BOSWELL
DERMATOLOGY

NEW ADDRESS: 6730 N. West Ave | Fresno, CA 93711
559.439.3000 phone | 559.439-3004 fax

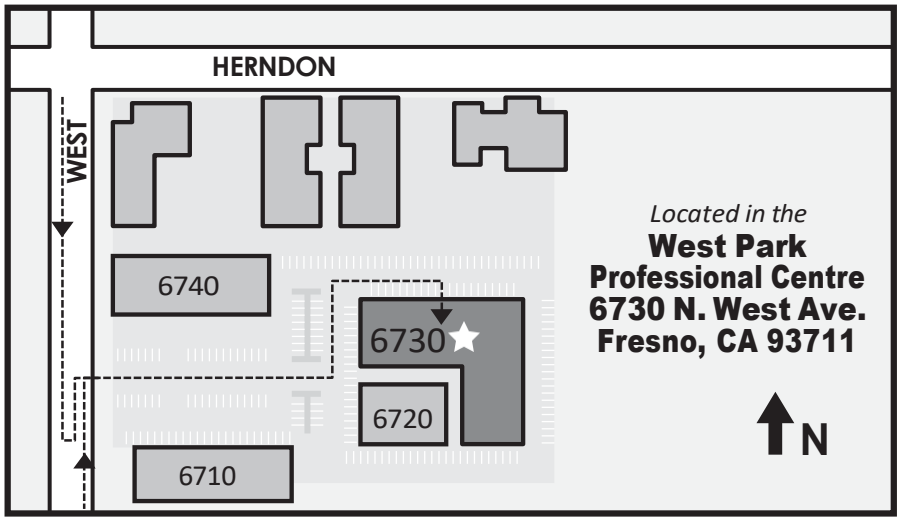
Welcome to Boswell Dermatology

_____ has an appointment on

Monday Tuesday Wednesday Thursday Friday

Date: _____ at _____ AM/PM

J. Scott Boswell, MD	**Jessica Krigbaum, DCNP**	**Brittney Stanley, DCNP**
Jared Lund, MD	**Christina Stempson, DCNP**	**Brittany Kalajian, DCNP**
Kent Saunders, MD	**Jordan Cutts, DCNP**	**Holly Miller, DCNP**
Vivian Young, DCNP	**Lea Pisching, DCNP**	**Edgar Botello, DCNP**



Please give at least 24 hour notice for any appointment changes to avoid a cancellation fee.

PLEASE ARRIVE 5 MINUTES PRIOR TO APPOINTMENT TIME NOTED ABOVE

Reminder: Patients under 18 years of age must be accompanied by a parent or guardian.

Please bring the following to your appointment:

- **Photo ID and Insurance Cards**
- Completed Paperwork and list of current medications
- Office visit co-pay, deductible or co insurance

Fill out attached paperwork and bring to your appointment
Thank you

If you have any questions about your appointment, please contact us at **559.439.3000**.

Dear New Patient,

Welcome to Boswell Dermatology! I am honored that you will be entrusting me and my team to your medical care - know that we are committed to treat you and your skin with compassion and expertise! Because I know it can be unnerving to go to a new doctor's office, let me explain a bit about our practice.

What makes our dermatology practice different?

We are the only dermatology practice in the Central Valley with 3 board-certified dermatologists. This means that Dr. Jared Lund, Dr. Kent Saunders and I have each completed a 3-year dermatology residency after medical school and passed a national board exam in dermatology (see American Board of Dermatology, www.abderm.org). In addition, Dr. Lund is a fellowship-trained Mohs skin cancer surgeon who is specially trained and additionally board-certified though the ABD to perform Mohs surgery on your skin. These board-certifications are very important and demonstrate that our physicians have the highest level of training, with both medical and surgical experts under one roof. This separates us from other practices in the area.

Why am I seeing a nurse practitioner? What is a DCNP?

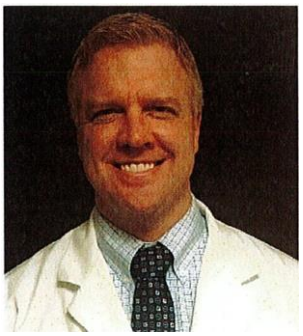
The Central Valley is *one of the most underserved areas in the country for dermatology*, so we also have talented nurse practitioners at our office *who have been practicing dermatology for years*. Often, I am asked, "Why am I scheduled with a nurse practitioner?" I'd like to explain the model at our practice, including how it benefits you:

- As mentioned above, our nurse practitioners have been at our practice for years, and respectfully, have far more expertise and training in skin disease and management than your primary care physician or an urgent care. To work at our practice, nurse practitioners are required to go through a 2-year rigorous training program with me personally, obtain over 3,000 hours of experience in dermatology, then pass a rigorous national exam to obtain board-certification in dermatology through the Dermatology Nurse Practitioner Certification Board (www.dnpcb.org). In doing so, they have earned the designation "DCNP" (Dermatology Certified Nurse Practitioner). I am unaware of any other dermatology practice in the Central Valley that requires dermatology board-certification of all their physicians and nurse practitioners - we are the only ones, because I require it for the benefit of our patients.
- Because we live in an underserved area for dermatology, patients can potentially have unacceptably long wait times to see me or one of the other dermatologists at our practice - which is very concerning to me. I am a dermatologist because I want to help you immediately with that urgent rash or that possible skin cancer you just noticed! Therefore, I recently changed my personal model of how I see patients, including how I can extend myself to see you with your urgent need. With some exceptions, I or one of the other dermatologists may see you in conjunction with a nurse practitioner. Please remember this means we can get you in sooner to be seen by an expert for your dermatologic need!

We look forward to welcoming you to our practice and thank you again for entrusting your health to our care and expertise!

J Scott Boswell MD FAAD

J. Scott Boswell, MD, FAAD



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PATIENT REGISTRATION INFORMATION

Please PRINT and complete ALL sections below.

PERSONAL INFORMATION Today's Date: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex: ☐ Male ☐ Female**

Name: _____
Last Name First Name Middle Initial Maiden Name

Street Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (_____) _____ Cell Phone : (_____) _____

Date of Birth: _____ /_____/_____ Social Security Number: _____

Email Address: _____

RESPONSIBLE PARTY INFORMATION **If self, please check box and go to insurance section below**

☐ Self ☐ Spouse ☐ Parent ☐ Male ☐ Female

Spouse/Parent Name: _____ Date of Birth: _____ /_____/_____

Billing Address: _____City: _____ State: ____ Zip: _____

Home Phone: (_____) _____ Cell Phone : (_____) _____

INSURANCE INFORMATION **Please present all insurance cards and notify us of changes in insurance**

Primary Insurance	**Secondary Insurance**
Primary Insurance: _____	Secondary Insurance: _____
ID #:_____	ID #: _____
Group #:_____	Group #: _____
Insured Name: _____	Insured Name: _____
Insured DOB: _____	Insured DOB: _____

Do you have an HSA/FSA? _____

As a courtesy, we will bill your primary and second insurance for your visit charges. Any other insurance will be the patient's responsibility to submit.

PERSONAL REPRESENTATIVE

I authorize the following person(s) to receive or know information regarding my health care or make health care decisions for me, should I become unable to make them for myself. This authorization may be revoked in writing at any time.

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

- I hereby give consent for medical/surgical treatment to the care providers with Boswell Dermatology.
- I authorize the release of information to facilitate treatment, payment or health care operations.

_____ Date: _____

Patient Signature (or Responsible Party Signature)

We're happy that you have chosen Boswell Dermatology. We are committed to excellence in helping you meet your health care needs and understand that billing/payment for health care services can be a confusing and sensitive topic. Please take the time to review the policies of our practice; we will be happy to answer any questions you may have.

Please initial to indicate that you have read each policy

____ **Insurance:** We are contracted with many insurance companies and will gladly bill on your behalf. It is the patient's responsibility to be sure that we have the correct information and that we are in-network with your insurance. Patients are responsible for co-payment, deductibles and co-insurance. All payments must be paid at your appointment per our contract with your insurance.

____ **MEDI-CAL:** We are not contracted with any Medi-Cal plan. We cannot accept, nor bill, these plans under any circumstance. Furthermore, if you have one of these plans, we will not be able to see you on a cash basis. To do so would jeopardize your health benefits and open our office to penalization by the State.

____ **Deductibles:** If you have not met your deductible, it is our policy to collect, at the time of your appointment, for services we know will not be paid by your insurance. We do not guarantee that the amount paid at the time of service settles your bill with us.

____ **Non-Covered Services:** Please be aware that there may be services rendered at your appointment that are not covered by your insurance. Hair loss, skin tags, and the removal of benign growths are common conditions that may not be paid by insurance companies; you may receive a bill from our office for these services. Please be aware that anything excised from your body will be sent out to a dermatopathologist and you may receive a separate bill from that office.

___ **Referrals/Pre-Authorizations:** It is your responsibility to obtain a current referral/pre-authorization for treatment, should your insurance dictate that one is necessary. In the absence of the appropriate documentation, you agree to accept full responsibility for the charges related to treatment.

____ **Proof of Identification/Proof of Insurance:** You will be asked to provide us with a copy of your ID and insurance cards for your chart. Please understand that we are helping to protect your identity as a patient. We are also required to send a copy of your insurance and ID to pharmacies for your prescriptions and a copy must accompany any pathology that may be sent out for testing.

____ **Payment:** If you do not have insurance and would like to be seen, we accept cash, check, VISA, Discover or MasterCard; all payments are due at the time of your appointment. A $25 fee will be added to any check that is returned for insufficient funds. Once we have received notification/payment from your insurance company, we will send you a statement. All balances are due upon receipt of the statement. It is never our intent to send a patient to collections for non-payment; please contact the billing office if you have any questions regarding your bill.

____ **No-Show/Late Cancellation/Surgeries:** We understand there may be times when you miss an appointment due to illness or emergencies. However, we ask that you call 24-hours prior to your appointment to make changes or cancel your appointment. Please understand that because appointment time slots are valuable, you will be charged a $75 no show/late cancellation fee if you do not give a 24-hour notice. This must be paid before you are scheduled for a future visit. If you are scheduled for any surgical procedure, or require an interpreter at your appointment, we require a 72-hour notice to cancel or reschedule. You will be charged a $300 fee if you do not give 72-hour notice.

____ **Consent to Photograph:** We will be asking permission to take your photo. Please understand that this is to be used for identification purposes and will aid us in keeping track of areas of concern for future treatment. We *WILL NOT* publish your photos without your permission. If a provider would like to use a photo to be used for medical education, you will be asked to sign a separate consent form to do so.

- I have read the policies set forth by Boswell Dermatology. My signature below signifies my understanding and willingness to comply with your policies.

_____ Date:_____

Patient Signature (or Responsible Party Signature)

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NEW PATIENT MEDICAL HISTORY

Name: _____ Date: _____ Age: _____

Pharmacy Name: _____ **Cross Streets:** _____

Medical History: In your own words, please state the reason for your visit **(chief complaint)**:_____

_____

_____

How long have you had this problem? **(duration)** _____

What parts of your body are affected? **(location)** _____

What makes it better? What makes it worse? **(change in severity)** _____

_____

How does this problem bother you? **(symptoms)** _____

What treatments have you received for this problem? **(previous therapy)** _____

_____

_____

Is your problem □ worsening? □ stable? □ improving? **(timing)** Explain: _____

_____

_____

Past medical/family/social history: Please list all past major illnesses and operations: _____

_____

_____

Please list all medications you are currently taking: _____

_____

Please list all drug and environmental allergies: _____

_____

Is there a family history of a condition similar to yours? ☐ Yes ☐ No Additional Information: _____

_____

Is there a family history of (please mark the square(s) that apply): □ adult acne □ asthma □ diabetes
□ eczema □ hay fever □ genetic disease □ hair loss □ melanoma □ psoriasis □ skin cancer
Additional information: _____

Occupation: _____

Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No

Review of Symptoms

Skin: Have you seen a doctor for other skin problems? □ Yes □ No Which one(s)? _____

_____

Do you have (please mark square(s) that apply: □ hair loss □ skin cancer □ abnormal moles

When you are exposed to sunlight, do you:

1. □ Always burn
2. □ Usually burn, rarely tan
3. □ Often burn, tan slowly
4. □ Sometimes burn, tan well
5. □ Rarely burn, always tan
6. □ Never burn, deeply tan

Women: Are you pregnant? □ Yes □ No Do you plan to become pregnant? □ Yes □ No

Are you nursing? □ Yes □ No Do you have breast problems? □ Yes □ No

Mark square next to any symptom or condition you are having:

General
□ fever
□ chills
□ weight loss
□ loss of appetite
□ fatigue

Head, Eyes, Ears, Nose, Throat
□ visual problems
□ dry eyes
□ eye disease
□ ringing in ears
□ ear disease
□ bloody nose
□ stuffy nose
□ swallowing difficulties
□ dry mouth
□ sore mouth
□ mouth ulcers

Cardiovascular
□ pacemaker
□ heart disease
□ mitral valve prolapse
□ hypertension
□ chest pain

Respiratory
□ cough
□ difficulty breathing
□ lung disease
□ tuberculosis
□ coughing up blood

Gastrointestinal
□ liver disease
□ intestinal disease
□ heartburn/indigestion
□ abdominal/stomach pain
□ diarrhea
□ constipation
□ blood in stool/black stool
□ rectal pain
□ nausea
□ vomiting

Genitourinary
□ kidney disease
□ bladder disease
□ blood in urine/dark urine
□ female problems
□ stillbirth/spontaneous abortion
□ problems with urination

Musculoskeletal
□ joint aches
□ swollen joints
□ muscle aches
□ muscle weakness
□ back pain
□ ankle swelling
□ fingers sensitive to cold

Neurologic
□ epilepsy/seizures
□ headaches
□ stroke
□ dizziness
□ disorientation
□ confusion
□ memory loss
□ numbness
□ double vision
□ loss of consciousness

Psychiatric
□ nervous breakdown
□ depression
□ insomnia

Endocrine
□ diabetes
□ enlarged glands
□ hormonal problems
□ thyroid disease

Hematologic/Lymphatic
□ anemia
□ free bleeding tendency

Immunologic
□ immune deficiency
□ frequent infections

If needed, please elaborate on any of the above: _____

_____

_____

_____ Date: _____

Patient Signature (or Responsible Party Signature)

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Pathology Services:

Please note that you may have a skin biopsy done during your visit, or on subsequent visits, here at our office. The safe and standard practice of medicine is to send your skin specimen to a pathologist (a type of doctor) for interpretation. *To keep in line with the standard of care, and because we have your health in our best interests, we must send the specimen to meet the high level of care you deserve*. Your biopsy will be interpreted by a board certified dermatopathologist, who are physicians who specialize in microscopic diagnosis of skin disorders. The pathologist who evaluates your biopsy will issue a report to our office listing the microscopic findings along with a diagnosis. We customarily send specimens to the following pathology laboratories:

Compass Dermatopathology, Inc.
6605 Nancy Ridge
San Diego, CA 92121
Telephone: 858 900-2700
Billing Contact: Sasha Lepes, 858 900-2712

University of California, San Francisco (UCSF) Dermatopathology
1701 Divisadero Street, Room 280
San Francisco, CA 94115
Telephone: 800 497-0244
Special Billing Issues Liaison: Paco De Asis at 415 353-7270

Pathology Associates
305 Park Creek Drive
Clovis, CA 93611
Telephone: 559 326-2800

There are many different insurance plans of varying coverage and complexities, so it is impossible for us to know the anticipated charges or coverage your particular plan will have with each pathology lab. Therefore, *before your visit* **we highly recommend that you call your insurance company to see which of the above pathology groups is covered by your insurance**, and what your anticipated cost will be for a pathology read of your skin specimen. This will avoid surprises and unexpected bills on your end. If you have a biopsy done during your visit, **please let our staff know which pathology laboratory above (Compass Dermatopathology, Inc., UCSF Dermatopathology or Pathology Associates) is preferred**. If you do not specify which laboratory you would like us to use, by default we will generally use Compass Dermatopathology, Inc.

Laboratory Services:

You may be sent for blood work after visits at our office. If this occurs, you will be given a Quest Diagnostics lab order form which should be taken to the facility that is covered by your plan. We recommend you call your insurance and confirm which local laboratory (Quest Diagnostics, LabCorp, Community Medical Center, St. Agnes, etc.) is covered before going for blood work. This will avoid surprises and unexpected bills on your end.

Imaging Services:

You may be sent for imaging (X-rays, CT scans, MRI's) after visits at our office. If this occurs, you will be given an imaging order form. We recommend you call your insurance and confirm which imaging facility (California Imaging, Advanced Medical Imaging, Community Medical Center, St. Agnes, etc.) is covered before going for your imaging test. This will avoid surprises and unexpected bills on your end.

I acknowledge the information presented above regarding pathology, laboratory and imaging services.

_____ _____

Name: Date

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

THE NOTICE OF PRIVACY PRACTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, AS IT EXPLAINS:

- **How this office will use and disclose your protected health information.**
- **Your privacy rights with regard to your protected health information.**
- **This office's obligations concerning the use and disclosure of your protected health information.**

I acknowledge that the office Notice of Privacy Practices is available at the front desk upon request. I have read and understand those rights.

_____ _____

Patient or Patient Representative Signature Date

_____

Patient or Patient Representative Printed Name