

**Jennifer Linder, M.D.**  
**PATIENT INFORMATION SHEET**

*Please print clearly*

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_ SS# \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ STUDENT \_\_\_\_\_

WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

EMAIL \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ CONTACT PHONE \_\_\_\_\_

WHOM MAY WE THANK FOR THE REFERRAL? \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

WHO'S RESPONSIBLE FOR THIS VISIT? YOURSELF SPOUSE GUARANTOR PARENT (PLEASE CIRCLE APPLICABLE ONE)

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

**INSURED'S INFORMATION**

NAME OF POLICY HOLDER \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

PRIMARY INSURANCE \_\_\_\_\_ HMO PPO ICA SELF PAY EMPLOYER \_\_\_\_\_

ID# \_\_\_\_\_ GROUP# \_\_\_\_\_ INSURANCE COMPANY PHONE \_\_\_\_\_

INSURANCE ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DO YOU HAVE COPAY? YES NO (PLEASE CIRCLE ONE) AMOUNT \_\_\_\_\_ EFFECTIVE DATES \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_ HMO PPO ICA SELF PAY POLICY HOLDER \_\_\_\_\_

ID# \_\_\_\_\_ GROUP# \_\_\_\_\_ INSURANCE COMPANY PHONE \_\_\_\_\_

INSURANCEADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Authorization to pay insurance benefits to physician: I hereby authorize payment directly to Jennifer Linder, MD. Authorization to release information: I hereby authorize Jennifer Linder, MD to release all medical information needed to process this claim. I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I hereby agree to pay for services rendered to the above mentioned patient as and when charges are incurred. In the event of default, I promise to pay any collection costs and reasonable attorney fees, as may be required to collect for my services.

SIGNATURE OF PATIENT or PARENT IF PATIENT IS A MINOR \_\_\_\_\_ DATE \_\_\_\_\_

# LINDER DERMATOLOGY

Skin Cancer Surgery Center  
6710 East Camelback Road, Ste 220  
Scottsdale, Arizona 85251  
PH: 480.946.7939 Fax 480.946.5258  
info@linderdermatology.com  
[www.linderdermatology.com](http://www.linderdermatology.com)

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>
<input type="checkbox"/> Size	<input type="checkbox"/> Bleeding	<input type="checkbox"/> No Symptoms	
<input type="checkbox"/> Elevation	<input type="checkbox"/> Tingling	<input type="checkbox"/> Occasional Symptoms	
<input type="checkbox"/> Other _____	<input type="checkbox"/> Pain	<input type="checkbox"/> Constant Symptoms	
<input type="checkbox"/> None	<input type="checkbox"/> Ulceration		

List all medications (including over-the-counter medications) that you are currently taking:

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

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

Are you currently:  Pregnant  Trying to conceive  Breastfeeding

## PAST HISTORY

Do you wear sunscreen?  YES  NO  
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: \_\_\_\_\_

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

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  Sibling

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

Reviewed By: \_\_\_\_\_

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

As required by the Health Information Portability and Accountability Act of 1996 (HIPPA), the practice of Dr. Jennifer Linder 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 its 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.**

\_\_\_\_\_  
Patient/Representative Signature

\_\_\_\_\_  
Date

Jennifer Linder, M.D.

6710 E Camelback Rd, Ste 220 Scottsdale, AZ 85251 PH: 480-946-7939 Fax: 480-946-5258

### Financial Policy & Patient Responsibility Notice

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./Angela Kenney PA-C provides many different types of medical services within her 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, ear lavage, and bone density etc. Consequently, it is impossible to know all of the many different employer group benefits from one employer to the next. Therefore, Jennifer Linder, M.D./Angela Kenney PA-C cannot be held responsible for informing the patient whether a particular service is covered or not. Although 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. Jennifer Linder, MD accepts cash, check, Visa and MasterCard.**

There are several **commercial insurance** plans that we do not participate with. If you are covered by a commercial insurance plan, we will expect you to make full payment at the time of service/treatment.

#### **Additional Practice Related Fees and Policies:**

- **\$25.00 Fee** = “NO SHOWS” (failure to provide cancellation notice) prior to his or her scheduled appointment
- **\$10.00 Fee = Request** to complete Life, Disability, FMLA, & many other various types of independent health forms. (Effective January 1, 2006).
- **\$25.00 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.
- **\$25.00 Fee = Requests for Medical Records.** All requests will be completed within seven business days. 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.

**By signing below, I acknowledge and understand the Financial Policy of Jennifer Linder, M.D. 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.**

\_\_\_\_\_  
Signature of Patient or Person Responsible for Account

\_\_\_\_\_  
Date

## **Understanding your Financial Obligations**

Your medical insurance policy is an agreement between you and your insurance company. Every insurance policy is different. Please make sure you understand your policy before you see our providers. It is ultimately your responsibility to ensure that you have authorization to see the provider and to understand what will and will not be covered by your policy. Please make certain that we are contracted with your specific healthcare plan. You can find out this information in your health plan directory or by going to the insurance company website.

### **Common Insurance Terms:**

The **Guarantor** is the person legally responsible for payment of any incurred charges. You are the guarantor not your insurance company.

### **Covered Expenses:**

Most health insurance plans, whether they are fee-for-services, HMOs or PPOs, do not pay for all services. Some may not pay for prescription drugs. Others may not pay for mental health care. Covered services are those medical procedures the insurer agrees to pay for. They are listed in the health insurance policy. Please be sure and review your policy before you agree to service from the provider.

### **Exclusions:**

These are specific conditions, Diagnoses, circumstances or procedures for which the policy will not provide benefits. In some cases, you are responsible for these charges and will be billed for them.

### **Co-payment:**

Another way of sharing medical cost: You pay a flat fee every time you receive a medical service. Some policies charge both co-pay and a co-insurance.

### **Coinsurance: (Note: this is billed to you after the insurance has paid – not at the time of service)**

The amount you are required to pay for medical care in a fee-for-service plan after you have met your deductible. The coinsurance rate is usually expressed as a percentage. For example, if the health insurance company pays for 80% of the claim, you pay 20%.

### **Deductible:**

An amount of money you must pay each year to cover your medical expenses before your health insurance policy starts paying. Your health insurance policy will not pay for visits or procedures until you have paid your deductible in full.