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 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 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 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*

_____ **Date:**_____

Relationship to Patient*

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

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

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

Other not listed? Please list: _____

Immunizations:

Have you received your recommended childhood vaccines?		Yes	No
Have you had the Gardasil or other HPV vaccine?	N/A	Yes	No
Have you had the shingles (Shingrix) vaccine series? (Over 55)	N/A	Yes	No

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

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

Other not listed? Please list: _____

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

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

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)

_____

_____

_____

Your Allergies:

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

_____

_____

Social History:

Regarding tobacco use, please circle:

Never smoker
Former smoker
Current smoker
Other forms of tobacco/nicotine? _____

Regarding alcohol use, please circle:

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		

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

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**	Eczema **M F S B** **A U GF GM**
Diabetes Type 1 or 2 (Circle one) **M F S B** **A U GF GM**	Hay fever / seasonal allergies **M F S B** **A U GF GM**	Hyperthyroidism Hypothyroidism (Circle one) **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**	Heart disease **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**	Non- Melanoma Skin Cancer **M F S B** **A U GF GM**	Other Cancers Type: _____ **M F S B** **A U GF GM**

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 INFORMTION
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: _____	COMPANY: _____
ADDRESS: _____	ADDRESS: _____
CITY, STATE, ZIP: _____	CITY, STATE, ZIP: _____
INSURED NAME: _____	INSURED NAME: _____
RELATIONSHIP TO INSURED: _____	RELATIONSHIP TO INSURED: _____
INSURED BIRTH DATE: _____	INSURED BIRTH DATE: _____
ID NUMBER: _____	ID NUMBER: _____
GROUP NUMBER: _____	GROUP NUMBER: _____
COPAY AMOUNT: _____	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.