PREMIER PROCEDURAL DERMATOLOGY

DATE: _____

PATIENT INFORMATION			
Last	First	Middle	
Address	City	State	Zip
Home Phone	Cell Phone	Emergency Contact	Emergency Phone
Date of Birth	Sex	Marital Status	Social Security No.
Referring Physician	Employer		Work Phone
BILLING INFORMATION			
Person Responsible for Bill:	Address (if different from above)		Home Phone
INSURANCE INFORMATION			
Primary Insurance	Insurance Address		Insurance Phone
Group Number	Policy Number		Insured's relationship to pt: circle one self spouse child other
Subscriber's Name	Address		Phone
Subscriber's Date of Birth	Sex	Social Security No.	Employer
Secondary Insurance	Insurance Address		Insurance Phone
Group Number	Policy Number		Insured's relationship to pt: circle one self spouse child other
Subscriber's Name	Address		Phone
Subscriber's Date of Birth	Sex	Social Security No.	Employer
Third Insurance	Insurance Address		Insurance Phone
Group Number	Policy Number		Insured's relationship to pt: circle one self spouse child other
Subscriber's Name	Address		Phone
Subscriber's Date of Birth	Sex	Social Security No.	Employer

AUTHORIZATION: I / We hereby state that the above information is true and correct to the best of my / our knowledge. I / We authorize the above named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payors, as required for certain claims filed.

ASSIGNMENT OF BENEFITS STATEMENT: I / We authorize direct payment to be made to the above named practice for any and all medical or surgical services rendered. I understand if any services or changes are not covered by my insurance carrier or my eligibility cannot be verified, I am responsible for all charges incurred.

_____ _____ _____

Signature of Patient / Parent / Guardian / Insured Printed Name Date

PREMIER PROCEDURAL DERMATOLOGY

PREMIER PROCEDURAL DERMATOLOGY, PLLC

CONSENT FOR TREATMENT

I hereby consent to all medical and surgical procedures, including but not limited to laboratory, biologic tests and administration of local anesthesia which are deemed appropriate and necessary at any time while under the care of the physicians at Premier Procedural Dermatology, PLLC.

Tissue samples may be needed to diagnose your condition. Both malignant and benign growths and conditions may require a surgical procedure called a biopsy. A local anesthetic is used prior to taking this tissue sample. This simple procedure carries with it minor risks such as: allergic reactions to the anesthesia, fainting, mild discomfort, minimal bleeding, the possibility of minor scarring and infection. The risks of not having the procedure done should be discussed with the physician.

It is the policy of this office to send all surgically removed specimens for expert consultation regardless of the pre-biopsy diagnosis. You may be responsible for any charges not covered by your health insurance.

I have read the above statements and understand the risks associated with a tissue biopsy. I also agree to have a biopsy performed by the practitioner if clinically indicated and sent to a pathology laboratory for analysis. I am aware that any outside services not covered by my insurance are my responsibility. I also authorize: Premier Procedural Dermatology, P.A. physicians to release any information regarding my examination or treatment to my insurance company for processing of claims and/or to my referring physician.

_____

SIGNATURE OF PATIENT (OR PARENT OR RESPONSIBLE PARTY)

_____

PRINTED NAME

_____

DATE

PREMIER PROCEDURAL DERMATOLOGY

Office and Financial Policies

Welcome and thank you for choosing Premier Procedural Dermatology for your medical care. We are committed to providing you with the highest quality medical care in an efficient and cost-effective manner. We hope that by providing our patients with our policies in advance, we can prevent any misunderstanding or frustration at the time of your visit.

Initials:_____**Insurance**: The patient is responsible for knowing their insurance benefits including their deductible and out- of-pocket expenses. Copay, deductibles and patient's financial portion including any balance will be collected at the time of service. You may be asked to reschedule your appointment for non-payment. We will gladly file your insurance claim on your behalf. We will not be involved in disputes between you and your insurance company regarding coverage and/or policy benefits. You are responsible for the timely payment on your account.

Initials:_____**Cancellations/No Show Fee**: Please call our office at least 24 hours in advance if you are unable to keep a scheduled appointment. You will be charged a No Show Fee of $50 for failure to keep the appointment as scheduled or a $30 fee if the appointment is cancelled with less than 24 hours' notice.

Initials:_____**Patient Balances**: Please be prepared to pay for the current visit as well as any past balances on your account. Copay, deductible, out-of-pocket expenses and non-covered services must be paid at the time of service. For your convenience we take cash, check and credit cards.

Initials:_____**Late Arrivals**: We do our best to reduce patient wait time but when a patient arrives late, it is impossible to stay on schedule. If you arrive 15 minutes or more after your scheduled appointment time, you will need to reschedule your appointment.

Initials:_____**Dishonored Checks**: A $30 Return Check Fee will be assessed on all dishonored checks. If you have 2 dishonored checks on file, check payment will no longer be a payment option for you, but we will gladly accept cash or credit card payments at your future visits.

Initials:_____**Collections**: You will be receiving at least 3 statements from our office for balances owed. Please make payment arrangements, if necessary, to keep your account current. If your address changes, it is your responsibility to inform Premier Procedural Dermatology to update our records. Your account will be turned over to collections when your statement returned due to a bad address. When your account is already in collections, you may not be seen until the account is paid in full at the collection agency.

Initials:_____**Prescriptions**: Please allow up to 48 hours to process your prescription refill request.

Initials:_____**Walk-in Appointments**: A limited number of walk-in appointments are available as the schedule allows for one acute issue or medication refill only. Therefore, please be advised that walk-in appointments may experience longer wait times or may be accommodated only after all scheduled appointments.

I have read understand and agree to the above office and Financial/Office policies. I hereby attest that I have given and agree to provide current demographics and insurance information and authorize release of information necessary for insurance filing by signing this statement.

Patient Name:_____Date:_____

Health Insurance Portability and Accountability Act (HIPAA)

A. Inspection and copies of protected health information – you may inspect and / or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that a request for copies be made in writing and we ask that request for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document. We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies. We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons: The information is psychotherapy notes; the information reveals the identity of a person who provided information under a promise of confidentiality; the information is subject to the Clinical Laboratory Improvements Amendments of 1988; the information has been compiled in anticipation of litigation. We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for review of our decision to deny access. Texas law requires us to be ready to provide copies or a narrative report within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing. HIPAA permits us to charge a reasonable cost-based-fee.

B. Amendments of Medical Information – you may request an amendment of your medical information in the designated records set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons: The information was not created by this practice or physicians in this practice; the information is not part of the designated records set; the information is not available for inspection because of an appropriate denial; the information is accurate and complete. Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical records. If we refuse to allow an amendment to be made and tell others that we now have the correct information.

C. Accounting of Certain Disclosures – HIPAA privacy regulations permit you to request, and us to provide, and accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by our or your representative. Please submit any request for an accounting to the person at the end of this document. You first accounting of disclosures (within a 12-month period) will be free. For additional request within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request before any costs are incurred.

D. Appointment Reminders, Treatment Alternatives, and Other Benefits – We may contact you by (telephone, mail or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

E. Complaints – If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. We will not retaliate against you for filling a complaint with us or the government.

F. Our Promise to you – We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of your privacy practices with respect to protected health information, and to abide by the terms of notice of privacy practices in effect.

G. Questions and Contact Person for Requests - If you have any question or want to make a request pursuant to rights described above, please contact: Ryan Ahern, MD, Tel# (979) 314-5400

I acknowledge that I have been given an opportunity to review Premier Procedural Dermatology Notice of Privacy Policies and have been provided a copy if I desire one.

_____	_____	_____
Signature of Patient or Legal Representative	Relationship to Patient	Date

Your Birthday AND address will be used to verify identity on your behalf.

NAME:_____

DATE:_____

PREMIER PROCEDURAL DERMATOLOGY

Date of birth:_____ Ethnic Group (Required by ACA-2010):_____

Referring Provider:_____ Primary Provider:_____ Occupation:_____

REASON FOR TODAY'S VISIT:_____

When did it start?_____ Has it been treated?_____

Any Past Skin Cancers/scars in the same area?_____

SURGICAL REVIEW OF SYSTEMS

Artificial Joints:_____

Artificial Heart Valve:_____

Pacemaker/Defribrilator:_____

Blood Thinners:_____

Organ Transplant:_____

Immunospressive Meds:_____

HIV/Hepatitis B or C:_____

Immunosupression:_____

Clotting Disorder:_____

Anxiety:_____

Circulation Disorder: (Reynauds)____

Scarring Issues:_____

Premedication Required:_____

MEDICAL REVIEW OF SYSTEMS

DIABETES:_____

SMOKING/HOW MUCH:_____

HIGH BLOOD PRESSURE:_____

LIVER DISEASE:_____

KIDNEY DISEASE:_____

STROKE OR NEUROLOGIC:_____

CANCER:_____

AUTOIMMUNE:_____

RADIATION TREATMENT:_____

RECENT SURGERY: _____

_____

FAMILY HX OF MELANOMA:_____

ALLERGIES (RASHES OR SWELLING) _____

_____

Any Allergies to: Adhesive___Epinephrine___ Lidocaine___ Latex___ Ointment____

Social history: Alcohol Use_____ Smoking_____ Tobacco_____ Other Substances of note_____

Pregnancy or Planning one_____ Breastfeeding currently_____

List of Current medications:_____

Recent illness:_____ Fever or Chills:_____ History of Cold Sores____ Fainting with Procedures____