HOUSTON INSTITUTE OF DERMATOLOGY

PATIENT REGISTRATION

Welcome and thank you for visiting our office today! My staff and I are committed to providing you with quality care. Please make yourself comfortable and let us know if we may assist you with anything.

Today's Date: _____ /_____ /_____ Name: _____
Address:_____
City/State/Zip:_____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____ Preferred Contact: ☐ Cell ☐ Home ☐ Work
Date of Birth: _____ /_____ /_____ Age: _____ Sex: ☐ M ☐ F Marital Status: _____
Social Security Number: _____ - _____ - _____ Drivers License #:_____
Referring Physician's Name: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Primary Insurance: _____	Secondary Insurance: _____
Insured's Name: _____	Insured's Name: _____
Social Security Number: _____	Social Security Number: _____
Policy #: _____	Policy #: _____
Group #: _____	Group #: _____
☐ Self ☐ Spouse ☐ Child ☐ Other	☐ Self ☐ Spouse ☐ Child ☐ Other
Insured's Employer: _____	Insured's Employer: _____
Insured's Date of Birth: _____ /_____ /_____	Insured's Date of Birth: _____ /_____ /_____

Pharmacy Name and Phone Number: _____

Patient's Employer: _____
Occupation: _____ Full-Time Student? ☐Ye s ☐No
Emergency Contact: _____ Phone Number: _____
Relationship of Emergency Contact: _____
Name of Parent or Guardian (if patient is a minor): _____

How did you hear about us? ☐Physician ☐ Family member ☐Friend
☐Employer ☐Insurance Company ☐Google/Internet Search ☐Magazine/Phonebook
☐Other: _____

I understand that office visit charges are payable on the day service is rendered. I authorize Houston Institute of Dermatology to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner.

Signature: _____ **Date:** _____

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MEDICAL HISTORY

Today's Date: _____ /_____ /_____ Name: _____
Please list the reason for your visit: _____
Height: _____ Weight: _____ Age: _____

Are you interested in treating wrinkles, skin texture, skin tone, reversing sun damage, or facial rejuvenation? ☐ Yes ☐No

Medical History: (Please check)

☐ Anxiety
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Atrial Fibrillation
☐ Benign Prostatic Hyperplasia
☐ Breast Cancer
☐ Colon Cancer
☐ COPD (Emphysema)
☐ Coronary Artery Disease
☐ Depression
☐ End Stage Renal Disease
☐ GERD (Acid Reflux)
☐ Hearing Loss
☐ Hepatitis
☐ Hypertension
☐ HIV/AIDS
☐ Hypercholesterolemia (High Cholesterol)
☐ Hyperthyroidism
☐ Hypothyroidisn
☐ Leukemia
☐ Lung Cancer
☐ Lymphoma
☐ Pacemaker
☐ Prostate Cancer
☐ Seizure
☐ Stroke
☐ Valve Replacement
☐ Other:_____

Please list any previous surgeries:_____
_____

Skin Disease History: (Please check)

☐ Acne
☐ Actinic Keratoses
☐ Asthma
☐ Basal Cell Skin Cancer
☐ Blistering Sunburns
☐ Dry Skin
☐ Eczema
☐ Flaking or itchy scalp
☐ Hay Fever/Allergies
☐ Melanoma
☐ Poison Ivy
☐ Pre-cancerous mole
☐ Psoriasis
☐ Squamous Cell Skin Cancer
☐ None
☐ Other: _____

For Women: Are you currently pregnant, actively trying to get pregnant OR breastfeeding?
☐Yes ☐No

Do you wear sunscreen regularly? ☐ Yes ☐ No
If yes, what SPF: _____

Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a family history of melanoma? ☐ Yes ☐ No
If yes, which relative(s)? _____
Any other family history? _____

Medications (please list all current medications): _____
_____
_____

Allergies (please list all allergies): _____

Social History:

Do you smoke cigarettes? ☐ Yes ☐ No
If yes, how much? _____

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

How often do you exercise?
☐ Once a day
☐ Few times weekly
☐ Sometimes
☐ Never

What is your caffeine use?
☐ Several times a day
☐ Once a day
☐ Few times a week
☐ Never

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NOTICE OF PRIVACY AND HIPAA

Today's Date: _____ /_____ /_____ Name: _____

You may be contacted by the practice to remind you of appointments, healthcare treatment options or other health services that may be of interest to you.

Leave a message on your preferred contact number regarding medical results? ☐Yes ☐No
Home Phone:_____ Mobile Phone:_____

Do we have permission to confirm your appointment via email? ☐Yes ☐No

Do you authorize emails pertaining to appointment reminders, specials, events, etc? ☐Yes ☐No

Do we have permission to discuss your medical condition with a family member? ☐ Yes ☐No

If yes, who? _____ Relationship: _____ Telephone: _____

Houston Institute of Dermatology has provided me with a copy of my rights (find a copy on our web site or ask for a copy in the office) as a patient under the HIPAA act. I have been provided the opportunity to read and understand my rights and ask questions regarding my rights and receive answers to my satisfaction. If you have any questions, please address them with the physician during your visit.

I acknowledge that Houston Institute of Dermatology has made the Notice of Privacy Practices available to me. I authorized 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. I also authorize payment of medical benefits to the physicians.

Signature: _____ **Date:** _____

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FINANCIAL POLICY

Houston Institute of Dermatology is committed to providing you with quality care. As a patient of Houston Institute of Dermatology, you are financially responsible for all medical services. Your clear understanding of our financial policy is important to our professional relationship. Our office will be pleased to discuss our professional fees with you at any time.

PATIENT/INSURANCE/VERIFICATION INFORMATION: As a patient, you are responsible for providing accurate and complete insurance information. Your health insurance is a contract between you and your insurance company. It is your responsibility to contact your carrier to verify if provider is in network, coverage and payment obligations. At the time of scheduling your appointment, you will be asked to provide your insurance information. Our office reserves the right to contact your health insurance carrier to verify your coverage and payment responsibilities. This is not a guarantee of payment. If we are providers with your insurance carrier, as a courtesy to you, we will file a claim with your insurance carrier. Again, your health insurance is a contract between you and your insurance company. We are not a party to your contract. Therefore, Houston Institute of Dermatology cannot become involved in disputes between you and your insurance company regarding deductibles, non-covered charges, co-insurance, secondary insurance, coordination of benefits, pre-existing conditions, or "reasonable and customary" charges other than to supply factual information as necessary. You are responsible for timely payment of your account. At check–in you will be asked to provide your insurance identification card, social security number, and state-issued identification. This is for your protection as well as to ensure that no changes in coverage have occurred.

REFERRALS: If you have a health plan that requires a referral from your primary care physician it is your responsibility to obtain this information prior to your appointment. It is also your responsibility to verify that you do not exceed the number of visits authorized by your primary care physician/health care plan. If you exceed your authorized visits you will be billed for all services rendered. If you are unable to obtain a referral, your appointment will be rescheduled or you will be expected to pay for charges in full at the time of service.

CO-PAYMENTS/DEDUCTIBLES/COINSURANCE: All co-payments, applicable deductibles and coinsurance amounts will be collected upon patient check-in. In compliance with our contract with your insurance carrier, Houston Institute of Dermatology cannot discount/waive any co-payment, deductible and/or coinsurance amounts.

CANCELLATION POLICY: Our office works very diligently to schedule all appointments in a timely manner; therefore if you request to reschedule or cancel an appointment, we ask for <u>at least 24 hours notice prior to your appointment date</u>. Houston Institute of Dermatology reserves the right to charge the patient a <u>$50 fee</u> if the patient does not cancel within 24 hours.

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SELF-PAY/NON-CONTRACTED PLANS/NON-COVERED SERVICES/THIRD PARTY CLAIMS: Payment in full will be collected at the time of your office visit.

MEDICARE PAYMENTS: If you have regular Medicare part B and a secondary carrier (Medi-Gap plan) we will not collect any payment at the time of your visit. O ur office will bill you for any portion of your bill not paid by Medicare and your secondary carrier. If you have regular Medicare Part B only and have not met your deductible, we will collect the deductible amount along with your 20% coinsurance at the time of your visit. If you have regular Medicare Part B only and have met your deductible, we will only bill your 20% coinsurance at the time of your visit.

OUT OF NETWORK PATIENTS: Any applicable deductible, co-payment, coinsurance, and non-covered services will be collected at the time of your office visit. Please contact your insurance carrier for guidelines pertaining to your coverage.

PATHOLOGY/LABORATORY: Skin samples are sometimes sent to a laboratory for microscopic evaluation to determine or confirm proper diagnosis. I authorize and understand that I am responsible for the cost of any testing or lab services performed for me and that billing of such services may be billed independently by another physician or laboratory if my insurance doesn't pay or I am a self-pay patient.

PATIENT BALANCES: Any patient balance due after your insurance company has processed your medical charges will be billed: this balance is due upon receipt. If the balance is not paid or payment agreement established, your account will be forwarded to an outside collection agency within 90 days of the first billing statement. Upon arrival for an appointment, any outstanding balance due will be collected at check-in.

METHODS OF PAYMENT

Our office accepts cash, Debit, VISA, Discover, MasterCard and American Express.

- I have read the Financial Policy of Houston Institute of Dermatology.
- I understand that I am personally responsible for payment on my account
- In the event my insurance company deems a service to be "non-covered", I understand that I am personally responsible for payment.

Signature: _____ **Date:** _____

Printed Name: _____