Patient Information

First Name: _____MI:___Last Name:_____ Date:_____

Social Security Number:_____Date of Birth:_____Sex: M F

Address:_____City, State, Zip:_____

Home Phone:_____Cell Phone:_____

Email Address:_____Preferred Language:_____

Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Other

Emergency Contact

Name:_____Relationship:_____

Phone Number:_____ Alt Phone Number:_____

Employment Information

Employer:_____Work Phone:_____

Responsible Party (if not patient)

Name:_____Relationship to Patient:_____

Address:_____City, State, Zip:_____

Primary Insurance

Insurance Company:_____Phone:_____

Policy ID Number:_____Group Number:_____

Name of Policy Holder:_____DOB:_____SSN:_____

Secondary Insurance (if applicable)

Insurance Company:_____Phone:_____Policy ID:_____Group #:_____

Name of Policy Holder:_____DOB:_____SSN:_____

Medical History

Past Medical History (please circle all that apply):

Anxiety	Coronary Artery Disease	High Cholesterol
Arthritis	Depression	Thyroid Problems
Asthma	Diabetes	Leukemia
Atrial Fibrillation	End Stage Renal Disease	Lung Cancer
Bone Marrow Transplant	GERD	Lymphoma
Breast Cancer	Hearing Loss	Prostate Cancer
Colon Cancer	Hepatitis	Radiation Treatment
COPD	High Blood Pressure	Seizures
Other:_____	HIV/AIDS	Stroke

Surgical History (please circle all that apply):

Appendix Removed	Coronary Artery Bypass	Prostate Biopsy
Bladder Removed	Mechanical Valve Replacement	TURP
Mastectomy	Heart Transplant	Spleen Removed
Lumpectomy	Joint Replacement, Knee	Testicles Removed
Breast Biopsy	Joint Replacement, Hip	Hysterectomy
Breast Reduction	Kidney Biopsy	
Breast Implants	Kidney Removed	
Colectomy	Kidney Stone Removal	
Colectomy:Diverticulitis	Kidney Transplant	
Colectomy:IBD	Ovaries Removed	
Gallbladder Removed	Prostate Removed	
Other:_____		

Skin Disease History (please circle all that apply):

Acne	Poison Ivy	Basal Cell Skin Cancer
Actinic Keratoses	Precancerous Moles	Squamous Cell Skin Cancer
Blistering Sunburns	Psoriasis	Melanoma
Flaking or Itchy Scalp	Dry Skin	Asthma
Hay Fever/Allergies	Eczema	Other_____

Do you wear sunscreen? 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

Medications (please list all current medications)

_____
_____
_____
_____
_____
_____
_____

Allergies (please list all allergies)

_____
_____
_____
_____

Social History (please circle all that apply)

Cigarette Smoking:

Currently smokes	Has smoked in the past
Never smoked	Former smoker

Alcohol Use:

None	Less than 1 drink per day
1-2 drinks per day	3 or more drinks per day

Other Family History (only first degree relatives)

_____
_____

Preferred Language: _____

Race [ ] White [ ] Black/African American [ ] Native Hawaiian/Pacific Islander
[ ] American Indian/Alaska Native [ ] Asian [ ] Other

Ethnicity: [ ] Hispanic/Latino [ ] Non-Hispanic/Latino

Preferred Pharmacy

Name:_____
Phone Number:_____
City or Zip Code:_____

Primary Care Physician Name: _____

Review of Systems: Are you currently experiencing any of the following?

Problem with bleeding	Yes	No	Anxiety	Yes	No
Problem with healing	Yes	No	Depression	Yes	No
Problem with scarring	Yes	No	Abdominal Pain	Yes	No
Rash	Yes	No	Shortness of Breath	Yes	No
Immunosuppression	Yes	No	Cough	Yes	No
Hay Fever	Yes	No	Joint aches	Yes	No
Chest pain	Yes	No	Muscle Weakness	Yes	No
Fever/Chills	Yes	No	Headaches	Yes	No
Night sweats	Yes	No	Seizures	Yes	No
Unintentional Weight Loss	Yes	No	Anemia	Yes	No
Thyroid problems	Yes	No	Other:	Yes	No

Alerts: (please circle all that apply)

Allergy to adhesive	Artificial heart valve	MRSA	Rapid heart beat with epinephrine
Allergy to lidocaine	Artificial joint replacement	Pacemaker	
Allergy to topical antibiotics	Blood thinners	Require antibiotics prior to surgery	

Are you pregnant or currently trying to become pregnant? Yes No

Consent to Treat

To our Patient: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test or treatment ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request Dr. Lambert to perform reasonable/necessary medical examination and testing/ treatment for the condition which has brought me to seek care at this practice. If necessary, this can include, but not limited to, minor procedures such as freezing or light cautery of skin lesions, skin biopsies, drawing blood for laboratory examination, and steroid injections into the skin or muscle for relief of various skin conditions. The potential risks and benefits of any treatment will be explained prior to administration. I understand that if additional testing, including invasive or interventional procedures are recommended (such as excisions, laser treatments, or chemical peels), I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I authorize South Tyler Dermatology to file claims and release medical information to any insurance company(s) I have listed in my financial record. I authorize South Tyler Dermatology to receive benefits directly from my company when an assigned claim is filed related to care I have received.

Pathology Charge: I understand that if I have a surgical procedure or biopsy done at South Tyler Dermatology, the slides may be interpreted by a Pathologist chosen by Dr. Lambert. Because Pathologists are also medical doctors, I will be billed separately for those services.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative_____

Relationship to Patient: _____ **Date** _____

Financial Policy

Thank you for selecting *South Tyler Dermatology* as your healthcare provider. Our personnel will be happy to discuss our fees and this policy with you at any time. Please read and sign this financial policy prior to seeing the physician. Payment for services is due at the time services are rendered. For any portion of your balance that is not covered by insurance, or for our private pay patients, we accept cash, check, VISA, MasterCard and Discover.

1. Your insurance policy is a contract between you, your employer and the insurance carrier. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurances, and "usual and customary charges."
   We are, however, contracted with most managed care plans. Please present your insurance card at the front desk so that we can file a claim on your behalf. We will follow their guidelines for submission of claims, co-pay amounts, and reimbursements. Any contractual provider discounts will be deducted from your balance.

2. Most insurance policies will only pay for laboratory services processed by specific labs. It is your responsibility to make our staff aware of specific labs designated by your insurance company.

3. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies and some employers decide what a covered benefit is and what is not. Please check your insurance plan document for any questions. Fees for these services along with unmet deductibles and co-payments are due at the time of treatment.

4. Returned checks and balances older than 90 days may be subject to collection placement and collection fees which will be charged to the responsible party. If we are forced to send your account to a collection agency, a 40% fee will be added to your balance.

5. There will be a $35 NSF charge on all returned checks.

6. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to our Office Manager, so that we can assist you in management of your account with a payment plan.

I give permission to *South Tyler Dermatology* to convert any paper check or check by phone to an electronic transaction.

Again, thank you for choosing *South Tyler Dermatology*. We appreciate the opportunity to serve you.

Patient Signature:_____ **Date:**_____

Parent/Guardian (if patient is a minor):_____

SOUTH TYLER DERMATOLOGY

NOTICE OF PRIVACY POLICIES - THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY.

Introduction

At South Tyler Dermatology, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect and how or when we use or disclose that information. It also describes your rights as they relate to your protected health information as defined by Federal Law.

Understanding Your Health Record/ Information

Each time you visit South Tyler Dermatology, a record of your visit is made. Typically, this record contains your symptoms, examination, and test results, diagnoses, treatment, and plan for future treatment. This information is often referred to as your health or medical record and serves as a:
-Basis for planning your care and treatment
-Means of communication among the many health professionals who contribute to your care
-Legal document describing care you received
-Means by which you or a third party payer can verify that services billed were actually provided
-A tool in educating health professionals
-A source of information for public health officials charged with improving the health of this state and the nation
-A source of data for our planning and marketing
-A tool with which we can access and continually work to improve the care we render and the outcomes we achieve.
Understanding what is in your record and how your health information is used helps you to: Ensure accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of South Tyler Dermatology, the information belongs to you. You have the right to:
-Obtain paper copies of the notice of policies upon request
-Inspect and copy your health record
-Amend your health record
-Obtain an accounting of disclosures of your health information
-Request communications of your health information by alternative means or alternative location
-Request a restriction on certain uses and disclosures of your information
-Revoke your authorization to use and disclose health information except to the extent that action has already taken place

Our Responsibilities

South Tyler Dermatology is required to:
-Maintain the privacy of your health information
-Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
-Abide by the terms of this notice
-Notify you if we are unable to agree to a requested restriction
-Accommodate reasonable requests you may have to communicate health information by alternative means and alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the mailing address we have on file. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer. If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, US Department of Health and Human Services. There will be no retaliation for filing a complaint with either office.

Acknowledgement of Notice of Privacy Practices and Disclosure of Protected Health Information

By signing the acknowledgement to the Notice of Privacy Practices and Disclosure of Protected Health Information, I further authorize South Tyler Dermatology to allow the following:

To leave a message on my answering machine or on my voice mail [ ] Yes [ ] No

To send me information via text message. [ ] Yes [ ] No

To send me information via e-mail. [ ] Yes [ ] No

To discuss my condition with the person(s) listed below. [ ] Yes [ ] No

Name: _____ Name: _____

Name: _____ Name: _____

By signing this page, agree to allow South Tyler Dermatology to disclose your health information with those you have indicated and above, and means in which we may leave information for you. Also, you acknowledge that you have received a copy of the "Notice of Privacy Practices"

_____	_____	_____
Signature of Patient or Representative	**Printed Name**	**Date**

Thank you for assisting in meeting our quality measures. Please answer the following questions as accurately as possible.

Name: _____ Date: _____

1. Have you *EVER* had a pneumonia vaccination? ❒ YES ❒ NO

   If yes when did you receive it? DATE: _____

The following question is gender and age specific

2. ***MALES (age 18-64)***

   How many times in the past year have you had 5 or more alcoholic drinks in a day?

   ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 or more

3. ***Females (age 18-64)***
   How many times in the past year have you had 4 or more drinks in a day?

   ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 or more

4. ***Patients age 65 and older***

   How many times in the past year have you had 4 or more drinks in a day?

   ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 or more