SUNFLOWER
DERMATOLOGY & MEDICAL DAY SPA

# Welcome to Sunflower Dermatology & Medical Day Spa!

You're undoubtedly looking for the best healthcare—healthcare that meets your and your family's needs. We are pleased that you have decided to partner with Sunflower Dermatology to pursue ***better skin for better life®***. It is an important decision.

You will find that at the core of our practice are our patients. Our team strives to demonstrate our core values each and every day. We desire to demonstrate the values of **Respect, Generosity, Loyalty, Integrity and Commitment**. We hope you feel this genuine commitment every time you visit.

One way that we demonstrate this commitment to high-level of patient care is in our simplified billing process and online patient portal. Our goal is to use technology to make your healthcare personal and easy again.

The patient portal will provide you the tools to quickly and easily review your medical visits, laboratory or biopsy results and provides an option to directly communicate with your doctor or physician assistant. This ensures that you receive the timeliest response to all of your questions. We enjoy staying in touch between visits, and the portal allows us to do so in a refreshing way. Please take advantage of this technology and activate your account today.

One of our goals is also to provide the best possible service for a fair price that makes healthcare, specifically skincare, affordable to all. One way we do this is through our simplified billing process. When you checked in for your appointment today, you were asked to keep a credit or debit card on file with us. Whether we have the pleasure of seeing you weekly, monthly or annually, this process simply ensures that you always receive exceptional service. By billing your card on file, only after your insurance is processed, we can continue to always provide the continuum of service you seek. You will continue to receive your explanation of benefits from your insurance provider and charges from Sunflower Dermatology will always reflect that.

Your health is one of your most valuable resources. Thank you for trusting us to care for you and to truly achieve *better skin for better life!*

**Brian Matthys D.O. • Molly Menser D.O. • Nicholas Rudloff D.O. • Lynn Swafford P.A.**

SUNFLOWER DERMATOLOGY & MEDICAL DAY SPA
1805 NW Platte Rd., Ste.120, Riverside, MO 64150
(816) 472-0400  Fax (816) 472-0813

SUNFLOWER
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PATIENT ID _____

PROVIDER _____

## PATIENT INFORMATION

**NAME:** _____ **DATE OF BIRTH:** ____ /____ /____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

**CELL** PHONE: _____ **HOME** PHONE: _____

EMAIL: _____ SS# _____

AGE: _____ MARITAL STATUS: _____ GENDER: _____ RACE: _____ ☐HISPANIC/LATINO?

**Primary Care Physician:** _____ **Phone:** _____

Were you referred by your Primary Care Physician? ☐ YES ☐ NO

How did you hear about our office? _____

Pharmacy Name & Address: _____

Emergency Contact Name:_____ Phone: _____ Relationship: _____

**Do you have a history of skin cancer?** ☐YES, List Type _____ ☐NO

**Does your family have a history of skin cancer?** ☐YES, List Type _____ ☐NO

**Tobacco Use:** ☐ YES ☐ NO **Alcohol Use:** ☐ YES ☐ NO

**Current Medications:** Please list all current medications you are taking (including over-the-counter medications and any vitamins and/or herbal supplements): _____

_____

_____

**Allergies to medications and your reaction:** _____

_____

**Please list any major hospitalizations or surgical procedures you received in the past 5 years:** _____

_____

## INSURANCE INFORMATION

**INSURANCE:** _____ **ID#** _____

**NAME OF POLICY HOLDER:** _____ **RELATIONSHIP TO POLICY HOLDER:** _____

**POLICY HOLDER SOCIAL SECURITY #** _____–_____–_____ **POLICY HOLDER DATE OF BIRTH**____ /____ /____

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Sunflower Dermatology & Medical Day Spa, LLC reserves the right to modify the privacy practices contained herein: Communication with the patient named herein should be directed to: **(Please check preferred contact method)**

☐ Home phone/Voicemail ☐ Cell phone/Voicemail ☐ Work phone/Voicemail

☐ Mail/Email ☐ Specific person by any above methods _____

**Sign up below to receive text messages for appointment information/reminders, office updates and specials. You may withdraw your consent at any time.** ☐ YES ☐ NO, thank you.

MOBILE # _____ WIRELESS CARRIER _____

**Reviewed by:** _____ **(Provider's Signature)**

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# CONSENT TO MEDICAL CARE

I understand the procedures standard to the care of dermatology and consent to undergo dermatologic care including any necessary procedures. These procedures include, but are not limited to cryosurgery, shave and punch biopsies and cosmetic and medically necessary procedures. I will be informed of potential risks/side effects PRIOR to the procedure.

# CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information will be used by SFD or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. You may review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed prior to signing this consent. You may request a restriction on the use or discloser of your protected health information. If SFD agrees to your request, the restriction will be binding on the practice. Use or discloser of protected information in violation of an agreed-upon restriction will be a violation of the Federal privacy standards. You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which you revocation of consent is received will not be affected. Sunflower Dermatology & Medical Day Spa, LLC reserves the right to modify the privacy practices outlined in the notice.

# FINANCIAL PARTNERSHIP

All contracted insurance is billed directly to your insurance company as a courtesy of Sunflower Dermatology and Medical Day Spa, LLC (SFD). Any remaining balances for non-covered benefits deductibles, copays and coinsurances are your responsibility. These may be collected prior to any potential procedure. It may take up to three months or longer for your insurance to process your claim. Therefore, the charge to your credit/debit card may be delayed and all sales are final. **We require a copy of a valid credit or debit card to be kept on file. You will not receive a bill but will receive an EOB (Explanation of Benefits) from your insurance company explaining costs incurred. Monies due to SFD based on your EOB, will be charged to the card on file upon our receipt of the EOB.**

**PLEASE INITIAL ACKNOWLEDGING THE ABOVE STATEMENT: _____**

- We accept cash, check, Visa, Master Card, Discover, American Express, Money Order, and Care Credit.
- There is a $30 fee for all returned checks.
- Out of respect for all patients waiting to see any provider (including physicians, physicians assistants, nurses or aestheticians), there will be a $75 fee for no showing to appointments.
- All accounts that become past due 45 days after your insurance pays, we reserve the right to send your account to a collection agency if the balance is not paid in full within 60 days.
- For all skin lesion removals (i.e. cosmetic or medical), a skin specimen is sent to the pathology lab for testing and to confirm clinical diagnosis. There may be additional charge by the lab, unrelated to any fee paid directly to Sunflower Dermatology and Medical Day Spa, LLC.
- A copy of this form will be available at your request.

*FINANCIAL PARTNERSHIP CONTINUED ON THE NEXT PAGE…*

**Reviewed by:** _____ **(Provider's Signature)**

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PATIENT ID _____

PROVIDER _____

## FINANCIAL PARTNERSHIP continued...

- I authorize the release of medical information to my primary care or referring physicians, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.
- I hereby acknowledge that I have read, understand and agree with the policies set forth by Sunflower Dermatology & Medical Day Spa, LLC and any change made by me will be made only in writing. I give my authorization for the charge of my valid debit/credit card and my consent for procedures as outlined above.

**I have had the opportunity to review the Notice of Privacy Practices and Consent above for Sunflower Dermatology & Medical Day Spa, LLC. I consent to the medical/cosmetic care and financial agreements above.**

| _____ | _____ | _____ |
|---|---|---|
| **Name of patient** | **Signature of patient** | **Date** |
| _____ | _____ | _____ |
| **Name of parent/guardian** | **Signature of parent/guardian** | **Date** |

## MAKE THE MOST OF YOUR VISIT TODAY

**Are you interested in having a complimentary skincare consultation today?**

☐ YES ☐ NO, thank you.

**If so, what services and/or items of concern—listed on the right—would you like to learn more about?**
(PLEASE MARK ALL THAT APPLY.)

Please list all skin care products and/or brand(s) currently being used:

_____

_____

_____

_____

Please list all past cosmetic procedures and/or treatments (with dates, if possible):

_____

_____

_____

_____

**CONCERNS:**

- ☐ Acne or Clogged Pores
- ☐ Acne Scarring
- ☐ Facial Line and Wrinkles
  - ☐ Smile Lines
  - ☐ Lines above Upper Lip
  - ☐ Forehead Lines
  - ☐ Frown Lines (Brow)
- ☐ Volume Loss in Midface
- ☐ Facial Folds
- ☐ Brown Spots/Pigmentation
- ☐ Freckles
- ☐ Broken Capillaries
- ☐ Rosacea or Facial Redness
- ☐ Sparse, Thin Eyelashes
- ☐ Unwanted Hair
- ☐ Thin Upper or Lower Lip
- ☐ Exfoliation
- ☐ Stretch Marks
- ☐ Surgical or Traumatic Scar(s)
- ☐ Double Chin

**FILLERS AND INJECTABLES:**

- ☐ Botox®
- ☐ Juvéderm XC®
- ☐ Juvéderm Voluma®
- ☐ Latisse®
- ☐ Kybella®

**LASER TREATMENT:**

- ☐ Fraxel® Restore
- ☐ IPL/Photofacials
- ☐ Laser Hair Removal

**SKIN CARE SERVICES:**

- ☐ Skin Care Products
- ☐ Deep Pore Cleansing Facials
- ☐ Dermaplane
- ☐ Chemical Peels
- ☐ Microdermabrasion
- ☐ Hydrafacial
- ☐ Other: _____
- ☐ Other: _____

**Reviewed by:** _____ **(Provider's Signature)**