



Marnie Ririe, MD, FAAD  
1636 Hadley Ave  
Boise, ID 83709  
(208) 258-2078  
FAX (208) 258-2079

**Consent to Treat, Medical Release of Information Notice,  
and Agreement to Pay Notice**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**CONSENT TO TREATMENT:** I voluntarily consent to receive medical and health care services provided by Marnie Ririe, MD, FAAD at BOISE SKIN CLINIC, PLLC, (BSC) including but not limited to outpatient medical, surgical, and therapeutic care; laboratory tests and procedures, administration of pharmaceuticals or local and topical anesthesia. I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment and payment purposes only. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

If BSC personnel suffer a needle stick or are exposed to your blood or body fluids, I consent to the testing for any blood-borne disease for the protection of BSC personnel.

I acknowledge that BSC may use health information exchange systems to electronically transmit, receive and/or access my medical information which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history, and other health care information.

I understand that this Consent to Treat, MEDICAL RELEASE OF INFORMATION AND AGREEMENT TO PAY NOTICE will be valid and remain in effect as long as I attend or receive services from BSC, unless revoked by me in writing with such written notice provided to each clinic I attend or from which I receive services.

**FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:** In consideration for receiving medical or health care services, I hereby assign to BSC physicians and providers my right, title, and interest in all insurance, Medicare/Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges, to BSC. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct.

**RELEASE OF MEDICAL INFORMATION:** I acknowledge that "protected health information" pertains to my diagnosis and/or treatment including, but not limited to, information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs, or communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, prescriptions, medical history, prescription history, treatment progress or any other such related information.

**NOTICE OF PRIVACY PRACTICES and PATIENT RIGHT'S AND**

**RESPONSIBILITIES:** The BOISE SKIN CLINIC, PLLC document "Your Information. Your Rights. Our Responsibilities." provides information about how BSC and its workforce may use and/or disclose protected health information about me for treatment, payment, health care operations, and as otherwise allowed by law. I understand BSC cannot be responsible for use or re-disclosure of information by third parties.

I acknowledge that I received the "Your Information. Your Rights. Our Responsibilities." on this or at prior visit. [Please initial]: \_\_\_\_\_

**ADVANCE DIRECTIVE:** Please indicate if the patient has executed any of the following advance directives: [ ] No, [ ] Living Will, [ ] Durable Power of Attorney, [ ] POST, [ ] Other.

**OWNERSHIP DISCLOSURE:** Boise Skin Clinic, PLLC is owned by Marnie Ririe, MD, FAAD.

**PAYMENT:**

I agree to pay for any co-payments, deductibles and charges for medical and health care services not covered by, or which exceed, the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer, except as prohibited by law or any agreement between Boise Skin Clinic, PLLC and my insurance company.

If my account becomes delinquent, I agree to pay interest and fees according to BSC's policies including, but not limited to reasonable costs of collection, collection agency fees, attorney fees and/or court costs. I understand I can receive a copy of BSC's collection policy.

I agree that any overpayments collected on my account may be applied to any delinquent payments on my account.

I certify that I have read this form or it has been read to me\*.

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**Print Name**

\_\_\_\_\_  
**Signature of Patient/Other legally Authorized Person** **Date:** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Witness/Translator\*** **Date:** \_\_\_\_\_

\_\_\_\_\_  
**Relationship to Patient\*** **Date:** \_\_\_\_\_



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Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Your Past Medical History: Please circle all that apply or circle: NONE

- Anxiety disorder, Arthritis, Asthma, Atrial fibrillation, BPH, COPD, Coronary arteriosclerosis, Depressive disorder, Diabetes mellitus, End-stage renal disease, Epilepsy, GERD, Hearing loss, HIV / AIDS, High blood pressure, Hyperthyroidism, Hypothyroidism, Inflammatory liver disease, Leukemia, Lymphoma, Lung cancer, Breast cancer, Colon cancer, Prostate cancer, Radiation treatment, Stroke, Bone marrow transplant

Other not listed? Please list: \_\_\_\_\_

Immunizations:

Table with 4 columns: Question, Yes, No. Rows include childhood vaccines, Gardasil/HPV vaccine, and shingles vaccine.

Your Past Surgical History: (Please circle all that apply or circle: No Previous Surgeries.)

- Coronary artery bypass graft, Colostomy, Tubal ligation, Appendectomy, Gallbladder removal, Colon removal, Liver surgery, Bladder removal, Hysterectomy, Lumpectomy of breast (R, L or Bilateral), Mastectomy (R, L or Bilateral), Ovary removal, Pancreas removal, Kidney stone procedure, Prostate surgery, Spleen removal, Kidney removal, Testicle removal, Hip replacement (R, L or Bilateral), Knee replacement (R, L or Bilateral), Heart surgery, Organ transplant: \_\_\_\_\_

Other not listed? Please list: \_\_\_\_\_

Your Skin Disease History: (Please circle all that apply or circle: NONE.)

- Acne, Actinic keratosis, Basal cell carcinoma, Poison ivy, Pre-cancerous moles, Eczema, Asthma, Hay fever, Malignant melanoma, Itchy scalp, Psoriasis, Squamous cell carcinoma, Intermittent severe sunburns

Other not listed? Please list: \_\_\_\_\_

Do you wear Sunscreen?	Yes	No
If yes, what SPF? _____		
Do you tan in a tanning salon?	Yes	No
Do you have a family history of Melanoma?	Yes	No
If yes, which relative(s)? _____		

**Your Current Medications:**

(Please write down all current medications including vitamins and herbs. Please specify dosage and frequency)

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**Your Allergies:**

(Please write all medication allergies and any other known allergies as well as your reaction.)

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**Social History:**

**Regarding tobacco use, please circle:**

**Regarding alcohol use, please circle:**

Never smoker  
 Former smoker  
 Current smoker  
 Other forms of tobacco/nicotine? \_\_\_\_\_

None  
 Less than 1 drink per day  
 1-2 drinks per day  
 3 or more drinks a day  
 Any use of illicit/street drugs? \_\_\_\_\_

**Occupation?** \_\_\_\_\_ **Hobbies?** \_\_\_\_\_

**Review of Systems:**

Are you currently experiencing or have you recently experienced any of the following?  
 (Please check Yes or No.)

Symptom	Yes	No
Headaches		
Eye problems		
Blurry vision		
Ear problems		
Hay fever		
Pain in mouth or sore throat		
Chest pain		
Shortness of breath		
Difficulty breathing/wheezing		
Cough		

Are you currently experiencing or have you recently experienced any of the following?  
(Please check Yes or No.)

Abdominal pain		
Nausea or vomiting		
Diarrhea		
Bloody stool		
Bloody urine		
Pain, ulcers, or blisters in the genital area		
Depression		
Anxiety		
Immunosuppression		
Recent illness or unintentional weight loss		
Joint aches		
Muscle aches or weakness		
Muscle stiffness		
Fever, chills, or night sweats		
Numbness or tingling		
Seizures		
Rash		
Thyroid problems		
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		

**ALERTS:** (Please **circle** all that apply.)

Do you take any blood thinners or aspirin? Yes    No  
 Do you take antibiotics before dental work or other procedures? Yes    No

Have you had, or are you experiencing any of the following?

- Allergy to adhesive
- Allergy to lidocaine
- Allergy to topical antibiotic ointments
- Artificial heart valve
- Artificial joints within past two years
- Blood thinners
- Defibrillator
- MRSA
- Pacemaker
- Premedication prior to procedures
- Rapid heart beat with epinephrine
- Pregnancy or planning a pregnancy

**Family History:**

Do you have a family history of any of the following? Please **circle** all that apply and circle family member designation:

**M** - Mother, **F** – Father, **S** – Sister, **B** – Brother,  
**A**- Aunt, **U** – Uncle, **GF** – Grandfather, **GM** – Grandmother

<p align="center">Acne</p> <p align="center"><b>M F S B</b> <b>A U GF GM</b></p>	<p align="center">Asthma</p> <p align="center"><b>M F S B</b> <b>A U GF GM</b></p>	<p align="center">Autoimmune disease (like lupus or MS)</p> <p align="center"><b>M F S B</b> <b>A U GF GM</b></p>	<p align="center">Eczema</p> <p align="center"><b>M F S B</b> <b>A U GF GM</b></p>
<p align="center">Diabetes Type 1 or 2 (Circle one)</p> <p align="center"><b>M F S B</b> <b>A U GF GM</b></p>	<p align="center">Hay fever / seasonal allergies</p> <p align="center"><b>M F S B</b> <b>A U GF GM</b></p>	<p align="center">Hyperthyroidism Hypothyroidism (Circle one)</p> <p align="center"><b>M F S B</b> <b>A U GF GM</b></p>	<p align="center">Hepatitis / liver disease</p> <p align="center"><b>M F S B</b> <b>A U GF GM</b></p>
<p align="center">High blood pressure</p> <p align="center"><b>M F S B</b> <b>A U GF GM</b></p>	<p align="center">Joint pain/arthritis</p> <p align="center"><b>M F S B</b> <b>A U GF GM</b></p>	<p align="center">Kidney disease</p> <p align="center"><b>M F S B</b> <b>A U GF GM</b></p>	<p align="center">Heart disease</p> <p align="center"><b>M F S B</b> <b>A U GF GM</b></p>
<p align="center">Psoriasis</p> <p align="center"><b>M F S B</b> <b>A U GF GM</b></p>	<p align="center">Tuberculosis</p> <p align="center"><b>M F S B</b> <b>A U GF GM</b></p>	<p align="center">Non- Melanoma Skin Cancer</p> <p align="center"><b>M F S B</b> <b>A U GF GM</b></p>	<p align="center">Other Cancers Type:</p> <hr/> <p align="center"><b>M F S B</b> <b>A U GF GM</b></p>

Other not listed? Please list: \_\_\_\_\_

**Pharmacy:**

Preferred pharmacy: \_\_\_\_\_

Phone number: \_\_\_\_\_ City or Zip code: \_\_\_\_\_

**Who is your primary care physician?**

\_\_\_\_\_  
 Name City State

**If you are being referred by a doctor, who is your referring physician?**

\_\_\_\_\_  
 Name City State

**PATIENT INFORMATION**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MIDDLE INITIAL: \_\_\_\_\_  
 PREFERRED NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ SEX: M F  
 ADDRESS: \_\_\_\_\_  
 CITY/STATE/ZIP: \_\_\_\_\_  
 HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_  
 WORK PHONE: \_\_\_\_\_ EXT: \_\_\_\_\_ EMAIL: \_\_\_\_\_

RESPONSIBLE PARTY (IF OTHER THAN PATIENT): \_\_\_\_\_  
 RESPONSIBLE PARTY CONTACT INFORMATION  
 ADDRESS: \_\_\_\_\_  
 CITY/STATE/ZIP: \_\_\_\_\_  
 HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_  
 WORK PHONE: \_\_\_\_\_ EXT: \_\_\_\_\_ EMAIL: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_  
 HOME/CELL PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ EXT: \_\_\_\_\_

PRIMARY INSURANCE:	SECONDARY INSURANCE:
COMPANY: _____ ADDRESS: _____ CITY, STATE, ZIP: _____ INSURED NAME: _____ RELATIONSHIP TO INSURED: _____ INSURED BIRTH DATE: _____ ID NUMBER: _____ GROUP NUMBER: _____ COPAY AMOUNT: _____	COMPANY: _____ ADDRESS: _____ CITY, STATE, ZIP: _____ INSURED NAME: _____ RELATIONSHIP TO INSURED: _____ INSURED BIRTH DATE: _____ ID NUMBER: _____ GROUP NUMBER: _____ COPAY AMOUNT: _____

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? YES NO

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to BOISE SKIN CLINIC, PLLC. I acknowledge that I am financially responsible for payment whether or not covered by insurance. I also give permission for BOISE SKIN CLINIC, PLLC to give me medical treatment. I understand I have the right to refuse any procedure or treatment and that I have the right to discuss all medical treatments with my provider.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*\*IF UNDER AGE OF 18 AND WITHOUT PARENT, PATIENT MUST HAVE A "CONSENT TO TREAT MINOR" FORM ON FILE.