KANSAS CITY
Skin & Cancer Center

PATIENT INFORMATION

(All information is confidential.)

PATIENT INFORMATION

Patient Name (Last, First, Middle Initial) | Date of Birth | Sex | Social Security #

Street Address | Apt# | City | State | Zip

Home Phone | Work Phone | Cell phone | Email Address

LANGUAGE/ETHNICITY/RACE (please circle)

Preferred Language: English or Other _____ Ethnicity: Not Hispanic or Latino/Hispanic or Latino/Unknown

Race: American Indian or Alaska Native/Black or African American/White/Other Race _____

EMERGENCY CONTACT

Emergency Contact | Relationship to Patient | Phone Number

RESPONSIBLE PARTY (If patient is a minor. We do not bill absent parents· the adult present with patient is responsible party.)

Responsible Party | Relationship to Patient | Social Security Number

Address | City | State | Zio

Home Phone | Work Phone | Cell Phone

PRIMARY PHYSICIAN (Please include location or group.) **REFERRING PHYSICIAN** (Please include location or group.)

IMPORTANT INFORMATION/ AUTHORIZATION

I hereby authorize Kansas City Skin & Cancer Center to release any information necessary to secure payment on behalf or on behalf of my dependent. I authorize payment directly to Kansas City Skin & Cancer Center for treatment on any and all services rendered I further understand that I am responsible for all fees not paid by my insurance and the balance is due within 30 days receipt of a patient statement. If my account balance becomes delinquent and is forwarded to an attorney or collection agency, I am responsible for any collection and interest fees, attorney fees and court costs. I certify all information given is try and accurate. A copy of my signature is as valid as the original.

Signature: Date:

ACKNOWLEDGMENT OF HIPAA PRIVACY ACT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ('HIPAA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, to obtain payment from third-party payers and to conduct normal healthcare operations such as quality assessments and physician certifications.

I have been made aware that there is a copy of Kansas City Skin & Cancer Center's Privacy Practices available in the waiting room or upon my request containing a more complete description of the uses and disclosures of my health information, I understand that this organization has the right to change its Notice of Privacy Practices at any time and that I may contact the Privacy Manager to obtain a current copy of the Notice. I understand that I may request in writing that you restrict how my information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, you are bound by such restrictions.

Signature: Date:

KANSAS CITY
Skin & Cancer Center

Patient Financial Policy

Thank you for choosing Kansas City Skin & Cancer Center for your dermatology care. Our goal is to build a positive, respectful physician-patient relationship. Please read the following office policies carefully, initial each section, and sign below. If you have questions about fees, insurance, or your financial responsibility, please ask—we're happy to help.

_____ AutoPay / Card on File

- Important exemptions: Patients with Medicare, Medicare replacement plans, or Tricare are exempt from this policy
- We require a credit card on file for any balances up to $100 after your insurance processes your claim.
- Consent: By providing your card, you allow us to securely store it and charge it for balances up to $100 or less than $100 as outlined by your insurance Explanation of Benefits (EOB).
- Security: Card data is stored through a secure, HIPAA-compliant third-party. Our staff cannot access full card numbers.
- Process:
  - We submit claims to your insurance.
  - Once the EOB is received, we charge your card for any balance up to $100.
  - If you owe more than $100, we will send you a statement to pay the remaining balance owed.
- Notification: You will receive a message with a link to your statement 3 days before any payment is processed (if we have your email on file).
- Declined Cards: If payment fails, we'll contact you to update your information.
- Responsibility: Please keep your card details current, including expiration date and billing address.

_____ Insurance

We participate with most major insurance plans. We'll file your claims unless the service is cosmetic. Because insurance networks can change, we recommend verifying our participation with your plan before your visit.

- Bring your current insurance card to each appointment.
- If we cannot verify active coverage, full payment is due at the time of service.
- If your plan requires a referral, you must obtain it before your visit.
- Failure to obtain a referral may result in reduced or no insurance payment—making you responsible for the balance.

_____ Surgery Costs

- We will verify your benefits before surgery and notify you of estimated costs. Payment of your estimated cost and any outstanding balance is due at the time of surgery.
- Insurance will still be filed, and any remaining balance will be billed after processing.

KANSAS CITY
Skin & Cancer Center

_____ Cosmetic / Non-Covered Services

Cosmetic and non-covered services must be paid in full at the time of service. You may be asked to sign a waiver acknowledging responsibility.

_____ "Covered" Services and Your Responsibility

- Your provider may tell you a procedure is "covered," meaning it is medically necessary and billable. However, insurance plans vary—coverage does not guarantee payment.
- You are responsible for any copays, deductibles, co-insurance, or exclusions per your plan.
- Example: Skin cancer screenings are not considered preventative under national insurance guidelines and will be billed as regular visits.
- (Note: If your employer offers enhanced coverage, notify our billing office.)

_____ Failure to Pay

We will send statements and reminders for any unpaid balance. Failure to respond may result in:

- Suspension of non-urgent services and possible dismissal from the practice
- Referral to a collection agency (which may affect your credit)

_____ No-Show / Late Cancellation Policy

You'll receive an appointment reminder 48 hours in advance. If you cancel with less than 24 hours' notice or miss your appointment, a $50 fee will apply. This must be paid before your next appointment.

_____ Return Check Fees:

Any returned check from the bank for non-payment shall result in the patient's or Guarantor's account being assessed a $35.00 fee per check

Acknowledgment

I have read, understand, and agree with the financial policies above. I accept responsibility for payment as described.

Patient Name: _____ DOB: _____

Responsible Party (if applicable): _____Relationship: _____

Signature: _____Date: _____

KANSAS CITY
Skin & Cancer Center

Authorization to Disclose Protected Health Information (PHI)

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

Disclosures to Be Made:
I, _____, hereby authorize KCSCC to speak to the following individual(s) regarding diagnosis, appointment information, and Rx information. This disclosure of my protected health information (PHI) is as described above.

Name: _____
Relationship: _____
Phone Number: _____

- ❑ I decline to authorize any individual to have access to my PHI.

Possible Risks:
I understand that the information disclosed under this authorization may no longer be protected by federal privacy laws and could be re-disclosed by the recipient. I have been informed of these risks and have chosen to authorize the disclosure of my health information willingly.

Right to Revoke Authorization:
I understand that I have the right to revoke this authorization at any time by notifying the provider or organization in writing.

Signature: _____**Date:** _____

This form should be signed in the presence of a healthcare provider, legal representative, or authorized person if applicable.

KANSAS CITY
Skin & Cancer Center

PATIENT INFORMATION

LEGAL NAME: _____

Nickname / Preferred Name: _____

DATE OF BIRTH: _____

PRIMARY CARE DOCTOR: _____

How did you hear about us? *(Please circle one)*

Referred by a doctor: (Name of referring doctor) _____

Friend / Family _____

Internet / Insurance Website

Self

Other: _____

Preferred Local Pharmacy:

Name: _____

Address: _____

_____

Phone: _____

Mail Order Pharmacy: (if applicable)

Name: _____

KANSAS CITY
Skin & Cancer Center

HISTORY AND INTAKE

Past Medical History: (Please circle all that apply, past and present. Include dates/year of diagnosis if applicable.)

None
Arthritis: _____
Asthma: _____
Atrial fibrillation (A-Fib): _____
Benign prostatic hyperplasia (BPH): _____
Cerebrovascular accident (TIA/Stroke): _____
Chemotherapy (when/for what?): _____
Chronic obstructive lung disease (COPD): _____
Coronary artery disease: _____
Depression/Anxiety: _____
Diabetes: _____
End-stage renal disease: _____
Epilepsy: _____
Gastroesophageal reflux disease: _____
Hearing loss: _____
HIV/AIDS: _____
High Cholesterol: _____

Hypertension: _____
Hyperthyroidism: _____
Hypothyroidism: _____
Hepatitis (type/treatment): _____
Leukemia (CLL or ALL): _____
Lymphoma (type): _____
Breast Cancer: _____
Bladder Cancer: _____
Colon Cancer: _____
Lung Cancer: _____
Prostate Cancer: _____
Radiation therapy (date(s)/reason):
_____
Bone Marrow Transplant: _____

Past Surgical History: (Please circle all that apply, past and present. Include dates/year performed.)

None
Coronary artery bypass graft: _____
Cardiac stent: _____
Heart valve replacement
(Mechanical/biological): _____
Appendix removed: _____
Gallbladder removed: _____
Colon resection/colectomy: _____
Liver removed: _____
Bladder removed: _____
Hysterectomy: _____
Ovaries removed: _____
H/O: tubal ligation: _____

Lumpectomy of breast (right/left): _____
Mastectomy of breast (right/left): _____
Pancreas removed: _____
Prostate removed: _____
Spleen removed: _____
Kidney removed(right/left): _____
Kidney transplant (right/left): _____
Kidney stone removal: _____
Replacement of hip joint (right/left): _____
Replacement of knee joint (right/left): _____
Organ transplant (specify): _____

KANSAS CITY
Skin & Cancer Center

HISTORY AND INTAKE

Skin Disease History: *(Please circle all that apply. Include dates/treatment if applicable.)*

None
Acne: _____
Actinic keratosis (precancerous lesions): _____
Basal cell carcinoma: _____
Biopsy of skin: _____
Dandruff/itchy scalp: _____
Dry skin: _____
Atypical/Dysplastic moles: _____
Eczema: _____
H/O: Asthma: _____
H/O: Hay fever: _____
Malignant melanoma: _____
Psoriasis: _____
Seasonal allergy: _____
Squamous cell carcinoma: _____

Do you wear sunscreen regularly? YES NO

If yes, what SPF? _____

Do you currently tan in a tanning salon? YES NO

Have you in the past? YES NO

Do you have a family history of melanoma? YES NO

If yes, which relative(s)? _____

Additional family history: _____

Social History: *(Please circle all that apply.)*

Smoking status:
- Current everyday smoker (tobacco, cigarette, vape)
- Current some day smoker (tobacco, cigarette, vape)
- Former smoker (when did you quit? _____)
- Never smoked

Sexual History:
- Not sexually active
- Sexually active with one partner
- Sexually active with more than one partner
- Same sex partner (male/male, female/female)

Illicit drug use:
- None
- Drug use
- IV drug use

Alcohol use:
- None
- Socially
- Less than 1 drink daily
- 1-2 drinks per day
- 3 or more drinks per day

KANSAS CITY
Skin & Cancer Center

HISTORY AND INTAKE

Medications and Supplements: *(Please list all current medications. **INCLUDING** supplements/vitamins, anything over the counter, AND as needed medications.)*

_____

_____

_____

_____

Drug Allergies/Reaction: _____

_____

_____

Review of Systems:

Symptoms:

Are you currently experiencing any of the following? *(Please circle "YES" or "NO")*

Immunosuppression	YES	NO
Anxiety	YES	NO
Problems with scarring	YES	NO
Fever or chills	YES	NO
Nightsweats	YES	NO
Headaches	YES	NO
Unintentional weight loss	YES	NO
Blurry vision	YES	NO
Depression	YES	NO
Joint aches	YES	NO
Hay fever	YES	NO
Muscle weakness	YES	NO
Problems with bleeding	YES	NO
Changing mole	YES	NO

Alerts:

Do you have any of the following? *(Please circle "YES" or "NO")*

Pacemaker	YES	NO
Defibrillator	YES	NO
Artificial heart valve	YES	NO
Artificial joint within past 2 years	YES	NO
Allergy to lidocaine	YES	NO
Allergy to latex	YES	NO
Pregnancy or planning a pregnancy	YES	NO
Breastfeeding	YES	NO
Allergy to adhesive	YES	NO
Blood thinners	YES	NO
Stomach upset with antibiotics	YES	NO
Yeast infection with antibiotics	YES	NO
Rapid heartbeat with epinephrine	YES	NO
Allergy to topical antibiotic cream/ointment	YES	NO

KANSAS CITY
Skin & Cancer Center

HISTORY AND INTAKE

Age 65 and older:

Do you have a health care proxy in the event you are unable to make your own medical decisions?

YES NO

If YES: Name and phone number _____

Age 9-13 years:

Have you had the meningococcal vaccine?

YES NO

Have you had the Tdap (Tetanus, diphtheria toxoids, and acellular pertussis) vaccine?

YES NO

Have you had at least 2 HPV vaccines with different dates of service between age 9-13?

YES NO