PATIENT REGISTRATION FORM

South Tyler Dermatology

DATE:_____

Patient's Legal Name: First Middle Last	Patient Date of Birth: Social Security Number:
Mailing Address (Street, City, State, Zip):	Patient Gender: O Male O Female Height: Weight: Marital Status:
Email Address:	Occupation:
Home Phone Number:	Employer:
Cell Phone Number:	Work Phone #:
Referred to Clinic by: Dr. _____ O Family/Friend O Internet search O TV O Other_____	Primary Care Physician:
EMERGENCY CONTACT Name: Phone Number: Relationship to patient:	Please list anyone you authorize to receive protected health information:

Responsible Party Information

Guarantor on Account:	Guarantor DOB:
Guarantor Mailing Address: Phone Number:	Relationship to Patient:

PATIENT REGISTRATION FORM

Insurance Information

Primary Insurance Company:	Policy/ID #:	Group Number:
Policyholder's Name:	Policyholder DOB:	Relationship to patient:
Secondary Insurance Company:	Policy/ID #:	Group Number:
Policyholder's Name:	Policyholder DOB:	Relationship to patient:

LEGAL INFORMATION

Assignment of Benefits: The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to South Tyler Dermatology/Lambert Dermatology Clinic. I understand that I am financially responsible for any balance. I also authorize South Tyler Dermatology to release medical information required to process claims.

Notice of Privacy Practices: I have read or been offered a copy of South Tyler Dermatology Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I authorize the release of my medical information necessary to provide care and bill on my behalf. I understand I am entitled to a copy of these practices. I authorize pictures of myself and of clinical focus areas to be stored in my medical record.

Consent for Communication: I understand South Tyler Dermatology will send appointment reminders via telephone, email and/or text message based on the contact information I have provided. I understand that I will have the option to opt out of future text/email reminders. I authorize South Tyler Dermatology to leave a message on my answering machine or voicemail.

Payment Policy: Payment is due at the time of service, including copays and balance due. I understand I am responsible for all charges for services rendered on my behalf, or on behalf of my dependents, less any amount paid by insurance to South Tyler Dermatology. I have read or been offered a copy of the South Tyler Dermatology Financial Policy.

SIGNATURE

Patient / Guardian Signature:

_____Date:_____

PATIENT REGISTRATION FORM

MEDICAL HISTORY AND INTAKE FORM

Patient Name:_____ Date of Birth:_____

Reason for Visit, location of problem, duration of problem:

_____

Past Medical History: (Check all that apply. If NONE, please check NONE)

O Allergies
O Asthma
O Bleeding Disorder (or bleeding issue)
O Cancer:_____
O Coronary Artery Bypass
O Depression
O Diabetes
O Fever Blister
O Heart Valve Replacement
O High Blood Pressure
O High Cholesterol
O HIV/AIDS
O Joint Replacement
O Kidney Transplant
O Liver Disease
O Rheumatoid Arthritis
O Lupus
O Mastectomy
O Organ Transplant
O Thyroid Disease
O Hepatitis (A, B, C)
O NONE

Do you have a history of Skin Cancer or Skin Disorder/Condition Yes_____ No_____
If yes please indicate condition or disorder:_____

Family History of Skin Cancer including Melanoma? Yes_____ No _____
If yes, whom:_____

Medications: (all current medications including non-prescription and birth control; if none mark NONE)

_____

Allergies: (Allergy to medications ONLY; if none mark NONE)

_____

Social History:

Do you smoke? Yes___ No___ If yes, how much? ____Do you drink alcohol? Yes___No___If yes, how much?____

Review of Systems: (Check all that apply)

O Problems with bleeding
O Problems with healing
O Problems with scarring/keloids
O Fever or Chills
O Abdominal Pain/Bloody stool
O Night sweats
O Unintentional weight loss
O Joint pain
O Headaches
O Bloody urine
O Cough/Shortness of breath
O Rash
O Muscle weakness/stiffness
O Depression/Anxiety
O Hair loss

Alerts: (Check all that apply. If NONE, please check NONE)

O Allergy to Adhesive
O Allergy to Lidocaine
O Allergy to topical antibiotics
O Artificial heart valve
O Require Antibiotics prior to surgical procedure
O Blood Thinners
O Defibrillator
O MRSA
O Pacemaker
O Allergy to Epinephrine
O Are you pregnant or trying to become Pregnant?
O Breastfeeding?

Preferred Pharmacy Name: _____Phone:_____

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

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):_____

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**

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.

To: All Patients

From: South Tyler Dermatology

Re: No Show Policy

South Tyler Dermatology is committed to helping you manage and maintain your dermatology needs. When you schedule an appointment with Dr. Lambert and/or Aestheticians, this is reserved exclusively for you. If you know that you will be unable to keep your appointment, we ask that you show consideration by calling our office at least 24 hours in advance to allow us time to offer this slot to another patient. This helps to reduce the wait time to schedule an appointment. Thank you for allowing us to serve you more effectively.

_____

Patient Signature