Marnie Ririe, MD, FAAD
Tiffany McCray, PA-C
1636 Hadley Ave.
Boise, ID 83709
Phone: (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 or Tiffany McCray, PA-C 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.

Boise Skin Clinic, PLLC's Consent to Treat, Medical Release of Information Notice, and Agreement to Pay Notice – Page 2

NOTICE OF PRIVACY PRACTICES and PATIENT RIGHT'S AND RESPONISBILITIES: 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 DICLOSURE: 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 t to any delinquent payments on my account.

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

_____

Print Name

_____ **Date:**_____

Signature of Patient/Other legally Authorized Person

_____ **Date:**_____

Signature of Witness/Translator*

_____

Relationship to Patient*

Marnie Ririe, MD, FAAD
Tiffany McCray, PA-C
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Medical History and Intake Form

Name: _____ DOB: _____ Sex: _____ Age: ____

Your Past Medical History: (Please **circle** all that apply or NONE.)

Anxiety	Depression	Hyperthyroidism
Arthritis	Diabetes	Hypothyroidism
Asthma	End Stage Renal Disease	Leukemia
Atrial fibrillation	GERD	Lung Cancer
Bone Marrow Transplantation	Hearing Loss	Lymphoma
Breast Cancer	Hepatitis	Prostate Cancer
Colon Cancer	High Blood pressure	Radiation Treatment
COPD	HIV/AIDS	Seizures
Coronary Artery Disease	High Cholesterol	Stroke

Other not listed? Please list:

_____

Your Past Surgical History: (Please **circle** all that apply or NONE.)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee
(Right, Left, Bilateral)
Joint Replacement, Hip
(Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

Other not listed? Please list:

_____

Immunizations:

Have you received your childhood recommended series of vaccines?	Yes	No
Have you had the Guardasil or other HPV vaccine?	Yes	No
Have you had the shingles vaccine?	Yes	No

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

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	

Other not listed? Please list: _____

Do you wear Sunscreen?	Yes	No
If yes, what SPF? _____		
Do you tan in a tanning salon?	Yes	No
Have you had blistering sunburns?	Yes	No
Have you had intermittent severe sunburns?	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.)

_____

_____

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

Your Allergies: (Please write down all medication allergies and any other known allergies.)

_____

_____

Social History:

Occupation? _____ **Hobbies?** _____

Any tobacco use? Please circle:
Cigarette Smoking:
Currently Smokes
Has smoked in the past
Never smoked
Other forms of tobacco/nicotine? _____
Any use of illicit/street drugs? _____
IV or intranasal use? _____
Other_____

Alcohol Use? Please circle:
None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks a day

Family History:

Do you have a family member with skin cancer? Yes No
If yes, what type? _____
Do you have a family history of any other types of cancer? Yes No
If yes, what type? _____

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

Acne **M F S B** **A U GF GM**	Asthma **M F S B** **A U GF GM**	Autoimmune disease (like lupus or MS) **M F S B** **A U GF GM**		Diabetes **M F S B** **A U GF GM**
Eczema **M F S B** **A U GF GM**	Hay fever or allergies **M F S B** **A U GF GM**	Heart disease **M F S B** **A U GF GM**	Hepatitis/liver disease **M F S B** **A U GF GM**	High blood pressure **M F S B** **A U GF GM**
Joint pain/arthritis **M F S B** **A U GF GM**	Kidney disease **M F S B** **A U GF GM**	Hyperthyroidism Hypothyroidism (Circle one) **M F S B** **A U GF GM**	Psoriasis **M F S B** **A U GF GM**	Tuberculosis **M F S B** **A U GF GM**

Do you have a family history of other medical problems? Please list:

_____

_____

The following section asks for information to study and hopefully improve the national quality of care.

Preferred Language: _____ Race: _____ Ethnic Group: _____

Pharmacy:
Name your preferred pharmacy: _____

Phone#: _____ City or Zip code: _____

Who is your primary care physician?

_____ _____ _____
Name City State

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		
Ear problems		
Hay fever/allergies		
Pain in mouth or throat/sore throat		
Chest pain		
Difficulty breathing/shortness of breath/wheezing/cough		
Abdominal pain		
Nausea/vomiting		
Diarrhea		
Bleeding from bowels or bladder		
Pain, ulcers or blisters in the genital area		
Depression/anxiety		
Immunosupression		
Recent illness or unintentional weight loss		
Joint aches		
Muscle stiffness/aches or weakness		
Fevers, chills or night sweats		
Thyroid problems		
Numbness, tingling or seizures		
Rashes		
Bleeding, healing or scarring, bruising		

Other Symptoms:

_____

ALERTS: (Please **circle** all that apply.)
Allergy to adhesive/Tape
Allergy to latex
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a surgical/dental procedure
Rapid heart beat with epinephrine
Pregnant or currently trying to get pregnant

BOISE SKIN CLINIC, PLLC

PATIENT INFORMATION

LAST NAME:_____ FIRST NAME:_____ MIDDLE INITIAL: ____

PREFERRED NAME:_____BIRTH DATE**:_____SEX: M F MARITAL STATUS: S M D W

ADDRESS:_____

CITY/STATE/ZIP:_____HOME PHONE:_____

CELL:_____ WORK PHONE:_____ EXT:_____ EMAIL:_____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT): _____

RESPONSIBLE PARTY CONTACT INFORMTION:

ADDRESS:_____

CITY/STATE/ZIP:_____HOME PHONE:_____

CELL:_____ WORK PHONE:_____ EXT:____ EMAIL:_____

EMERGENCY CONTACT INFORMATION

NAME:_____ RELATIONSHIP:_____

HOME PHONE:_____ CELL:_____ WORK:_____

PRIMARY INSURANCE

COMPANY:_____

ADDRESS:_____

CITY, STATE, ZIP:_____

INSURED NAME:_____

PATIENT'S RELATIONSHIP TO INSURED

SELF SPOUSE CHILD OTHER:_____

INSURED BIRTH DATE:_____

ID NUMBER:_____

GROUP NUMBER:_____

COPAY AMOUNT (IF ANY):_____

SECONDARY INSURANCE

COMPANY:_____

ADDRESS:_____

CITY, STATE, ZIP:_____

INSURED NAME:_____

PATIENT'S RELATIONSHIP TO INSURED

SELF SPOUSE CHILD OTHER:_____

INSURED BIRTH DATE:_____

ID NUMBER:_____

GROUP NUMBER:_____

COPAY AMOUNT (IF ANY):_____

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 16 AND WITHOUT PARENT, PATIENT MUST HAVE A "CONSENT TO TREAT MINOR" FORM ON FILE.