Texas Surgical Dermatology PA
Experience the Excellence in Dermatology

Today's Date: _____

Provider seeing you today: ☐ Dr Nguyen ☐ Dr Hughes ☐ Nurse Rosann

How did you hear about us? (please check all that applies)

☐ Another patient ☐ My doctor ☐ Insurance Referred ☐ Website/Internet

Other: _____

Patient Name: Last _____ First _____ Birth date: _____

How do you prefer to be addressed? _____

Gender: ☐ Male ☐ Female Social Security Number: _____ - _____ - _____

Address (Street, City, State, Zip Code): _____

Email (We only contact you about your care): _____

Home phone: _____ Cell Phone: _____

What is your preferred method of contact? ☐ Email ☐ Home Phone ☐ Cell/Text

Preferred Pharmacy: _____ Phone: _____

Address: _____

Emergency Contact -Full Name: _____ Phone:_____

May we discuss your medical information with this person? ☐ YES ☐ NO

Relationship to you: _____

Signature: _____ **Date:** _____

Date: _____ Patient name _____ Birthdate _____

Self-Pay? ☐ YES ☐ NO. If Yes, then please skip to Important Notices below.

Insurance - Financial Information

Primary Insurance:_____ Policy number: _____

Phone Number Primary Insurance: _____

Secondary Insurance: _____ Policy number: _____

Phone Number Secondary Insurance: _____

Name Policy Holder: _____ Birthdate Policy Holder: _____

Social Security Number of Policy Holder (if different than patient): _____

Relationship of Policy Holder to Patient: ☐ SELF ☐ OTHER: _____

IMPORTANT NOTICES: If a biopsy is performed during your visit, the specimen will be sent to an outside pathology lab for diagnosis. You will be billed *separately* for this service from the pathologist.

I understand that I am responsible for any additional charges that may result from procedures done in the office that are not included in my copay, and for any charges due to my deductible in cases where my deductible has not been met.

I understand that if any services or charges are not covered by my insurance carrier, or my eligibility cannot be verified, that I am responsible for all charges incurred.

I understand that payment is due at the time of service.

Assignment of Insurance Benefits and Authorization for Release of Information

I request that payment of authorized Medicare, Medigap or other insurance benefits be made on my behalf to **Texas Surgical Dermatology PA** for any services furnished to me by its providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) , its agents, my insurer, or any organization any information needed to determine these benefits or as required for certain claims to be filed. This authorization shall continue until such time as I revoke it in writing.

By signing below, I am verifying that the information above is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Date: _____ Patient name _____ Birthdate _____

Referring Doctor:_____

Address (Street, City, State, Zip Code): _____

_____

Phone:_____ Fax:_____

Primary Care Doctor: (if different from above) _____

Address (Street, City, State, Zip Code): _____

_____

Phone:_____ Fax: _____

How can we help you? *Please check all that apply*

☐ Changing Lesion ☐ Worrisome spot ☐ Skin Cancer ☐ Rash

☐ Vein evaluation ☐ Scar Revision ☐ Cosmetic Consult ☐ 2nd Opinion

Other reasons for visit_____

_____

Social History

Occupation: _____Retired☐

Marital Status ☐Married ☐Single ☐Divorced ☐Widowed

Spouse/Partner's name _____

How many children do you have? _____

Do you live by yourself? ☐Yes ☐No

Do you smoke or chew? ☐Yes ☐No If Yes, how much?_____

_____

Do you drink alcohol? ☐Yes ☐No If Yes, how much?_____

_____

Date: _____ Patient name _____ Birthdate _____

Do you faint or feel light headed with blood draws or with surgery? ☐ Yes ☐ No

ALLERGIES	What reaction do you have to this drug?
1	
2	
3	
4	
Do you have any other reactions or precautions we should know?	

Vitamins /Herbals/ Over the Counter Medications:

_____

_____

Please list your medications	**Directions/Dosage (if known)**
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	

Date: _____ Patient name _____ Birthdate _____

Personal Skin Cancer History:

	☐ None		If yes, where?
Melanoma	☐ Yes	☐ No	_____
Basal Cell Cancer	☐ Yes	☐ No	_____
Squamous Cell Cancer	☐ Yes	☐ No	_____
Actinic Keratosis (Precancer)	☐ Yes	☐ No	_____
Have you had skin cancer surgery?	☐ Yes	☐ No	_____

Other:_____

Family Skin Cancer History:

	☐ None		If Yes, who?
Melanoma	☐ Yes	☐ No	_____
Basal Cell Cancer	☐ Yes	☐ No	_____
Squamous Cell Cancer	☐ Yes	☐ No	_____

How sensitive are you to the sun? *Please Check only one answer*

☐ I Always burn, never tan
☐ II Always burn, but sometimes tan
☐ III Sometimes burn, but always tan
☐ IV Never burn, always tan

Sun Protection Practices:

Do you wear sunscreens with UVA and UVB protection (broad spectrum) and SPF 30 or greater?	☐ Yes	☐ No
Do you wear a hat with 4 inch brim all around?	☐ Yes	☐ No
Do you wear long sleeve clothing?	☐ Yes	☐ No
Do you avoid sun exposure during peak sun hours (between 10 AM and 4 PM)?	☐ Yes	☐ No

Please list any rejuvenation or cosmetic products you are using: _____

_____

Would you like to learn more about rejuvenating your skin? ☐ YES ☐ NO

Date: _____ Patient name _____ Birthdate _____

Please check all that apply

- ☐ Previous cosmetic surgery
- ☐ **Pacemaker/Defibrillator**
- ☐ Brain stimulator
- ☐ Hip replacement- if yes when?
- ☐ Need antibiotics before dental surgery?
- ☐ Heart valve surgery
- ☐ Heart valve infection (endocarditis)
- ☐ Heart bypass surgery
- ☐ Heart rhythm problems
- ☐ Heart failure
- ☐ High blood pressure
- ☐ Blood thinners
- ☐ Circulation problems (Arterial or Veins?)
- ☐ Blood clots in deep veins
- ☐ Pulmonary embolus (clot to lungs)
- ☐ Asthma
- ☐ Emphysema, COPD
- ☐ Tuberculosis
- ☐ Immune system problems
- ☐ HIV/AIDS
- ☐ Organ transplant patient (please list below): kidney, heart, lung, bone marrow, liver, pancreas
- ☐ Are you pregnant or may be pregnant?
- ☐ Diabetes
- ☐ Dialysis
- ☐ Kidney problems
- ☐ Liver disease/Cirrhosis
- ☐ Hepatitis A or B or C (circle all that apply)
- ☐ History of blood transfusions
- ☐ Bleeding problems (problems clotting)
- ☐ X-ray treatment for acne
- ☐ Radiation treatment for anything
- ☐ Anxiety or nervousness
- ☐ Psychiatric conditions
- ☐ Problems with local anesthesia
- ☐ Problems with general anesthesia
- ☐ Abnormal scarring or keloids
- ☐ Seizures
- ☐ Strokes
- ☐ Neck injuries or surgery
- ☐ Back injuries or surgery
- ☐ Raynaud's
- ☐ Autoimmune disease (please list below): Lupus, Scleroderma, CREST, Sjogrens, Dermatomyositis, Rheumatoid arthritis

☐ History of any cancer, other than skin cancer (circle all that apply): Breast, lung, colon, thyroid, kidney, prostate, bone , leukemia, lymphoma, sarcoma, brain, pancreas, ovarian.

Do you have any other medical issues not listed above?

_____

_____

_____

_____

Date: _____ Patient name _____ Birthdate _____

Please check all that apply (within past 3 months)

- ☐ unplanned weight loss, weight gain
- ☐ fevers, chills
- ☐ night sweats
- ☐ nausea and vomitting
- ☐ appetite or diet changes
- ☐ easily faints
- ☐ easily falls or balance problems
- ☐ unusual headaches
- ☐ sudden vision changes
- ☐ unusual change in coordination
- ☐ recent seizures (within past 3 months)
- ☐ black or bloody stools
- ☐ recent stomach pains (within 3 months)
- ☐ blood in urine
- ☐ problems controlling bladder
- ☐ swelling in groin, armpits, or neck
- ☐ bleeding in joints when injured
- ☐ difficulty lying flat
- ☐ neck pain
- ☐ chest pain or angina
- ☐ shortness of breath
- ☐ cough (bloody or greenish sputum)

Do you wish to share anything else that may help us care for you?

_____

_____

_____

_____

Thank you for your time and for helping us take care of you.

TEXAS SURGICAL DERMATOLOGY PA

Experience, Excellence, Commitment

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. PLEASE READ CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

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You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of 09-26-2016 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

If you have any questions, then please contact our Practice Compliance Officer, Tiffany Dunn for more information, in person or in writing.

As a patient, or parent/legal guardian of the patient, I acknowledge receipt of Texas Surgical Dermatology PA's Notice of Privacy Practices.

_____ _____

Signature of patient Date

TEXAS SURGICAL DERMATOLOGY PA

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BEING TIMELY POLICY

We will provide every patient with an Experience of Excellence in Dermatology. Critical to this mission is to see you on time. Your time is valuable to us and we strive to see you within 15 minutes of your scheduled appointment. To achieve this goal, we ask that you arrive at least 15 minutes *before* your appointment time to complete any necessary paperwork.

We also know that life happens. Sometimes you may be late or sometimes you may not even make your appointment. We understand.

IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT DATE

- *Please inform us (call, email) 24 hours in advance so that we may open this time for other patients who are in need of our expertise.*
- We will be glad to reschedule you when you call.
- If you do not show and do not notify us beforehand, then you will be considered a "NO-SHOW."

IF YOU WILL BE MORE THAN 15 MINUTES LATE TO YOUR APPOINTMENT TIME

- *Please call and inform us that you will be late. We will still see you if you are within a 30-minute window. You may have to wait longer but we will be glad to see you.*
- *If you arrive more than 15 minutes late WITHOUT calling us beforehand, then you will be considered a "NO SHOW."* (You do not want to be a no-show)

IF YOU ARE A NO-SHOW (not informing us 24 hours in advance that you cannot keep your appointment or not informing us that you will be arriving more than 15 minutes late):

- We all deserve a second chance. Congratulations, your first NO-SHOW is a freebie but it is also a precaution!
- Your second NO-SHOW is bad. We will charge you $50 for not showing up. This late fee may be paid on the next visit when you arrive on time.
- Your third NO-SHOW is worse. If you are a NO-SHOW for the third time within 12 months, we will no longer be able to care for you. We will regretfully dismiss you from the practice and will help you find another provider for your care.

Woody Allen once said "…80% of success is just showing up."

So make haste, don't be late!

_____ _____

Signature of Patient or Parent/Legal Guardian of patient Date

Experience the Excellence in Dermatology

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