OFFICE USE ONLY

NextGen MRN#:
EMA MRN#:
Appointment Date/Time: -
Appointment Location:

Provider:
Referring provider:
Copay / Coinsurance:
Rem Ded / Rem OOPMax:
Diagnostic Lab:

Please verify that the following information is correct. If any of the information is not correct, please mark through it and print the correct information.

Patient Demographic Information

Patient Name (Last, First, Middle) _____ **Nickname** _____

SSN _____ **Birth Date** _____ **Age** _____ **Sex** _____

Address _____ **City, State, ZIP** _____

Home Phone _____ **Cell Phone** _____

Email Address _____

Emergency Contact Name _____ **Emergency Contact Phone** _____

Marital Status _____ **Race** _____ **Ethnicity** _____

Preferred Language _____ **Employer** _____

Primary Care Physician (Name, Address, Phone Number) _____

How did you hear about us: *Please circle*

Patient Referral Family Member:_____ Provider referral:_____ Insurance referral Web search
Social Media Event Direct Mail or Magazine Radio/TV Billboard Other:_____

Responsible Party Information (if different than above or if patient is a minor)

Guarantor Name (Last, First) _____ **Relationship** _____

SSN _____ **Birth Date** _____ **Sex** _____

Address _____ **City, State, ZIP** _____

Home Phone _____ **Cell Phone** _____

Email Address

Insurance Information

Primary Insurance	_____	**Secondary Insurance**	_____
Policy Holder Name	_____	**Policy Holder Name**	_____
Relationship to Patient	_____	**Relationship to Patient**	_____
Policy Holder DOB	_____	**Policy Holder DOB**	_____
Policy # / Member ID	_____	**Policy # / Member ID**	_____
Group #	_____	**Group #**	_____

Patient / Guarantor Signature _____ **Date** _____

Medical History

Name: _____ Date of Birth: _____
Pharmacy name: _____ City and street: _____
EMA MRN: _____ Referring Physician: _____

Select any of the following medical conditions you currently have:

Anxiety	Depression	Hyperthyroidism	Transplant
Arthritis	Diabetes	Hypothyroidism	NONE
Asthma	Kidney Disease	Leukemia	Other
Atrial Fibrillation	GERD	Lung Cancer	_____
BPH	Hearing Loss	Lymphoma	_____
Breast Cancer	Hepatitis	Prostate Cancer	_____
Colon Cancer	Hypertension	Radiation Tx	_____
COPD	HIV / AIDS	Seizures	_____
Coronary Artery Disease	High Cholesterol	Stroke	

Please list any surgeries you have had:

_____
_____

What past skin issues have you had?

_____
_____

Do you wear zinc oxide sunscreen? Yes or No

Have you used tanning beds in past? Yes or No

Do you have a family history of melanoma? Who? _____

Please list all current medications:

_____
_____

Please list medication allergies:

_____
_____

Smoking status (please choose one):

___ Current every day smoker
___ Current occasional smoker
___ Former smoker
___ Never smoker
___ Total Years Smoking

Alcohol intake: ___ NONE ___1 or >/day ___2+ /day ___3+/ day

<u>Government required question:</u>

MEN: How many times in the past year have you had more than 5 drinks in a day? _____

WOMEN or ADULTS OVER AGE 65: How many times in the past year have you had more than 4 drinks in a day?

_____

MRN#:

Please indicate any alerts below:	Yes	No
History of Melanoma		
Allergy to adhesive		
Artificial Joints or valves		
Blood thinners		
Pacemaker or other implant		
Lightheaded when giving blood		

Please indicate any current symptoms:	Yes	No
Fever or Chills		
Problems with bleeding		
Problems with healing		
Abnormal scarring		
Rash		
Suppressed immune system		
Hay Fever		
Chest Pain		
Night Sweats		
Unintentional Weight Loss		
Thyroid Problems		
Sore throat		
Blurry vision		
Abdominal cramps or pain		
Blood stool		
Blood in urine		
Joint aches		
Muscle weakness		
Neck stiffness		
Headaches		
Seizures		
Cough or Shortness of Breath		
Wheezing		
Anxiety		
Depression		

I attest that I have read and answered all the above questions on both pages.

Signature: _____ Date: _____

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Date of Birth:

ACKNOWLEDGEMENT OF OFFICE POLICIES

Please review and sign after reading each policy listed below

General Patient Authorization: I hereby authorize providers of Advanced Dermasurgery Associates to render care to me during my office visits and to fulfill the orders of my physicians, including consultants, associates, and assistants of the physicians' choice.

Receipt of Notice of Privacy Practices: Advanced Dermasurgery Associates's Notice of Privacy Practices provides information about how may use and disclose protected health information about me. The Notice of Privacy Practices contains a Patient Rights section describing my rights under the law. I acknowledge that I have had the opportunity to review the Notice of Privacy Practices of Advanced Dermasurgery Associates. Advanced Dermasurgery Associates reserves the right to change the Notice of Privacy Practices.

Cancellation Policy: If a patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel within 24 hours of the scheduled appointment. Advanced Dermasurgery Associates reserves the right to charge a $50 fee if a patient does not cancel his/her appointment within 24 hours or a loss of a deposit if a patient does not cancel a surgical appointment within 24 hours. Administrative fees incurred for failure to provide cancellation notice are not billable to insurance or any other third party payor. These policies include appointments with all providers and estheticians.

Release of Medical Information:

I do / do not (*circle one*) authorize Advanced Dermasurgery Associates and its designated representatives to release my medical information to my primary care physician. If authorized, please provide name of physician: _____.

If at any time you should need a copy of your medical records, we require a written release to be signed and dated. The form is available at our front desk and can be requested by email. Please allow up to 15 business days to complete your request. If your request is urgent, please mark the request as urgent and someone from our staff will contact you to expedite your request. Absent providing a secure fax number, records must be MAILED to your address of record. Copies of blood work and pathology reports are provided at no charge, copies of your complete medical record or office notes will require $25 fee. You may also submit a request electronically to HealthMark Group by registering for an account at www.medrelease.com/360. Once logged in, you may select Submit Request from the menu options and enter all required fields to submit an authorization to HealthMark Group directly. HealthMark Group will process your medical record request and provide notification via mail or email once complete. A complimentary copy of your record will be made available for you to download through HealthMark Group's MedRelease 360 website.

Advanced Dermasurgery Associates requires a written records release form to transmit records to any physician or medical organization that is not listed as your referring physician. If you have a consulting physician you would like to have listed as an authorized recipient of your medical information, please request and complete a release form for each physician you wish to receive your records.

Contact Permission: In the event that Advanced Dermasurgery Associatesneeds to contact you (the patient), regarding an appointment, lab result, medication, or any other reason, it is permissible to:

Yes **No** (*circle one*) Leave a message on an answering machine/voicemail system.

Yes **No** (*circle one*) Speak with other authorized individuals listed below.

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Yes **No** (*circle one*) Send a text message to the following number: _____

Expiration of and Right to Revoke Authorization to Disclose Protected Health Information: I understand that I can withdraw my permission set forth above at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "Release of Medical Information" and "Contact Permission". 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.

The duration of this authorization is valid until the earlier to occur of the death of the individual; the individual reaching the age of majority; permission is withdrawn; or the following specific date (optional): *Month:* _____ *Day:* _____ *Year:* _____.

Physician Assistant, Nurse Practitioner, & Esthetician Information: Advanced Dermasurgery Associates may staff physician assistants, nurse practitioners, and estheticians to assist in the delivery of medical dermatology care. A physician assistant ("PA") is not a doctor but is a graduate of a certified training program and is licensed by the Texas Physician Assistant Board. Under the supervision of a physician, a PA can diagnose, treat, and monitor common acute and chronic diseases. Supervision does not require the constant physical presence of a supervising physician, but rather overseeing their work. In collaboration with a physician, nurse practitioners can diagnose, treat, and monitor common acute and chronic diseases. Estheticians provide services as directed by a PA, nurse practitioner or physician. I understand that at any time I can request to see a physician. I have read the above and hereby consent to the services of a PA, nurse practitioner, or esthetician for my health care needs

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Unaccompanied Minors (Under 18 Years Old): New patients who are minors must have a parent or legal guardian present for the new patient visit. Many times parents/guardians find themselves unable to accompany their teen or young adult children to appointments. Should you wish for us to see your teen/young adult child when they arrive at the office unaccompanied please read, indicate and sign below:

YES NO (*circle one*) I hereby grant the physicians and providers at Advanced Dermasurgery Associates permission to treat my child when they arrive at the office unaccompanied. I understand this may include changes in current therapy my child is receiving including treatments or minor skin surgery.

Signature: _____ Date: _____

Proof of Identity: Advanced Dermasurgery Associates requires proof of identity on file. I understand that I will be asked to provide a photo ID such as a driver's license at check-in. This will be scanned into your private medical record as a means to document who we are treating.

By signing this Acknowledgement of Office Policies you acknowledge that you have read, understand, and accept the above policies.

_____ _____
Signature of Patient or Guardian **Date**

_____
Relationship

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Date of Birth:

FINANCIAL POLICY NOTICE

Thank you for choosing Advanced Dermasurgery Associates. Please understand that the services you elect to participate in imply a financial responsibility on your part and you are ultimately responsible for payment of your bill. If you have any financial questions about your visit please contact our billing department as soon as possible. We strongly encourage each patient to contact their insurer directly prior to receiving services to ensure that they fully understand their benefits and coverage. We accept cash, checks, MasterCard, Visa, Discover, American Express and CareCredit.

Please review and sign after reading each policy listed below

Private Pay (Self-Pay): I understand that if I do not have health insurance, full payment is due at the time of service.

Policy Benefits / Non-Covered Charges: I understand it is my responsibility to know my insurance policy coverage and benefits and to notify Advanced Dermasurgery Associates of any insurance changes in a timely manner. Many insurance companies have additional stipulations that may affect my coverage. I understand that I am responsible for any amounts not covered by my insurer. Routine in-office procedures, including but not limited to, biopsies, injections, destruction of precancerous and non-cancerous growths and surgical removal and repair of cancerous and non-cancerous growths and Mohs surgery are billed separately from my office visit and may be subject to my deductible or coinsurance. I agree to fulfill all policy provisions which my insurance companies may require for payment.

Copayments: I understand that all copays are due at the time of my appointment and before I see the provider. Given that Advanced Dermasurgery Associates physicians are specialists, a higher copay may be required.

Deductibles: I understand that if it is determined that my insurance policy has an unmet deductible, payment for services at the contracted rate between Advanced Dermasurgery Associates and my insurer will be due at the time of service.

Managed Care (HMO) Plans or Health Select: I understand it is my responsibility to obtain any and all necessary referrals including referrals for follow up visits if my plan requires one. Advanced Dermasurgery Associates will strive to keep me informed of visits remaining on a referral and/or the expiration date but it is ultimately my responsibility to know this information and to make the necessary arrangements through my primary care physician. I understand that failure to obtain a referral, if required by my insurance for coverage, will result in me bearing complete financial responsibility for any and all services received.

Benefit Representation: I understand that the staff of will make every effort to accurately verify my insurance benefits but I will not solely rely on this preliminary verification as a basis for making financial decisions regarding treatment. I understand that I have a right to refuse any and all services before they are rendered if I think they are non-covered services or non-payable by my insurance. I understand that the final determination regarding my benefits and any amounts owed will be made by my insurer at the time of claim processing according to the provisions of the policy contract that I have with them.

Assignment of Benefits: I understand I must provide a copy of my current insurance card in order to file an insurance claim. I assign directly to the providers at Advanced Dermasurgery Associates all insurance benefits, if any, otherwise payable to me for services rendered. If a Medicare patient, I request that payment of authorized benefits be made on my behalf. I understand that I am financially responsible for all charges whether or not paid by insurance or Medicare. I further agree to pay for any items or services not covered by insurance or Medicare, as applicable. I hereby authorize the Advanced Dermasurgery Associates to release all information necessary to secure all payments or approvals of benefits.

Payment for Ancillary Services (Laboratory/Pathology): I understand that Advanced Dermasurgery Associates utilizes the services of outside laboratories for pathology (biopsies), microbiology (cultures) and blood chemistry. These laboratories will bill for services separately from Advanced Dermasurgery Associates. I acknowledge that payments made to Advanced Dermasurgery Associates are for services rendered by Advanced Dermasurgery Associates and authorize the use of outside laboratories as deemed necessary and warranted by my doctor(s). I understand that this may result in a financial responsibility to the laboratory providing these diagnostic services.

Worker's Compensation: I understand that Advanced Dermasurgery Associates does not accept Worker's Compensation cases.

Returned Checks: I understand that checks presented to as payment for services rendered and subsequently returned by my bank for any reason as unpaid will be charged a returned check fee of $25. Balances must be handled by cash, credit card or money order. Advanced Dermasurgery Associates reserves the right to represent returned checks electronically for their face value plus the returned check fee.

Past Due Accounts: I understand that all outstanding accounts will be turned over to a collection agency after three statements and one pre-collection letter. I acknowledge that I must contact Advanced Dermasurgery Associates before this time if I wish to make other payment arrangements.

By signing this Financial Policy Notice you, the guarantor, acknowledge that you have read, understand and accept all of the above policies.

Signature of Patient or Guardian/Guarantor **Date**

Relationship