

|  |  |  |
| --- | --- | --- |
| **PATIENT INFORMATION** | |  |
| Patient Name: Address: Apt #: City/State/Zip: Primary Phone: Alternate Phone: Patient Date of Birth: Age: Sex: Marital Status: Patient EmailAddress:  Race: Asian Black White Native American/Alaskan  Native Hawaiian/Other Pacific Islander Other  Preferred Language: English Spanish Other:  Ethnicity: Hispanic/Latino Not Hispanic/Latino  Smoking Status: Every Day Smoker Occasional Smoker Never Smoked Former Smoker | | |
| **Insurance Information** | | |
| **Primary Insurance**  PrimaryInsurance: Insured’s Name: Policy #: Group #:  Relationship Self Spouse to Insured: Child Other  Insured’s Employer: Insured’s DOB: | **Secondary Insurance**  Secondary Insurance: Insured’s Name: Policy #: Group #:  Relationship Self Spouse to Insured: Child Other  Insured’s Employer: Insured’s DOB: | |

No

Yes

Patient Employer: Full Time Student:

Occupation: Emergency Contact: Relationship of Emergency Contact: Emergency Contact’s Phone Number: Name of Parent or Guardian, if Patient is a Minor:

How were you Referred?

Referring Physician’s Phone Number:

ReferringPhysician’sAddress:

Referring Physician’s Name:



|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Physician | □ Family | □Friend | □Internet Search | □Insurance Co. | □Magazine |
| “FindADoctor” | □Website | □Care Credit | □Other |  |  |

**PATIENT MEDICAL HISTORY**

|  |  |  |
| --- | --- | --- |
| Name | | : |
| Date: | | **Drug Allergies** |
| Acct#: | DOB: |

# MEDICALHISTORY

Cataracts

None

Cancer

Yes (check all that apply)

Osteoarthritis Osteoporosis

Glaucoma Hay Fever Tuberculosis

Ulcerative Colitis Asthma

Organ Transplant Depression Pregnant

Elevated cholesterol Elevated triglycerides High Blood Pressure Heart Disease

Liver Disease Emphysema Anxiety

Due Date

Rheumatoid Arthritis Diabetes

Anemia Peptic Ulcer

Acid Reflux (GERD) Irritable Bowel Syndrome ADD/ADHD

Trying to get Pregnant

Kidney Disease Thyroid Disease HIV+/AIDS

Nail Disorders Stroke/TIA Epilepsy

Other:

**REVIEW OFSYSTEMS**

Tendency to scar Joint Replacement

Pacemaker/Defib

None apply

Yes (check all that apply)

Daily aspirin/anticoagulant Immunosuppressed

Mitral Valve Prolapse

Difficulty with oral antibiotics

Allergic to antibiotic ointments Allergic to bandages and/or tape

Other

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CURRENT MEDICATIONS** None Yes (list all) | | |  | See Attached List | |
|  |  |  | | |  |
|  |  |  | | |  |
|  |  |  | | |  |

**PERSONALHISTORY**SkinCancer:

None

Yes(listall)

Basal cell carcinoma Squamous cell carcinoma Melanoma

**DoyouhaveotherSkinProblems**When? Body Location? When? Body Location? When? Body Location? None Yes (listall)

**FAMILY HISTORY OF SKIN CANCERS**

No/Unknown

Yes(listall)

Basal or Squamous cell carcinoma Melanoma Unknown type of Skin Cancer

**Are there other skin problems in the family**

Relationship? Relationship? Relationship? None Yes (listall)

**PERSONAL SOCIAL HISTORY** (Check all that apply)

|  |  |  |
| --- | --- | --- |
| Drink Alcohol | Special Diet Regular Exercise | Tanning Bed Moderate to severe sun exposure |
|  | | |
| Smoking Status: | Every Day Smoker Occasional | Smoker Never Smoked Former Smoker |

# OCCUPATION

**PHARMACY** CVS Walgreens Walmart Other Address City/Zip Phone #





**PATIENT RESPONSIBILITYFORM**

1. **INDIVIDUAL’S FINANCIAL RESPONSIBILITY**

 I understand that I am financially responsible for my health insurance deductible, coinsurance or non- covered service.



Co-payments are due at time of service.

If my plan requires a referral, I must obtain it prior to my visit.

In the event that my health plan determines a service to be “not payable”, I will be responsible for the complete charge and agree to pay the costs of all

services provided.

 If I am uninsured, I agree to pay for the medical services rendered to me at timeof service.

 I understand after 2 statements received without any payment I will incur a $25 penalty.

1. **INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS**

I hereby authorize and direct payment of mymedical benefits to Prestige Dermatology on my behalf for any services furnished to me by the providers.

1. **AUTHORIZATION TO RELEASE RECORDS**

I hereby authorize Prestige Dermatology to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

1. **MEDICARE REQUEST FORPAYMENT**

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Prestige Dermatology. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Signatureof Patient,AuthorizedRepresentative or ResponsibleParty Date

Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient

621 SW Johnson Ave. Suite C | Burleson, TX 76028 | Office: (817) 766 – 7421 |Fax (817) 447 – 8100

3629 Western Center Blvd. Suite 211 | Fort Worth, TX 76137 | Office: (817) 766 – 7422 |Fax (817) 847-5200

1100 Orchard Dr. Suite B | Arlington, TX 76012 | Office: (682) 712 – 0100 | Fax (817) 303 – 2700

320 Hawkins Run Rd. Suite 1| Midlothian, TX 76065 | Office: (469) 758-4800 | Fax: (972)775-4567



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**HIPPA Acknowledgement and Consent Form**

I understand that under the Health Insurance Portability and AccountabilityAct of 1996(HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
* Obtain payment from designated third-party payers.
* Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information(available in the office in print form or at www.prestigedermatology.com). I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient’s Name DOB: (mm/dd/yy)

Signed (Patient or Legal Representative for Patient) Date: Legal Representative’s Relationship to Patient



**PHOTO RELEASE**

I, authorize Prestige Dermatologytotake photographs of my face. Thesephotoswill bekeptin a chart bearing my name and will be kept and used with the utmost respect. These photos may be chosen for the office photo album to help educate future patients. We do thiswiththe soleintent of educationforothersthat maybe considering the same or similar procedure. At no time will any personal informationornamesbegiven.These photographsmay beusedforpatient referrals and/or educational purposes.

PatientSignature Date



## Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure



**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**

Developed for Texas Health & Safety Code §181.154(d)

effective June 2013

**NAME OF PATIENT OR INDIVIDUAL**

**of protected health information.** Covered entities as that term is

defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual’s legally authorized representative to electronically disclose that indi- vidual’s protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise au-

Last First Middle

## OTHER NAME(S) USED

**DATE OF BIRTH** Month Day Year

## ADDRESS

thorized by law. **Covered entities may use this form or any other**

**form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

**CITY STATE ZIP PHONE** ( ) **ALT. PHONE** ( )

**EMAIL ADDRESS** (Optional):

## I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL’S PROTECTED HEALTH

**INFORMATION:**

Person/Organization Name: Prestige Dermatology

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State TX Zip Code \_ \_\_\_

|  |  |  |
| --- | --- | --- |
| Phone (\_ \_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_Fax (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?** | ¨  ¨  ¨ | Billing or Claims  Insurance Legal Purposes |
| Person/Organization Name:\_\_\_\_\_\_\_\_\_\_\_\_ | ¨ | Disability Determination |
| Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ¨ | School |
| Address:\_\_\_\_ | ¨ | Employment |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_ | ¨ | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

## REASON FOR DISCLOSURE

**(Choose only one option below)**

Treatment/Continuing Medical Care Personal Use

¨

¨

**WHAT INFORMATION CAN BE DISCLOSED?** Complete the following by indicating those items that you want disclosed. The signature of aminor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

|  |  |  |  |
| --- | --- | --- | --- |
| ¨ **All health information** | ¨ History/PhysicalExam | ¨ Past/PresentMedications | ¨ Lab Results |
| ¨ Physician’s Orders | ¨ PatientAllergies | ¨ OperationReports | ¨ Consultation Reports |
| ¨ Progress Notes | ¨ DischargeSummary | ¨ DiagnosticTestReports | ¨ EKG/Cardiology Reports |
| ¨ PathologyReports | ¨ BillingInformation | ¨ RadiologyReports&Images | ¨ Other |

## Your initials are required to release the following information:

Mental Health Records (excluding psychotherapy notes) Genetic Information (including Genetic Test Results)

Drug,Alcohol, or SubstanceAbuseRecords HIV/AIDS Test Results/Treatment

**EFFECTIVE TIME PERIOD.** This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reach- ing the age of majority; or permission is withdrawn; or the following specific date (optional): Month Day Year

**RIGHT TO REVOKE:** I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this au- thorization to the person or organization named under “WHO CAN RECEIVE AND USE THE HEALTH INFORMATION.” I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

**SIGNATURE AUTHORIZATION:** I have read this form and agree to the uses and disclosures of the information as described. I un- derstand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provid- ed by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursu- ant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

## SIGNATURE X

**Signature of Individual or Individual’s Legally Authorized Representative DATE**

Printed Name of Legally Authorized Representative (if applicable):

If representative,specifyrelationshiptotheindividual:

¨ Parent ofminor

¨ Guardian

¨ Other

A minor individual’s signature is required for the release of certain types of information, including for example, the release of information related to cer- tain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

## SIGNATURE X

**Signature of Minor Individual DATE**

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