Sound Dermatology

INTAKE FORM

First Name:_____ **Middle Name:**_____ **Last Name:**_____
Address:_____ **City:**_____ **State:**_____ **Zip:**_____
Date of Birth:_____ **Email Address:** _____
Preferred Phone:_____ □ Home □ Mobile □ Work
Alternative Phone: _____ □ Home □ Mobile □ Work
□ Check this box if it is OK to leave a detailed message on your voicemail
□ By checking this box, you authorize Sound Dermatology to contact you using the phone numbers or email address provided above for appointment reminders, scheduling updates, and other limited healthcare communications. These communications may include voicemail, text message, or email. You understand that electronic communication may not always be secure.

DEMOGRAPHICS

Sex assigned at Birth: □ Male □ Female □ Prefer not to answer
Gender Identity: □ Male □ Female □ Non-binary □ Prefer not to answer □ Other: _____
Marital Status: □ Single □ Married □ Divorced □ Widowed □ Partnered □ Prefer not to answer
Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Prefer not to answer
Race (please select all that apply): □ Black or African American □ American Indian or Alaska Native (Native American)
□ Native Hawaiian or Other Pacific Islander □ Asian □ White □ Prefer not to answer □ Other: _____
Employer:_____ **Job Title:**_____
Primary Care Provider:_____ **Preferred Pharmacy:** _____

EMERGENCY CONTACT

Name:_____ Relationship:_____ Phone Number:_____

INSURANCE

Primary Insurance Company Name:_____ **Policy Holder:** □ Self □ Other:
Member ID: _____ Group Number: _____
Policy Holder Name:_____DOB:_____Relationship to Patient:_____
Secondary Insurance Company Name:_____ **Policy Holder:** □ Self □ Other:
Member ID: _____ Group Number: _____
Policy Holder Name:_____DOB:_____Relationship to Patient:_____

PERSON RESPONSIBLE FOR PAYMENT (Required for patients under 18 years old)

□ Self □ Other - Name: _____ Date of Birth:_____
Address:_____ Phone:_____ Relationship:_____

AUTHORIZATION OF PAYMENT & RELEASE OF INFORMATION

I authorize payment of authorized insurance benefits directly to Sound Dermatology for services rendered. I also authorize Sound Dermatology to release medical information necessary to process insurance claims and determine payable benefits. I understand that I am financially responsible for all charges incurred, regardless of insurance coverage or benefit determination. All biopsies are submitted for histopathologic examination. Sound Dermatology utilizes Pro-Path Dermatopathology for histopathologic review unless otherwise required by your insurance plan. Pathology services are billed separately by the dermatopathologist and are not included in Sound Dermatology's charges.

_____ _____
Signature of Patient/Personal Representative Printed Name

_____ _____
Relationship to Patient Date

Sound Dermatology

Medical/Surgical History Form

Name: _____ Date of Birth: _____

Past Medical History

Please indicate whether you have had or currently have any of the following medical conditions:

- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Atrial Fibrillation
- □ Autoimmune Disease
- □ Benign Prostatic Hyperplasia
- □ Bleeding Disorder
- □ Blood Clots
- □ Breast Cancer
- □ Colon Cancer
- □ COPD
- □ Coronary Artery Disease
- □ Depression
- □ Diabetes
- □ Renal (Kidney) Disease
- □ GERD (Acid Reflux)
- □ Hepatitis
- □ Hypertension (High Blood Pressure)
- □ HIV/AIDS
- □ High Cholesterol
- □ Hypothyroidism
- □ Hyperthyroidism
- □ Inflammatory Bowel Disease (UC/Crohn's)
- □ Leukemia
- □ Lung Cancer
- □ Lymphoma
- □ Prostate Cancer
- □ Rheumatoid Arthritis (RA)
- □ Seizure Disorder
- □ Stroke
- □ No Previous Medical History
- □ Other (please write in below):

_____
_____
_____
_____
_____
_____

Past Surgical History

Please indicate if you have had any of the following surgical procedures:

- □ Bone Marrow Transplant
- □ Cancer Surgery
  Type: _____
- □ Breast Surgery
- □ Cardiac Surgery
- □ Colon Surgery
- □ Coronary Stent Placement
- □ Joint Replacement
  Which Joint: □ Shoulder □ Hip □ Knee
  Which Side: □ Left □ Right □ Both
- □ Lymph Node Dissection
- □ Bariatric Surgery
- □ Hysterectomy
- □ Oophorectomy
- □ Thyroid Surgery
- □ Radiation Therapy
- □ No Prior Surgeries
- □ Other (please write in below)

_____
_____
_____
_____

Sound Dermatology

Dermatologic History

Please indicate if you have had any of the following dermatologic conditions or surgeries:

□ Acne
□ Actinic Keratoses
□ Asthma
□ Atypical Moles (Dysplastic Nevus)
□ Eczema
□ History of Basal Cell Carcinoma
□ History of Squamous Cell Carcinoma
□ History of Skin Cancer (type unspecified)
□ History of Mohs Surgery
□ Keloids (Hypertrophic Scarring)
□ Personal History of Melanoma
□ Psoriasis
□ Seasonal Allergies (Hay Fever)
□ Tanning Bed Use
□ History of Blistering Sunburns
□ No Previous Dermatologic History

Do you regularly use sunscreen?
□ Yes □ No
If yes, what SPF? _____

Do you have a family history of Melanoma?
□ Yes □ No
If yes, which relative: _____

Current Medications

□ No Current Medications

Please list all current medications, including prescriptions, over-the-counter medications, and supplements below (you may ask for an additional sheet if needed):

Medication Name	Dosage (mg, mcg, mL)	Route (Oral, injection, topical)	Frequency

Allergies

□ No Known Drug Allergies

Please list any medication allergies and reactions if known below (please include any topical medications, adhesives, latex, as well as oral or injectable medications):

Allergy	Reaction (Example: rash, hives, swelling, difficulty breathing, nausea)

Tobacco Use

□ I do not use tobacco
□ I previously used tobacco (Year Stopped: _____)
□ I currently use tobacco
If current, type: □ Cigarettes □ Vaping □ Cigars □ Smokeless
Packs per day (if applicable): _____

Alcohol Use

□ I do not drink alcohol
□ I previously drank alcohol
□ I currently drink alcohol
If current, approximately how many drinks per week? _____

Why We Ask: Tobacco and alcohol use may affect certain dermatologic conditions, wound healing, and medication safety. This information helps us provide safe and appropriate care.

Sound Dermatology

FAMILY AND OTHER INDIVIDUALS INVOLVED IN YOUR CARE

I authorize Sound Dermatology to verbally disclose my medical, financial, and appointment information to the individuals listed below, unless otherwise specified. This may include, but is not limited to, information related to my medical condition, treatment, billing, insurance, and appointment scheduling.

□ I do NOT authorize Sound Dermatology to disclose my information to anyone.

Name of Individual	Relationship	Phone Number

□ Include Emergency Contact(s) listed on Intake Form

This authorization will remain in effect unless revoked in writing by the patient.

_____ _____

Signature of Patient/Personal Representative Date

_____ _____

Printed name of patient or responsible party Relationship to patient

Sound Dermatology

CONSENT FOR TREATMENT

Sound Dermatology

I voluntarily consent to evaluation, examination, and medical treatment by the physicians, providers, and clinical staff of Sound Dermatology.

I understand that medical care may include, but is not limited to:

- Dermatologic examination
- Diagnostic testing
- Minor medical procedures (such as skin biopsies, cryotherapy, injections, or lesion removal)
- Prescribing medications
- Laboratory testing or pathology services
- Referral to other healthcare providers when appropriate

Dermatologic examinations may require visualization of areas of skin normally covered by clothing in order to provide appropriate medical evaluation.

The nature and purpose of my care will be explained to me when appropriate, and I will have the opportunity to ask questions about recommended treatments or procedures.

I understand that:

- The practice of medicine is not an exact science and no guarantees have been made regarding the results of my treatment.
- I have the right to accept or refuse recommended care or treatment at any time.
- Additional informed consent may be required for certain procedures or treatments.

If I am signing as the parent, guardian, or personal representative of the patient, I certify that I have the legal authority to consent to medical treatment on behalf of the patient.

Consent for Treatment of Minors

For patients under the age of 18, consent must be provided by a parent or legal guardian unless otherwise permitted by law.

Consent to Treat

By signing below, I acknowledge that I have read and understand this consent and authorize Sound Dermatology to provide medical care and treatment as described above.

_____ _____

Patient/Representative Signature Date

_____ _____

Printed name of patient or representative Relationship to patient

Sound Dermatology

Clinical Photography Consent Form

Clinical photographs may be taken during your visit to document skin conditions, monitor treatment progress, or assist in medical decision-making. These images may become part of your confidential medical record.

Medical Record Photography

I authorize Sound Dermatology to take clinical photographs of my skin condition for purposes of:

- Documentation of my medical condition
- Monitoring treatment progress
- Medical consultation or referral
- Inclusion in my medical record

These photographs will be stored securely and will be treated as part of my Protected Health Information (PHI) in accordance with applicable privacy laws.

□ **I consent to clinical photographs being taken and stored in my medical record.**
□ **I decline clinical photographs as part of my medical record.**

Educational Use (Optional)

Photographs may occasionally be used for educational purposes such as medical teaching, professional presentations, or academic publications. Reasonable efforts will be made to remove identifying features whenever practical; however, complete anonymity cannot be guaranteed.

□ **I authorize use of my photographs for educational purposes.**
□ **I do not authorize educational use of my photographs.**

Marketing / Public Use (Optional)

Separate permission is required before photographs are used for marketing or public-facing materials such as:

- Website
- Social media
- brochures or advertisements
- other promotional materials

□ **I authorize Sound Dermatology to use my photographs for marketing purposes.**
□ **I do not authorize marketing use of my photographs.**

If authorization is given, reasonable efforts will be made to remove identifying features when possible.

Withdrawal of Consent

I understand that I may withdraw my authorization for future use of photographs at any time by submitting a written request to Sound Dermatology. Withdrawal will not affect photographs already used or published before the request was received.

_____ _____

Patient/Representative Signature | Date

_____ _____

Printed name of patient or representative | Relationship to patient

Sound Dermatology

FINANCIAL POLICY

Thank you for choosing Sound Dermatology. We are committed to providing high-quality dermatologic care while maintaining clear and transparent financial policies. This policy outlines patient financial responsibilities for insured, self-pay, and non-covered services.

Payment at Time of Service: Patients are responsible for payment of all co-payments, co-insurance amounts, deductibles, and any outstanding balances. Payment is due at the time of service unless prior written arrangements have been made. We accept cash, check, Visa, Mastercard, American Express, Discover, HSA, and FSA cards. A $30 fee will be assessed for returned checks or declined payments.

Payment is for services rendered and not for specific clinical outcomes.

Insurance Participation: Sound Dermatology participates with select insurance plans. A current list of participating plans is available upon request. Insurance coverage is a contract between the patient and their insurance carrier. Final determination of coverage and payment is made by the insurance carrier after claims processing.

If an insurance carrier denies payment for any reason, including but not limited to:

- Lack of medical necessity
- Coverage limitations
- Eligibility issues
- Failure to obtain referral or authorization
- Non-covered services

The patient remains financially responsible for all charges, including services determined by the insurer to be not medically necessary or not covered under the patient's specific plan benefits. Patients are encouraged to contact their insurance carrier directly with questions regarding coverage and benefits.

Medicare Beneficiaries: Sound Dermatology is enrolled with Medicare and will submit claims for covered services. Medicare beneficiaries are responsible for applicable deductibles, coinsurance, and non-covered services in accordance with Medicare guidelines. Services determined by Medicare to be non-covered may require a signed Advance Beneficiary Notice (ABN) prior to service, when applicable.

Medicaid: Sound Dermatology participates with Kansas Medicaid (KanCare) and will submit claims for covered services. Medicaid beneficiaries are responsible only for those amounts permitted under applicable federal and Kansas Medicaid regulations. Covered services will not be billed directly to Medicaid beneficiaries except as permitted by law. Patients remain financially responsible for services that are not covered under Kansas Medicaid when permitted by applicable law.

Proof of Insurance: Patients must present a current insurance card at each visit. Failure to provide proof of active coverage will result in self-pay status, and payment in full will be required at the time of service unless other arrangements are approved by Sound Dermatology. Patients are responsible for notifying our office of any changes to insurance coverage prior to their appointment.

Referrals and Authorizations: If your insurance plan requires a referral or prior authorization, our office may assist when possible; however, it remains the patient's responsibility to ensure it is obtained before services are rendered. If required authorization or referral is not obtained and the claim is denied, the patient will be responsible for the full balance.

Pathology Services: Biopsy specimens are submitted for histopathologic examination when medically indicated. Pathology services are performed by an independent dermatopathology laboratory and are billed separately by that laboratory. Patients are financially responsible for pathology charges not covered by insurance.

Self-Pay: Patients without active insurance coverage are considered self-pay. Payment in full is due at the time of service unless prior written arrangements have been made.

Sound Dermatology

FINANCIAL POLICY (cont.)

Minors: Patients under the age of 18 must have consent for treatment from a parent or legal guardian in accordance with applicable law. The parent or legal guardian accompanying the minor, or who authorizes treatment, assumes full financial responsibility for all services rendered.

Refund Policy: Overpayments will be refunded once identified and verified. Refunds will be issued to the original method of payment whenever possible. Refunds will not be issued for services already rendered except in cases of billing error.

Past Due Accounts: Accounts are considered past due if not paid within 30 days of the statement date. If payment in full cannot be made, patients must contact our Business Office to establish payment arrangements. Patients with outstanding balances may be required to resolve balances prior to scheduling future appointments. Accounts not resolved may be referred to a collection agency and may be reported to credit bureaus as permitted by law. The patient is responsible for any additional costs incurred in the collection of unpaid balances including reasonable attorney's fees if permitted by law.

Non-Covered Services: Removal of benign lesions that do not meet an insurance carrier's medical necessity criteria (such as documented symptoms including itching, bleeding, pain, growth, drainage, or recurrent trauma) may be considered cosmetic or non-covered by the insurance plan. An office visit may still be billed to insurance for evaluation of the lesion. Non-Covered Services fees are separate from evaluation charges and must be paid in full at the time of service. If there is uncertainty regarding insurance coverage, the patient may elect to proceed as self-pay. Sound Dermatology will not knowingly submit services to insurance as medically necessary when they do not meet the insurer's criteria. Payments and prepayments for non-covered services are non-refundable unless otherwise specified in writing.

Credit Card on File Authorization: Sound Dermatology may require a valid credit or debit card to be securely stored on file. Card information is processed and stored using secure, PCI-compliant payment processing systems. Sound Dermatology does not directly store full credit card numbers. By signing below, I authorize Sound Dermatology to charge my card on file for:

- Non-covered services
- Cancellation or no-show fees
- Patient responsibility balances after insurance processing*
- Outstanding balances not paid within 30 days*

*Sound Dermatology will make reasonable efforts to notify patients prior to charging balances when feasible. Charges may be processed without additional notice when authorized under this agreement. I will receive an itemized receipt for charges made to my card. This authorization remains in effect until revoked in writing and does not apply retroactively to services already rendered.

Financial Agreement: I acknowledge that I have read and understand this Financial Policy. I agree to be financially responsible for all charges for services rendered that are not paid by my insurance carrier or other responsible payer, in accordance with this policy.

_____ _____

Patient/Representative Signature Date

_____ _____

Printed name of patient or representative Relationship to patient