e.g., as a specialist visit), I agree to pay this copay at the time of service. I further understand that Tareen Dermatology will send me an invoice for any coinsurance or deductible balances due, and I agree to timely pay the amount specified on this invoice.

III. NOTICE OF PRIVACY PRACTICES.

a. **Confidentiality.** It is the policy of Tareen Dermatology to protect the privacy and confidentiality of my health information in compliance with applicable law.

b. **Notice of Privacy Practices.** Tareen Dermatology's Notice of Privacy Practices explains how Tareen Dermatology may use and disclose my health information. It also explains my rights regarding this kind of information. Tareen Dermatology may revise its Notice of Privacy Practices at any time and will provide me with a copy of the revised Notice of Privacy Practices at my request. Tareen Dermatology's Notice of Privacy Practices is available at each of its clinics and on its website (www.tareendermatology.com).

c. **Acknowledgment of Receipt.** I acknowledge that I have received Tareen Dermatology's Notice of Privacy Practices.

IV. **CONSENT FOR TREATMENT.** I understand that I have the right to be informed of the nature and purpose of all services provided to me at Tareen Dermatology, as well as alternatives, risks, consequences, or complications of such services. I hereby authorize and consent to the examination, diagnosis, procedures, and treatments which my practitioner and I agree are appropriate. I understand that no guarantee has been made as to the results of the care, treatment, and/or medications given to me. This consent shall remain in effect until I choose to revoke it in writing.

V. **PUBLIC COMMENTS.** Before publicly making or posting any negative or critical comments about Tareen Dermatology (e.g., on social media, the internet (including review sites), etc.), I agree to notify Tareen Dermatology of my concerns in writing and wait thirty (30) days before publicly making or posting any such comments, thus allowing Tareen Dermatology the opportunity to address my concerns.

I have fully read, understand, and agree to the information contained in this Consent and Authorization Form ("Form"). I have had the chance to ask questions about the information contained in this Form, and all my questions have been answered to my satisfaction. This Form will remain in effect until I revoke it by sending a written request to Tareen Dermatology's Privacy Officer, which I may do at any time. I understand that any such revocation shall have no effect on any actions taken in reliance on this Form before to my revocation.

______________________________	______________________
Patient's Name (please print)	Patient's Date of Birth
______________________________	______________________
Patient's Signature (or Patient Representative's Signature)	Today's Date

If patient is under the age 18 or unable to provide informed consent:

______________________________	______________________
Representative's Name (please print)	Relationship to Patient

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LATE ARRIVAL, CANCELLATION AND RETURN POLICY

Tareen Dermatology, P.A.'s ("Tareen Dermatology") healthcare professionals and staff strive to provide timely, convenient, and professional services to our patients. To help achieve this goal, Tareen Dermatology has implemented this Late Arrival, Cancellation and Return Policy.

- **Late Arrivals: If you are more than 15 minutes late for your appointment, we may reschedule your appointment**. We understand that patients sometime experience unavoidable delays and will do our best to accommodate patients that arrive more than 15 minutes after their scheduled appointment. However, if we are unable to make this accommodation without negatively impacting other patients (e.g., by increasing their wait time), we will work with you to find a new day and time that works well for your schedule. We may decide to terminate our professional relationship with you if you have three or more late arrivals.

- **"No Show" Appointments: If you do not attend your scheduled appointment without giving us any prior notice, you may be charged a "no show" fee in the amount of $50.00.** We may decide to terminate our professional relationship with you if you have two or more "no show" appointments.

- **Late Cancellations: If you cancel an appointment less than 24 hours before the appointment, you may be charged a "no show" fee in the amount of $50.00.** We may decide to terminate our professional relationship with you if you cancel two or more appointments with less than 24 hours' notice.

- **Surgical Appointment Cancellations: Cancellation of a surgical appointment must be made at least 2-3 days in advance.** This allows us ample time to offer the appointment slot to another patient in need. **Failure to provide a minimum of 2-3 days' notice for a cancellation of a surgical appointment, you may be charged a "no show" fee in the amount of $50.00.** This fee will be discussed with you at the time of cancellation and will depend on the specific circumstances.

- **Return Policy: Products purchased from Tareen Dermatology may only be returned if they are unopened and unused.** Refunds will be returned via the original method of payment.

- **All Tareen Dermatology no-show fees are donated to charity.**

By signing below, I signify that I have read, understand, and agree to this Late Arrival, Cancellation and Return Policy.

______________________________	______________________
Patient's Name (please print)	Patient's Date of Birth
______________________________	______________________
Patient's Signature (or Patient Representative's Signature)	Today's Date

If patient is under the age 18 or unable to provide informed consent:

______________________________	______________________
Representative's Name (please print)	Relationship to Patient

*** Please talk with Tareen Dermatology's business office about no-shows and late cancellations caused by an emergency.***

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INFORMED CONSENT FOR TREATMENT AND THE PERFORMANCE OF MINOR SURGERIES AND/OR PROCEDURES

Please read and be certain that you understand the information contained in this form. This form is a consent for the treatment described below, and contains a summary of the risks and benefits associated with the treatment. Before you receive the treatment, your provider will provide you with additional information about these risks and benefits and answer any questions that you may have about the treatment or related matters. If you have any questions or concerns at any time, please contact your provider.

1. **General Consent to Treatment.** My provider and I have discussed the treatment(s) and/or procedure(s) that have been deemed advisable, desirable, or necessary for diagnostic, therapeutic or investigational purposes for me or my minor child (collectively, "Treatment"), and I understand that such Treatment may involve the administration of drugs and anesthetics, the performance of a skin biopsy, the use of cryosurgery with liquid nitrogen and/or the injection of triamcinolone (cortisone). During these discussions, my provider told me about the Treatment's intended purpose, risks and potential side effects, benefits, alternatives, and related information, and I had the opportunity to ask any questions that I may have had, all of which have been answered to my satisfaction. Based on this discussion and any related written materials that have been provided to me, I hereby consent to Tareen Dermatology, P.A.'s ("Tareen Dermatology") administration of the Treatment to me or to my minor child.

2. **Consent to Skin Biopsy, Testing and Disposal.**

- Biopsy. I understand that skin biopsies involve the removal of a piece of skin and may result in a permanent mark, scar or skin discoloration at the site of the biopsy, and that more than one biopsy may occur during a single visit. I consent to the performance of a skin biopsy(ies) when deemed necessary by my provider for the purposes of diagnosis or treatment. I understand that based on the results of the pathology, I may need to have additional tissue removed at a future office visit and that this will result in an additional charge.

- Testing. I understand and agree that (1) any tissue sample obtained during the Treatment will undergo a dermatopathological analysis, which is conducted by specially trained providers in a laboratory setting, the results of which will assist in the development of a diagnosis and treatment plan; (2) such analysis may be conducted by a third party (i.e., an entity other than Tareen Dermatology); and (3) additional testing and/or a second opinion may be needed to obtain a definitive diagnosis and develop the most appropriate treatment plan. I further understand and agree that any such analysis will be billed to my insurance, and that I am personally responsible for paying any charges relating to such analysis that are not paid for by my insurance.

- Disposal. I consent to the disposal of any tissue sample obtained by or on behalf of Tareen Dermatology when such samples are no longer needed or viable for testing.

3. **Consent to Use of Liquid Nitrogen to Treat Precancerous Lesions, Warts and Mollusca.**

- Precancerous Lesions. I understand and consent to the destruction with liquid nitrogen of precancerous lesions, which are also known as actinic keratoses or solar keratoses, when deemed necessary or advisable by my provider to prevent the risk that these lesions will evolve into squamous cell carcinomas (a form of skin cancer). I understand that these lesions may require more than a single treatment.

- Warts or Mollusca. I understand and consent to the destruction with liquid nitrogen of potentially contagious warts or mollusca, which are not cancerous and do not absolutely require treatment, when deemed necessary or advisable by my provider to prevent their spread. I further understand and agree that the destruction of a wart or mollusca may require multiple treatments.

4. Consent to Injection of Triamcinolone (Cortisone). I understand and consent to the injection of triamcinolone (cortisone) when deemed necessary or advisable by my provider for the treatment of scars, cysts, acne and/or inflammatory conditions like psoriasis, atopic dermatitis and alopecia areata.

5. Risks and Possible Side Effects. The risks and possible side effects of the Treatment include, but are not limited to, the following:

- Permanent scarring
- Permanent discoloration of the skin at the site of treatment
- Atrophy (thinning or depression of the skin)
- Infection
- Bleeding
- Nerve damage resulting in temporary or permanent numbness or temporary or permanent loss of function of certain muscles (paralysis)
- Surgical site re-opening- including but not limited to the following factors; movement, weight bearing, personal medical history and wound location.

The above list is not meant to be inclusive of all possible risks associated with the Treatment as there are both known and unknown side effects and complications associated with any treatment or procedure.

ACKNOWLEDGEMENTS. By signing below, I acknowledge and agree to the statements listed above and the following:

- The nature and purpose of the Treatment has been explained to me, and I understand the information contained on this form in its entirety.
- I understand the risks associated with the Treatment and the alternative treatment methods have been explained to me. I know that I have the right to refuse the Treatment and, by signing below, I am consenting to the Treatment and accepting the associated risks and possible complications.
- I understand that medical attention may be required to address complications associated with the Treatment.
- I understand that the results of the Treatment are not guaranteed.
- I understand that any rescheduling of an appointment must be done at least 24 hours before the appointment and that, if I fail to timely cancel or reschedule an appointment, I may be billed for my missed appointment consistent with Tareen Dermatology's Late Arrival, Cancellation and Return Policy.
- I understand and agree that all services rendered to me may be charged to me directly and that I am personally responsible for payment for the full cost of the Treatment.
- I certify that I am a competent adult of at least 18 years of age and that this consent form is signed freely and voluntarily. I hereby release any right to claim that the performance of any operation or procedure provided to me was not properly authorized.

______________________________	______________________________
Patient's Name (please print)	Patient's Date of Birth
______________________________	______________________________
Patient's Signature (or Patient Representative's Signature)	Today's Date

If patient is under the age 18 or unable to provide informed consent:

______________________________	______________________________
Representative's Name (please print)	Relationship to Patient

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______________________________________ ______________________

Patient's Name (please print) Patient's Date of Birth

Please answer the following questions to the best of your ability.
Please note that the United States Federal Government REQUIRES us to ask these questions.

1. Do you currently smoke cigarettes or use smokeless tobacco?
   YES NO I AM A FORMER SMOKER

2. If you answered YES to Question #1, are you aware of resources available to help you quit smoking?
   YES NO

3. **Patients 65 years of age and older:** Do you have a health care proxy in the event you are unable to make your own medical decisions?
   YES NO

4. If you answered YES to Question #3, please list your designee's name and phone number below:

   ____

5. **Patients 65 years of age and older:** Do you have a living will?
   YES NO

6. **Patients 13-18 years of age**: Did you receive one dose of meningococcal (meningitis) vaccine on or between your 11th and 13th birthdays?
   YES NO

7. **Patients 13-18 years of age**: Did you receive one tetanus, diphtheria, and pertussis (Tdap) vaccine on or between your 10th and 13th birthdays?
   YES NO

8. **Patients age 13-18 years of age**: Have you had at least three HPV vaccines on or between your 9th and 13th birthdays?
   YES NO