

Dallas Dermatology LLC

Forney____ Frisco____ Greenville____ Rockwall____

Patient Information

How did you hear about us? _____

Last Name _____

Date of Birth: _____ Sex: _____

First Name _____ MI _____

Marital Status: _____

Mailing Address _____

Social Security Number: _____

City _____

Driver's License Number: _____

State _____ Zip Code _____

Number for appointment reminders and test results: _____

Primary Care Physician: _____

Cell Number: _____ Work Number: _____

Phone number: _____ City: _____

Occupation: _____

Did a doctor refer you here for a specific reason? _____

Employer: _____

If yes, name of referring provider? _____

Responsible Party, if different from patient above:

Name: _____

Adult Emergency Contact:

Name: _____

Address: _____

Address: _____

City: _____ State: _____

City: _____ State: _____

Zip Code: _____ Date of Birth: _____

Zip Code: _____ Phone: _____

Phone: _____ Male or Female

Relationship to patient: _____

Relationship to patient: _____

SUBSCRIBER INFORMATION (REQUIRED if patient is not primary

PHARMACY INFORMATION:

Insurance policy holder):

Name: _____

Name: _____

Location (City or address): _____

Social Security number: _____

Date of Birth: _____

Phone: _____

INSURANCE INFORMATION: If the patient is not the primary card holder, the Responsible Party section above must be completed.

Primary Insurance Co.: _____ Policy number: _____

Secondary Insurance Co.: _____ Policy number: _____

WE WILL NEED TO MAKE COPIES OF YOUR INSURANCE CARD/CARDS AND DRIVERS LICENSE.

SIGNATURE: _____

DATE: _____

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Medical History

Patients Name: _____

Do you have or have had any of the following? (If yes, please circle)

Artificial heart valve	Depression	Psoriasis	Seasonal allergies/asthma
Artificial joints or metal implants	Diabetes	Atopic Dermatitis	Heartburn/Reflux
Atypical moles	Bleeding disorder	Blood clot	Cold sores/Herpes
Autoimmune disease (lupus, rheumatoid arthritis)	Hepatitis Type: _____	HIV	Keloids or scarring problems
Kidney disease	Liver disease	Lung disease	Skin cancer (melanoma)
Skin cancer (basal/squamous carcinoma)	Skin pre-cancer (actinic keratosis)	Thyroid trouble	Ulcers (stomach)

Other conditions please list: _____

Female patients (circle all that apply): I am pregnant nursing planning to become pregnant in the near future

Please list any medications, herbal supplements and/or vitamins you are currently taking:

Are you allergic to any medications/anesthetics? YES OR NO

If yes, please list: _____

Please list major surgeries/hospitalizations:

_____ Date: _____ _____ Date: _____
_____ Date: _____ _____ Date: _____

Please list IMMEDIATE FAMILY that has had any of the following (mother, father, grandmother, grandfather, brother, sister)

Skin Cancer-Melanoma: _____ Psoriasis: _____
Skin Cancer-other: _____ Eczema: _____
Other Cancers: _____ Other: _____

Have you RECENTLY had any of the following? (Please circle all that apply)

Other skin complaints	Fever/chills/weight change	Itching	Joint aches
Other systemic complaints	Sun sensitivity	Muscle aches	Ringings in ears

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Do you use sunscreen daily? YES OR NO

Have you traveled outside the U.S. the past 3 months? YES OR NO

Do you smoke? YES OR NO

Have you ever has blisters form the sun? YES OR NO

Do you use smokeless tobacco? YES OR NO

Have you ever used a tanning bed? YES OR NO

Do you drink alcoholic beverages? YES OR NO

Do you currently use a tanning bed? YES OR NO

RELEASE OF MEDICAL INFORMATION

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions electronically to your pharmacy.

SIGNATURE: _____

DATE: _____

Personal Representative Authorization for Medical Release Form

Under HIPAA requirements, we are not allowed to discuss any of your health information with anyone else without your consent.

I authorize this Facility to speak to the following family members or my personal representative regarding

___ All medical information, including but not limited to: appointments, billing, test results, diagnosis, and procedures.

___ Only the following types of information: _____

1. _____ Relationship: _____ Phone number: _____

2. _____ Relationship: _____ Phone number: _____

3. _____ Relationship: _____ Phone number: _____

WHEN SIGNING BELOW I AGREE TO RETURN FOR A FOLLOW UP VISIT IF NECESSARY. LAB/BIOPSY RESULTS ARE NOT GIVEN OVER THE PHONE.

WHEN SIGNING BELOW I UNDERSTAND THAT I AM REPSONSIBLE TO PAY \$25.00 FEE IF I MISS AN APPOINTMENT WITHOUT GIVEN A 24 HOUR NOTICE.

SIGNATURE: _____

DATE: _____

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Financial Policy

Payment is required for all services at the time they are rendered unless the patient is in an insurance plan with which we participate. For those patients, applicable co-payments and deductibles will be collected for services rendered. Once our office has received payment from your insurance, if for some reason insurance decides to pay your charges at a higher benefit level than what was quoted to our office at the time of service; we will then issue the patient a refund for the over payment amount or apply a credit on the account. In an effort to ensure the most accurate refund amount please be advised that our office cannot issue any refunds until all line items have been finalized by your insurance.

We accept payment in the form of cash, check, Visa, MasterCard, and Discover. In the event that your account must be turned over to collections, you will not be able to be seen until all past due amounts are paid in full. Also there will be a \$10.00 late fee applied to your account each month if balance is not paid in full.

Dallas Dermatology LLC does not make payment arrangements.

SIGNATURE: _____

DATE: _____

In addition to the above, if I am a Medicare patient, I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in assignment. Regulations pertaining to Medicare assignment of benefits apply.

SIGNATURE: _____

DATE: _____

REFERRALS

If my insurance company requires a referral, I understand it is my responsibility to obtain a referral from my Primary Care Physician and assure it is available on the day of my appointment. I also understand that if I do not have a valid referral at the time of my first appointment, I will be financially responsible for all charges incurred at each visit.

Privacy Practices (HIPAA)

It is the policy of our practice that all physicians & staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians & staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its physicians & staff for purposes of treatment, payment and healthcare operations (TPO). To that end, our practice and its physicians & staff will--

Adhere to the standards set forth in the Notice of Privacy Practices.

SIGNATURE: _____

DATE: _____

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Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians & staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.

Use and disclose PHI to remind patients of their appointments only within their consent.

Recognize that PHI collected about patients must be accurate, timely, complete and available when needed. Our practice and its physicians & staff will:

1. Implement reasonable measures to protect the integrity of all PHI maintained about patients.

Recognize that patients have a right to privacy. Our practice and its physicians & staff respect the patient's individual dignity at all times. Our practice and its physicians & staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.

Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians & staff will:

1. Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
2. Not disclose PHI data unless the patient (or his or her authorized representative) has properly consented to or authorized the release or the release is otherwise authorized by law.

Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believe his/her information is inaccurate or incomplete. Our practice and its physicians & staff will--

1. Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.
2. Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.

All physicians & staff of our practice will maintain a list of all disclosures of PHI for purposes other than TPO for each patient. We will provide this list to patients upon request, so long as their requests are in writing.

All physicians & staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.

All physicians & staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.

Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

SIGNATURE: _____

DATE: _____