



Maverick Skin and Cancer

Name: _____

Date: _____

We would like to know how you heard about us...

Please circle one of the following:

- Yahoo
- Phonebook: _____
- Google
- Friend/ Relative Who? _____
- Doctor _____
- Insurance _____
- Walk-In/ Drive By
- News Paper
- Facebook
- Instagram
- Mailers
- Other _____



Maverick Skin and Cancer

Patient Information Form

Name _____ Date _____
First Middle Last

Address _____ City _____ State _____ Zip _____

Cell # _____ Home phone _____ Soc. Security # _____ Birthdate _____

Email _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If college student, F.T/P.T., name of school _____ City _____ State _____

Patient or parent's employer _____ Work phone _____

Business address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work phone _____

Whom may we thank for referring you _____

Person to contact in case of an emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____

Birth Date _____ Soc. Security # _____

Employer _____ Work phone _____

Is this person currently a patient in our office ☐ Yes ☐ No

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Soc. Security # _____

Name of employer _____ Union or local # _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D.# _____

Do you have any additional insurance ☐ Yes ☐ No If yes, complete the following:

Name of insured _____ Soc. Security # _____ Date employed _____

Name of employer _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D. # _____

Ins. Co. address _____ City _____ State. _____ Zip _____

I authorize release of my medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _____ Date _____



MEDICAL HISTORY FORM

Name _____ Date of Birth _____ Date _____

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____

ALLERGIES: _____

DERMATOLOGIC HISTORY: Do you have a history of:

1. ☐ Melanoma
2. ☐ Squamous Cell Carcinoma
3. ☐ Basal Cell Carcinoma
4. ☐ Skin Cancer, Uncertain Type
5. ☐ Dysplastic (Atypical) Moles
6. ☐ Actinic Keratosis (Pre-cancer)
7. ☐ Eczema
8. ☐ Psoriasis

Other _____

FAMILY HISTORY: Do family members have a history of any of the following?

1. ☐ Melanoma (if yes who _____)
2. ☐ Squamous Cell Carcinoma
3. ☐ Basal Cell Carcinoma
4. ☐ Skin Cancer, Uncertain Type
5. ☐ Dysplastic (Atypical) Moles
6. ☐ Eczema/Psoriasis

Other _____

SURGICAL HISTORY

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

SOCIAL HISTORY

1. **Alcohol:** Y / N
2. **Smoking:** Y / N
3. **Lifetime sun exposure:** Light Medium Heavy
4. **Current sun exposure:** Light Medium Heavy
5. **Pneumonia Vaccine:** Y / N
6. **Living will or Advance Care plan:** Y / N

MEDICATIONS: please list current medications

Skin Medications

1. _____
2. _____
3. _____

Other medications

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

☐ SEE LIST

Pharmacy: _____

Cross roads: _____

RACE: (circle one) American Indian or Alaskan Native Asian African American

Caucasian Hispanic Native Hawaiian or Pacific Islander Other Decline

LANGUAGE:

English Spanish Other: _____



Payment Policy

1. **We do not accept checks for any amount!**
2. Cosmetic Procedures must be paid for in cash or by credit card before services are rendered.
3. No refunds will be issued; **All payments are final.**
4. **All Product sales are final, no returns.**

Cancellation Policy

A \$50.00 cancellation fee will apply to appointments not cancelled 24 hours prior to their scheduled time. This fee pertains to all **Appointments. The \$50 fee must be collected prior to scheduling the next appointment.**

Please PRINT Patient's Name

Date

Patient/ Parent/ or Legal Guardian's Signature

Date

Post-op Care Policy

Maverick Skin and Cancer is committed to providing appropriate post-operative care and follow-up for services performed in our office. Patients are encouraged to contact the practice with any questions, concerns, or complications following a procedure so that they may be appropriately evaluated and addressed in accordance with our Post-Operative Care and Revision Policy.

By signing below, I acknowledge that I have read and understand this policy. I agree to contact Maverick Skin and Cancer directly regarding any concerns related to my procedure, treatment, results, or post-operative care before initiating a payment dispute or chargeback.

I understand that this acknowledgment does not waive any rights or protections that cannot legally be waived under applicable law or the terms of my credit card, debit card, or financing agreement.

Patient name (Print): _____

Patient Signature: _____

Date: _____

TO ALL PATIENTS WITH INSURANCE COVERAGE

PLEASE READ AND SIGN

If you have insurance coverage, it is your responsibility to know the policy and guidelines of that company. What this means is, you are responsible to know your deductible, co-pay, type of coverage, and whether or not you need an authorization to be seen at this office. If we are not your primary care physician, most companies require you to have a written authorization before seeing any other doctor. This is why it is important that you notify us before doing so.

With so many different insurance policies around, it is virtually impossible for this office to know the details of every insurance policy. We will try to help you as much as possible, but should your insurance deny your bill, you will be held liable for any charges.

I, _____, have been informed by my physician or a
(Last name) (First name)
representative of Maverick Skin and Cancer that I will be responsible for services provided that are deemed medically unnecessary by insurance company.

IMPORTANT! If you have an HMO or Managed Care Plan, you must have an authorization to be seen. If we do not have an authorization, you will not be seen by the doctor.

If we can answer any questions, or assist you in any way, we will be happy to do so.

Thank you.

Please PRINT Patient's Name

Patient or Responsible Party's Signature

Date

PHYSICIAN- PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompletely rendered, will be determined by submission to arbitration provided by Nevada law, and not by a lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute in a court of law before a jury, and instead are accepting the use of binding arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against a Physician, including any fee dispute, whether or not the subject of any existing court action shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Nevada Revised Statutes (ARS) 12-1501-12-1518 and the Federal Arbitration Act (9 U.S.C 1-4), and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees, and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: Revocation: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 5: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with Arizona and federal law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____
Physician or Duly Authorized (Date)
Representative Signature

By: _____
Patient's Signature (Date)

By: _____
Print or Stamp Name of Physician,
Medical Group or Association Name

By: _____
Print Patient's Name

By: _____
Signature of Translator (Date)
(If applicable)

By: _____
Patient's Representative's Signature (Date)

By: _____
Print Name of Translator

By: _____
Print Name and Relationship to Patient

A signed copy of this document is to be given to the patient. The Original is to be filed in Patient's medical records.



Maverick Skin and Cancer

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL RECORDS

I hereby authorize the physicians or employees of _____ to forward my medical records.

DURATION: *Authorization shall be effective immediately and remain in effect for one year.*

REVOCATION: *Written revocation will be effective upon receipt.*

SPECIFY RECORDS:

Check the box and initial which type of information is to be disclosed:

- ☐ Progress Notes
- ☐ Pathology Reports/ Lab Results
- ☐ MOHS notes/ MOHS map cards
- ☐ _____

Please provide records in the following format:

- ☐ FAX
- ☐ PAPER RECORD
- ☐ EMAIL

PLEASE PROVIDE RECORDS FROM THE FOLLOWING SERVICE DATES:

RELEASE MEDICAL RECORDS FROM:

Doctor/Clinic: _____

Address: _____

City/State/Zip: _____

Telephone Number: _____ Fax: _____

FORWARD MEDICAL RECORDS TO:

Doctor/Clinic: **MAVERICK SKIN AND CANCER CLINIC**

Address: **340 FALCON RIDGE PKWY BLDG. 100 STE D**

City/State/Zip: **MESQUITE, NV 89027**

Telephone Number: **435-599-7877** Fax: **435-359-5021**

- ☐ Under Federal Regulations known as HIPAA, patients may be charged a copying fee. Maverick Skin and Cancer charges .60 cents per page for medical records forwarded to an attorney, insurance company, or for personal use. There will be no charge for records transferred to another physician.

PATIENT NAME: _____

DOB: _____

PATIENT SIGNATURE: _____

DATE: _____



HIPAA CONTACT DISCLOSURE

Maverick Skin and Cancer

I, _____ (DOB) _____, give Maverick Skin and Cancer and staff, authorization to disclose my protected health information to the following family, friends and/or caregivers:

Name: _____	Relationship: _____	Phone: _____
Name: _____	Relationship: _____	Phone: _____
Name: _____	Relationship: _____	Phone: _____
Name: _____	Relationship: _____	Phone: _____

In the event Maverick Skin and Cancer may need to give your test results or medical information may we.....(check all that apply)

_____ Leave a detailed voice message on this phone, the number is _____

_____ Call you on your cellular phone, the number is _____

_____ Call you at work, the number is _____

_____ Speak to you directly. **ONLY**

Disclaimer: Certain Sensitive health information (treatment / testing) are specifically protected and will not be disclosed outside of the clinic setting without specific authorization. This includes the following:

- Mental / behavioral Health records
- Sexually transmitted disease (STD)
- HIV testing results / AIDS treatment

Please indicate if you allow or deny Maverick Skin and Cancer the ability to share this information with you, per the indicated communication option above.

I allow Maverick Skin and Cancer to share sensitive health information as noted above per the communication options checked on this form. _____ (Patient Signature)

I DO NOT allow Maverick Skin and Cancer to share sensitive health information as noted above. _____ (Patient Signature)

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Medical Records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment, payment or healthcare operations as sighted in the Notice of Privacy Practices.

I understand that authorizing the disclosure of this health information is voluntary. Maverick Skin and Cancer and its entities will not condition treatment, payment, enrollment, or eligibility for benefits on providing, or refusing to provide this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have questions about the disclosure of my health information, I can refer to my Notice of Privacy Practices, which I obtained from my doctor's office.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

If I fail to specify a date, this authorization will expire one (1) year from the signature on this form.

_____ Date _____

Signature of Patient

_____ Date _____

Signature of Guardian or Personal Representative

_____ Date _____

Signature of Maverick Skin and Cancer Employee