

**Jennifer Linder, M.D. PLLC**  
**Cynthia Price, M.D.**  
**Linder Dermatology & Skin Cancer Surgery Center**  
6710 East Camelback Road, Ste 220 Scottsdale, Arizona 85251  
480.946.7939 Fax 480.946.5258  
info@linderdermatology.com [www.linderdermatology.com](http://www.linderdermatology.com)

**Patient Information (Please print clearly)**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Last First M.I.

Social Security#: \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status: \_\_\_\_\_ Spouse \_\_\_\_\_ DOB \_\_\_\_\_

Race/Ethnicity: White (Non-Hispanic) \_\_\_\_\_ White (Hispanic) \_\_\_\_\_ African American \_\_\_\_\_ Asian \_\_\_\_\_  
American Indian \_\_\_\_\_ Other \_\_\_\_\_ Refuse to Report \_\_\_\_\_

**Mailing Address**

\_\_\_\_\_  
Apt/Unit City State Zip

Home Phone \_\_\_\_\_ Cellular \_\_\_\_\_ Work \_\_\_\_\_

Email \_\_\_\_\_ Do you wish to receive e-mail information/service/product updates or news related  
to our practice?  Yes  No

Patient Employment:  Student  Retired  Unemployed  Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**In case of Emergency**, who should we contact? \_\_\_\_\_ Relationship:  Spouse  Parent  \_\_\_\_\_

Contact Numbers: \_\_\_\_\_ or \_\_\_\_\_

**Responsible Party (if different from patient)**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_  
Last First M.I.

Mailing Address \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Home Phone \_\_\_\_\_ Cellular \_\_\_\_\_ Work \_\_\_\_\_

**Pharmacy Name/Address/Phone #/Fax:** \_\_\_\_\_

**How did you hear about our office?** Doctor \_\_\_\_\_ Patient \_\_\_\_\_  Staff \_\_\_\_\_

Seminar \_\_\_\_\_  Insurance Web site  Phone Book  Our Web Site  Magazine/Newspaper/TV

Other \_\_\_\_\_

Please list  Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

List family members that are patients of our practice: \_\_\_\_\_

**No Insurance** I will pay with Cash Check Credit Card Visa MasterCard  
AMEX Discover Card Care Credit

**Insurance information** Please complete information completely and present Insurance card at time of check in to office.

**Primary** Name of Insurance \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

Insurance Claim Mailing Address: \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Specialist Copay \_\_\_\_\_ Deductible \_\_\_\_\_ Effective Date: \_\_\_\_\_

Self Name of Policy Holder: \_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_\_

**List name as seen on insurance card**

Policy Holder SS# \_\_\_\_\_ Relationship of patient to the insured Spouse Parent Male Female

**Secondary** Name of Insurance \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

Insurance Claim Mailing Address: \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Specialist Copay \_\_\_\_\_ Deductible \_\_\_\_\_ Effective Date: \_\_\_\_\_

Self Name of Policy Holder: \_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_\_

**List name as seen on insurance card**

Policy Holder SS# \_\_\_\_\_ Relationship of patient to the insured Spouse Parent Male Female

I certify that the information I provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare) or other third parties for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to Jennifer Linder M.D. PLLC/ Linder Dermatology & Skin Care Surgery Center. **Any pathology and laboratory fees are billed independently of Linder Dermatology & Skin Care Surgery Center and are ultimately the patient's responsibility.** I am aware of HIPAA policies and Privacy Act of 1974. \_\_\_\_\_ Initial

Payment is required for all services at the time of service. I understand that I am financially responsible for any unpaid or nonpaid balances. **All applicable co payments, co insurance and deductibles will be collected at the time of service.** Our terms are net 45 days. Appointments that are no show may be charged a \$50.00 fee. In the event that your account must be turned over to collections, a collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy. \_\_\_\_\_ Initial

**I understand that my insurance is a contract between my insurer and myself. I am responsible for understanding the terms of my policy, including deductibles, copays, coinsurance and referrals. I am responsible for obtaining any required referrals, and in absence of such, I will be held responsible for the cost of service provided.** \_\_\_\_\_ Initial

**Patient/Responsible Party Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Jennifer Linder, M.D. PLLC**  
**Cynthia Price, M.D.**  
**Linder Dermatology & Skin Cancer Surgery Center**  
 6710 East Camelback Road, Ste 220 Scottsdale, Arizona 85251  
 480.946.7939 Fax 480.946.5258  
 info@linderdermatology.com www.linderdermatology.com

Patient Name: \_\_\_\_\_ Date of visit: \_\_\_/\_\_\_/\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Sex: \_\_\_ Occupation (if retired, prior occupation): \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Detailed description of symptoms: \_\_\_\_\_

Skin areas involved: \_\_\_\_\_

How long has the problem been present: \_\_\_\_\_

List any previous treatment: \_\_\_\_\_

Was a biopsy performed? Yes No  
 If Yes, when? \_\_\_\_\_ Name of Doctor that performed biopsy \_\_\_\_\_

**Check all that apply to today's problem**

<b>A change in:</b>	<b>Quality</b>	<b>Associated Symptoms</b>	<b>Severity</b>
	Size	Bleeding	No Symptoms
	Elevation	Tingling	Occasional Symptoms
	Other _____	Pain	Constant Symptoms
	None	Ulceration	

List all medications (including over-the-counter medications) that you are currently taking and the reason why:  
 \_\_\_\_\_  
 \_\_\_\_\_

List any medications you are allergic to: \_\_\_\_\_

Are you currently:      Pregnant      Trying to conceive      Breastfeeding

What is your current skin care regimen (Facial wash, moisturizers, sunscreen, etc.)? \_\_\_\_\_  
 \_\_\_\_\_

**PAST HISTORY**

Do you wear sunscreen?    NO    YES    List products you use? \_\_\_\_\_    On face    On body  
 How Often?    EVERYDAY    SOMETIMES    NEVER

Have you ever had a blistering sunburn?      YES      NO  
 How Many? \_\_\_\_\_

Have you ever used a tanning bed?      YES      NO  
 How frequently? \_\_\_\_\_

Do you take antibiotics before undergoing dental procedures or surgeries?    YES      NO

Have you ever received a blood transfusion?      YES      NO      If yes, when? \_\_\_\_\_

Have you previously been diagnosed with skin cancer?    YES    NO

If yes, what type?      Melanoma      Basal Cell      Squamous Cell      Other \_\_\_\_\_

Please list Date and Location on body the cancer was found and how it was treated: \_\_\_\_\_

Radiation treatment (not routine dental or chest x-rays)? YES NO  
If yes, for what? \_\_\_\_\_ When? \_\_\_\_\_

Ultraviolet light treatment? YES NO if yes: UVA UVB PUVA Other \_\_\_\_\_

**Please list any surgeries you have had (including cosmetic):**

\_\_\_\_\_  
\_\_\_\_\_

Have you been seriously ill or hospitalized in the last 6 months? YES NO  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY**

Has any person in your immediate family ever been diagnosed with the following (please check all that apply):

Melanoma	Basal Cell	Squamous Cell	Other _____	None
Who?	Mother	Father	Brother	Sister

**SOCIAL HISTORY**

Do you wear: Glasses Contact Lenses Dentures Hearing Aid

Do you drink alcohol? YES NO If yes, how many drinks per week on average? \_\_\_\_\_

Do you smoke? NO Former YES packs per day \_\_\_\_\_ Pipe  
Cigar Chewing Tobacco Nicotine (patch/tablet)

**SYSTEM REVIEW:**

**Check all that apply regarding your health and any other important problems**

<b>Skin</b> Abnormal bleeding Keloids Poor healing Other _____	<b>Cardiovascular</b> Normal High blood pressure Heart Murmur Artificial Heart Valve Arrhythmia(irregular heart beat) Pacemaker Defibrillator Angina (chest pain) Heart Attack(when? _____) Heart transplant Other _____	<b>Gastrointestinal</b> Normal Stomach ulcer Colitis Liver damage Liver transplant Other _____	<b>Respiratory</b> Normal Asthma Emphysema/ChronicBronchitis Other _____
<b>Infections</b> None Cold Sores/Fever blisters/Herpes Hepatitis/Jaundice HIV/AIDS Tuberculosis (TB) Immunosuppression Other _____	<b>Endocrine</b> Normal Diabetes Thyroid disease Kidney disease Kidney Transplant Other _____	<b>Hematologic/Lymphatic</b> Normal Anemia Bleeding problems Enlarged lymph nodes Arsenic exposure Other _____	<b>Psychiatric</b> Normal Anxiety attacks Depression Other _____
<b>Constitutional Symptoms</b> None Weight loss Fever Dizziness or Fainting Other _____		<b>Musculoskeletal</b> Normal Arthritis Artificial joint Other _____	<b>Neurological</b> Normal Stroke Seizure Other _____
			<b>Ears/Eyes/Nose/Throat</b> Normal Glaucoma Other _____

**Jennifer Linder, M.D. PLLC**  
**Cynthia Price, M.D.**  
**Linder Dermatology & Skin Cancer Surgery Center**  
6710 East Camelback Road, Ste 220 Scottsdale, Arizona 85251  
480.946.7939 Fax 480.946.5258  
info@linderdermatology.com [www.linderdermatology.com](http://www.linderdermatology.com)

**Financial Policy & Patient Responsibility Notice**

Thank you for choosing us as for your Dermatology and Skin Care needs. We are committed to providing you with quality care. Please read this policy, ask us any questions you may have and sign in the space provided. A copy will be provided to you upon request.

We consider payment of services to be the responsibility of the patient in the patient-physician relationship. Therefore, we would like to explain our payment policy and patient responsibility expectations to you to ensure understanding and compliance.

Jennifer Linder, M.D. PLLC/Linder Dermatology & Skin Cancer Surgery Center/Cynthia Price, M.D. provides many different types of medical services within our practice. Many insurance carriers have their own specific criteria set for how frequently an exam, test or procedure can be performed in addition not paying for certain types of services such as routine/ screening testing i.e. blood work, removal of certain skin conditions, etc. Consequently, it is impossible to know all of the many different employer group benefits from one employer to the next. Therefore, Linder Dermatology Skin Cancer Surgery Center cannot be held responsible for informing patients whether a particular service is covered or not. However our staff will make every effort to try to assist you in understanding your health benefits or supply you with other health plan related resources.

For those insurances we do participate with, we will file on your behalf directly to the insurance carrier for payment: **Insurance co-payments, coinsurance, deductibles, and non-covered services are expected to be paid at the time of service. The office accepts cash, check, American Express, Visa, MasterCard, Discover Card and Care Credit.**

**INSURANCE** - We participate in multiple insurance plans, including Medicare. However there are several commercial insurance plans that we do not participate with. **If you are insured with a plan we are not contracted with, payment in full** is expected at each visit. If you are insured by a plan we are contracted with, but, do not have an up to date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. It is advised that you call and confirm with your insurance carrier that we are contracted with your insurance plan.

**COPAYMENTS, COINSURANCE AND DEDUCTIBLES** - All copayments, coinsurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. When we do not collect copayments, coinsurance and deductibles from patients at the time of service, it can be considered fraud. Please help us in upholding the law by paying your contracted fees at each visit.

**PROOF OF INSURANCE** - All patients must complete our patient information forms before seeing a provider. We must obtain a copy of your driver license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

**CLAIMS SUBMISSION** - We will submit your claims for the insurance companies that we are contracted with and assist you in any way we reasonably can to help get your claim paid. Your insurance may need you to supply certain information directly. It is your responsibility to comply with their request in a timely manner. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefits are a contract between you and your insurance company.

**COVERAGE CHANGES** - If your insurance plan changes, please notify us before your visit so that we can make the appropriate changes to help you receive your maximum benefits.

**NONPAYMENT** - If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. If your account is over 30 days past due after the insurance company has paid their portion and a statement has been sent out, partial payment will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. In the event of finding it necessary to turn your unpaid balance over to a collection agency, all collection fees and/or legal fees will be owed in addition to the remaining balance. If this occurs, you will be notified by regular or certified mail that you have 30 days to find alternative medical care. During that 30 day period, our providers will only be able to treat you on an emergency basis.

**PRIVATE PAY/SELF PAY** – Payment is due at time of visit and will be collected before you see the doctor. We will request \$250.00 deposit at check in. The cost of our treatment will be reconciled at the end of your visit.

**CREDIT CARD ON FILE** – Insurance Patient Financial Responsibility – We have implemented a policy, which enables you to maintain your credit card information on file in our office. This information will be securely held until your insurance provider has paid their portion of your bill and notified us of the amount that is your responsibility. At that time, any balance, which you owe, will be charged to your credit card. This in no way compromises your ability to dispute a charge or question your insurance company’s determination of payment.

**Additional Practice Related Fees and Policies:**

- \$50.00 Fee “NO SHOWS” (failure to provide cancellation notice prior to your scheduled appointment)
- \$50.00 Fee Request to complete Life, Disability, FMLA, & many other various types of independent health forms. (Effective January 1, 2006).
- \$30.00 Fee returned checks for non-sufficient funds, which is a charged back processing fee to the patient. We will be unable to accept any personal checks until account balance and associated services fees are paid in full. If this is a repeated occurrence, we will only be able to accept cash or credit card as method of payment. This fee is not required for physicians who are part of your care, reports you require for your personal records or insurance companies to complete payment of an open claim.
- \$30.00 Fee Requests for Medical Records. A signed medical records release form must be signed by the patient before records can be sent. We will try our best to send within seven business days of request. In the event they are needed more quickly, please inform the office of the special circumstances and we will make every effort to accommodate your request.
- Biopsy, Pathology and Lab Samples sent to outside of our office is billed independently of Linder Dermatology & Skin Cancer Surgery Center. You may receive a bill from the outside lab and will be responsible for payment to that facility.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

By signing below, I acknowledge and understand the Financial Policy of Linder Dermatology & Skin Cancer Surgery Center and accept all payment terms under this Policy as well as my responsibilities as a patient to know and understand my health insurance benefits for services provided.

---

**Print Name of Patient**

---

**Signature of Patient or Person Responsible for Account**

---

**Date**

**Jennifer Linder, M.D. PLLC**  
**Cynthia Price, M.D.**  
**Linder Dermatology & Skin Cancer Surgery Center**  
6710 East Camelback Road, Ste 220 Scottsdale, Arizona 85251  
480.946.7939 Fax 480.946.5258  
info@linderdermatology.com [www.linderdermatology.com](http://www.linderdermatology.com)

**Notice and Acknowledgement of Privacy Policy and Procedures**

As required by the Health Information Portability and Accountability Act of 1996 (HIPPA), the practice of Linder Dermatology & Skin Cancer Surgery Center may not use or disclose your personal health information without your authorization.

**THE PRACTICE HAS POLICIES AND PROCEDURES THAT MUST COMPLY WITH HIPPA LAWS. EVERY ATTEMPT HAS BEEN MADE TO KEEP THE PROCESS FOR PATIENTS AND STAFF AS EFFICIENT AS POSSIBLE; HOWEVER, THE REQUIREMENTS ARE EXTENSIVE AND TAKE TIME, EFFORT, AND COOPERATION TO PROCESS REQUIRED TASKS.**

All patients are presented with certain notices and must sign certain forms. Depending on the course of treatment, some patients may be required to sign additional forms. The following is a summary of the most common notices and forms:

**Notice of Privacy Practices:** This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

**Authorization for use or disclosure of protected health information:** The practice may not use or disclose your health information for purposes other than treatment, payment, or health care operations without your authorization. Your signature on this form indicates that you are giving permission to the people listed on this form, for the use and disclosure of the health information listed on the form, for the purpose on the form, to the people/organizations listed on the form. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

**Complaint:** You have the right to complain about "The Practices" privacy policies, procedures, or actions. "The Practice" will not engage in any discriminatory or other retaliatory behavior against you because of a complaint.

**Request to Amend protected Health Information:** You have the right to request that health information that pertains to you be amended if you believe that it is incorrect or incomplete. "The Practice" will review your request and either grant your request or explain the reason why it will not be granted. In the event that your request is not granted, you have the right to submit a statement of disagreement that will accompany the information in question for all future disclosures.

**Request for Inspection of Protected health information:** You have the right to request the opportunity to inspect and copy health information that pertains to you. "The Practice" will evaluate your request and will either grant it or explain the reason why the request will not be granted. In the event that your inspection request is not granted, you may request that the decision be reviewed by someone other than the person who denies the request.

**Request for Accounting of Disclosure of Protected Health Information:** You have a right to request an accounting of disclosures of health information that pertains to you

**Confidential Channel Communications Request:** You have the right to request that communications concerning your personal health information be made through confidential channels. The practice will do it's best to accommodate all reasonable requests.

**Designation of Personal Representative:** You have the right to nominate one or more persons to act on your behalf with respect to protection of health information that pertains to you. By making this request, you are informing "The Practice" of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

**Acknowledgement of Receipt of Notice of Privacy Practices**

**I acknowledge that I have received and read the above Notice of Privacy Policy and Procedures and that I have had any questions regarding this noticed answered to my satisfaction.**

\_\_\_\_\_  
Print Patient Name/Representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Jennifer Linder, M.D. PLLC**  
**Cynthia Price, M.D.**  
**Linder Dermatology & Skin Cancer Surgery Center**  
6710 East Camelback Road, Ste 220 Scottsdale, Arizona 85251  
480.946.7939 Fax 480.946.5258  
info@linderdermatology.com [www.linderdermatology.com](http://www.linderdermatology.com)

**Release of Information**

I have received the HIPAA Privacy Notice regarding the uses and disclosures of my protected Health Information and I understand my rights and responsibilities with respect to my medical records.

I hereby authorize Linder Dermatology & Skin Cancer Surgery Center to release any medical and incidental information to my referring physician or any other physicians who have been or may become involved with my care.

I also authorize the release of information that may be necessary in the processing of any insurance claims including Medicare.

I also authorize the release of any medical records including pharmacy records to Linder Dermatology & Skin Cancer Surgery Center upon request.

**May we leave personal medical information on your answering machine at home?**  Yes  No

**May we leave personal medical information on your cell phone voicemail?**  Yes  No

**Personal representative** (Family members, attorneys, etc...) I hereby authorize Linder Dermatology & Skin Cancer Surgery Center and it's employees permission to discuss, send and/or receive medical information to/with the following

Please provide their name and phone number below.

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone # \_\_\_\_\_ or \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone # \_\_\_\_\_ or \_\_\_\_\_

3. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone # \_\_\_\_\_ or \_\_\_\_\_

\_\_\_\_\_  
**Print Patient Name/Representative**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**