TYPE OF VISIT:
□ **New Patient** □ **Follow up** □ **Cosmetic Services**

Dallas Dermatology Partners

DEMOGRAPHIC INFORMATION

Name: _____ **DOB:** ___/___/_____ **AGE:** _____ **Social Security:** _____

Last **First** **Middle Initial**

Address: _____

Number **Street** **City** **State** **Zip**

Cell Phone: _____ **Home Phone:** _____ **EMAIL:** _____

Who referred you to our office? _____ Phone Number **:** _____

Who is your primary care doctor? _____ Phone Number **:** _____

Emergency Contact? _____ Phone Number: _____

□ Male □ Female **Marital Status:** □ Married □ Single □ Other: _____

Race: □ Caucasian □ Black □ Hispanic □ Asian □ Native American □ Other
Ethnicity: □ Hispanic □ Non-Hispanic/Non-Latino □ Other/ Non-determined
Languages Spoken: □ English □ Spanish □ Other: _____

Occupation: _____ **Employer:** _____ **Phone:** _____

Preferred Pharmacy: _____ **Phone:** _____

Preferred Pharmacy Address: _____

CANCELLATION / NO SHOW POLICY

I understand that I must call to cancel an appointment at least 48 hours (Business days) before the time of the appointment. If I do not cancel and do not come to my appointment, I will be charged the following fees based on the appointment type. This fee is NOT covered by your insurance plan.

Dermatology Appointment - $50 fee
Filler Appointment - $95.50 fee
Sculptra Appointment - $250 fee/per vial
Surgery Appointment - $150 fee

My signature below shows that I understand and agree with this policy.

_____ _____

Signature of Patient/Guardian Date:

Besides regular mail, I authorize Dallas Dermatology Partners to contact me by the following methods: (please checkboxes)

□ **Cell phone** □ **Text messaging** □ **Home phone** □ **Email**

Are you interested in hearing more about our Advanced Aesthetics services? □ Yes □ No

PATIENT NAME:_____DATE: _____

RELEASE OF INFORMATION TO OTHERS (HIPAA)

I acknowledge that I have received a copy of "Notice of Privacy Practices". I authorize Dallas Dermatology Partners and its staff to use and disclose the protected health information described below, to the individuals named. These individuals may also pick up prescriptions, medical records and other health related items on my behalf.

What level of information can we release?

□ All information including specific medications and dosages, lab results and information related to sensitive issuessuch as sexually transmitted diseases (including but not limited to AIDS and Hepatitis C).

□ **No information whatsoever**

To whom can we release information (please list names):

□ _____
Name Phone# Relationship to Patient

□ _____
Name Phone# Relationship to Patient

□ **No one except the patient can obtain information.**

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing that the revocation will not apply to information already released in response to this authorization.

2._____ _____
Signature of Patient/Guardian Date

TREATMENT CONSENT AND AUTHORIZATION

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment.I understand that this information serves as:

- A basis for planning my care and treatment and is a means of communication among the many healthcareprofessionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill and a means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence ofhealthcare professionals.

I hereby authorize Dallas Dermatology Partners to furnish to any designated attorney or insurance Company all information necessary to file a health insurance claim form, or to obtain reimbursement. *I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, and any other health plans to Dallas Dermatology Partners.*

I understand that I am financially responsible for all charges whether paid or not paid by my insurance company. Also, I hereby authorize the disclosure of health information in any data format regarding my treatment during hospitalization and/or outpatient care to Dallas Dermatology Partners. I understand that this facility will maintain medical records in accordance with state requirements. By my signature below, you are fully authorized to disclose such information when requested by Dallas Dermatology Partners.

The foregoing information is true and correct to the best of my knowledge. I authorize Dallas Dermatology Partners toprovide medical treatment to me in the office or in the hospital.

3._____ _____
Signature of Patient/Guardian Date

FINANCIAL AND GENERAL POLICY SIGNATURE

I have read and understand the Dallas Dermatology Partners Financial and General Office Policies. My signature indicates compliance and understanding of these policies and that I have completed all the forms to the best of myknowledge.

4._____ _____
Signature of Patient/Guardian Date

Dallas Dermatology Partners Financial Policy

We are honored to be your dermatologic provider.
We know you have a choice and appreciate your trust.

Please be aware of the following:

- Patients are responsible for payment at the time of service. We accept most forms of payment
- Patients should be prepared to pay their copay and any applicable co-insurance for dermatologic procedures. Most dermatologic procedures go toward your deductible. Should you be due a refund, we will make every effort to refund within 30 days.
- Should your health plan determine a service uncovered, you will be responsible for the complete charge.
- Please make sure to update your insurance information in the event you have a change of insurance.
- Lab fees may be billed separately from an off-site lab
- Cosmetic services are considered a patient expense and are not billed to insurance.
- We will make every effort to work with you regarding any need for financial arrangements

Procedure Pricing List

Most dermatology procedures will be applied towards your insurance deductible/co-insurance. Please be aware that if in your visit with Dallas Dermatology Partners you have any of these procedures done, we will collect an estimated payment for them at the time of service. Should your insurance pay a portion or in full for these procedures, we will refund you upon receipt of your insurance payment.

Below is a list of the most common procedures in this office that will apply to your deductible/co-insurance

Common Procedures	**Estimated Cost Range**
- Biopsy of skin lesion	
o Shave method (one lesion)	$115.00
o Each additional lesion(s)	$63.00
o Punch method (one lesion)	$150.00
o Each additional lesion(s)	$75.00
- Destruction of wart or molluscum	$135.00
- Destruction of actinic keratosis/actinic keratoses	$75.00-$250.00
- Surgical repair of skin lesions	$380.00-$450.00
- Excision of Skin Lesions	$150.00-$460.00

_____ _____
Name of Patient Date

_____ _____
Signature of Patient or Responsible Party Date

DALLAS DERMATOLOGY PARTNERS

Date: _____

Medical Questionnaire

Name_____ DOB_____ Age_____

Medical History: Reason for visit: _____
How long have you had this problem? _____
Symptoms (How does it bother you?) _____
Treatments you have tried:_____
_____

Please list all MEDICATIONS (with dosing) that you are taking including over the counter medications:

***Please list any MEDICATIONS you are allergic to*: _____**

Medical problems (check if yes)

___Diabetes	___High Blood Pressure	___Heart disease	___Pacemaker	
___Artificial joint/valve	___Asthma	___other Lung disease	___Thyroid disease	
___Hepatitis, type ___	___HIV	___other Liver disease	___Autoimmune Disease	
___Cancer, type___	___Depression	___Kidney Disease	___Transplantation	

___Other (comments):_____

Past Surgeries/Other Medical problems _____
_____

***Female Patients*: Pregnant/trying to get pregnant?** __ yes __ no (___ weeks) Breastfeeding? ___ yes ___ no

History of Skin Cancer? ____yes ____no: Melanoma ____Basal cell carcinoma ____Squamous cell carcinoma

Area of body:_____How treated:_____

History of Skin Disease, past or current: _____
_____

Social History: What is your smoking status: ___Smoker ___Never Smoker

Advance Care (65 and older): Do you have a living will? ___ Yes ___ No

Alerts: Please Check all that apply

__ Allergy to Adhesive __ Allergy to Lidocaine __Allergy to Topical Antibiotics

__ Artificial Heart valve __ Artificial Joint Replacement in the last 2 years __ Require antibiotics prior to surgical procedures

__ Blood thinners __Defibrillator ___ Pacemaker