TEXAS DERMATOLOGY

Patient Information

Patient Name:	Birth Date:	Sex: M / F

Mailing Address: City/ State: Zip Code:

Primary Phone:	Secondary Phone:

Email Address: (please print clearly)

Authorized person to disclose health information to:	Phone Number:	Relationship to patient:

Responsible Party Information

○ ***Please check here if self-pay***

Insurance Policy Name and ID#

_____ # _____

Policy Holder Name:

Birth Date:	Gender: M / F	Relationship to patient: *Child / Spouse / Guardian / Other:*

Address: City/ State Zip Code

APPOINTMENT AUTHORIZATION

Should a parent or guardian not be able to accompany the patient to his/her appointment, please list all persons authorized to bring your child/children to their Dermatology appointment at our office. At your child's appointment, an update will be required; therefore, the person bringing your child will be responsible for providing a photo ID, information about any medical changes, current medications and concerns.

The person accompanying your child will have to be 18 years old or older in order to complete the medical update

Authorized Adults:

1. _____ **Relationship:** _____
2. _____ **Relationship:** _____

ASSIGNMENT OF BENEFITS

I authorize all insurance benefits be paid to the provider rendering services on behalf of Texas Dermatology and Laser Specialist, I understand for payment for professional services, including co-payments, deductibles and fees for cosmetic services, are due at time services are rendered.

I have read, understood and agreed to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Signature: _____ **Date:** _____

Print: _____ **Relationship to patient:** _____

HIPAA & Financial Policy

Patient Name: (Print) _____ DOB: _____

THIS DOCUMENT CONTAINS INFORMATION THAT REQUIRES YOUR CONSENT AND ACKNOWLEDGMENT. IF YOU WOULD LIKE A COPY OF THIS CONSENT TO TAKE WITH YOU, PLEASE REQUEST A COPY FROM THE FRONT DESK RECEPTIONIST.

HIPAA CONSENT:
I hereby permit Texas Dermatology and Laser Specialists to use my health information, and/or to disclose my health information to any third-party payor (health insurance company), or to any party involved in my health care. I understand that there is a **Notice of Privacy Practices** in the practice reception area available for me to read. This consent shall be in force and effect as long as I am a patient at this practice. I understand that I have the right to revoke this consent, in writing, at any time by sending such written notification to my physician(s) at this practice. I understand the information used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I also understand that I have the right to: Inspect or copy the protected health information to be used or disclosed as permitted under federal law; refuse to sign this consent form.

EMAIL CONSENT:
I understand that by providing my email address on my patient data sheet, I am subject to receiving email communication from Texas Dermatology and Laser Specialists but can request to be removed from the mailing list at any time.

PAYMENTS:
Patient responsibility is expected at the time services are rendered. This includes all deductibles, co-insurance, co-payments, and any non-covered services such as cosmetic procedures. It should be noted that any procedure performed in the office, such as freezing a wart or performing a biopsy on a mole is considered “office surgery” by most major insurance carriers and may be subject to your deductible.
To simplify your experience when receiving care and to make the payment process transparent and convenient we require patients to authorize the card on file via the pocket patient app, the patient portal during pre-visit check-in, or via the patient kiosk at time of in-office check-in. All information is fully encrypted and protected and will not be charged without your consent. Once your insurance company processes your claim, you will receive an email notifying you of any remaining balance from today’s visit. We will automatically deduct that balance from the card you provided five business days after receiving the e-Statement via text or email. If you do not wish to leave your card on file, you may pay for services in full at time of visit and request a copy of your claim form to submit to your insurance carrier for reimbursement. We do not accept cash or check payments.

NO SHOW/LATE POLICY:
If you are unable to attend an appointment, please let us know as soon as possible. We ask for at least 48 hours for the cancellation of all appointments. We reserve the right to charge the following “late cancellation fees” or “no show fees” of $50.00 for office visits, and 50% of quoted fees for procedures or surgeries. As a courtesy, we make every effort to confirm appointments in advance; however, it remains patient responsibility to know and to keep appointments. Emergencies will be considered on an individual basis. If you are more than 15 minutes late to your

scheduled appointment, we will make every effort to work you back into the providers' schedule. However, we may have no choice but to reschedule your appointment.

CLAIM DENIALS:
Texas Dermatology will bill patient insurance plans as a courtesy to our patients. It is patient responsibility to ensure information provided is true and accurate. You must confirm with your insurance company that our group is in-network with your policy prior to your scheduled appointment. To avoid claim denials, please submit all primary, secondary, and tertiary insurance information to us. If your claim is denied for any reason, you will be billed for services rendered based on a self-pay fee schedule.

PATHOLOGY/LABWORK:
Pathology readings and blood testing are ordered by our physicians to properly diagnose and treat certain skin disorders. Charges for these services are billed to your insurance by the pathologist or processing lab. Your skin sample or bloodwork may be sent to one of the following labs: Pathology Watch, Aurora Diagnostics: (South Texas Dermatopathology), Quest Diagnostics, Pathology Reference Lab, Sagis, or LabCorp. Our providers make every effort to send lab work to the corresponding lab authorized by your insurance company. However, if you have a specific lab you wish to use, please inform your provider in the exam room at the time of testing.

REQUESTS FOR MEDICAL RECORDS AND COMPLETION OF FORMS:
You may access most medical records through your online patient portal at no cost to you by visiting https://txdermandlaser.ema.md/ema/PatientLogin.action There will be a charge of $35.00 per paper request. Upon receipt of payment, documentation will be returned or can be picked up within 5-7 business days.

COSMETIC APPOINTMENTS
Cosmetic consultation appointments do not include time for treatment. Your provider will assess your skin and recommend a treatment plan based on your skincare goals during your consultation. Some patients are recommended to start a dermatologic treatment plan before beginning cosmetic treatments, so that the underlying skin condition can be treated first. There is no additional fee for the dermatologic treatment plan recommended by a dermatologist or physician assistant.
A late cancellation fee equal to 50% of cosmetic service(s) will be charged if an appointment is cancelled within 48 hours of the reserved appointment time. Late arrivals past 15 minutes are subject to be rescheduled or worked in on the same day if possible. Any missed appointments will be charged in full.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
We are required by law to provide you with a copy of our Notice of Privacy Practices. If you would like a copy of this policy, please ask the front desk receptionist. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice.

By signing this form, you have read and agree to these terms and conditions.

Patient/Guarantor Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Thank you for choosing Texas Dermatology for your healthcare needs.

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice.

_____
Signature of Patient (or Legal Representative)

_____
Date

_____	_____	_____
Signature of Staff Member	Title	**Date**

Comments:

TEXAS DERMATOLOGY

Weight:_____kg Room _____

Medical History & Information

Patient Name:_____ DOB: _____

Sex: ☐ M ☐ F Date: _____

Primary Care/ Referring Physician Name:_____Phone:_____

Pharmacy:_____Phone/Address: _____

Reason for visit:

1. _____ Duration:_____Location: _____
2. _____ Duration:_____Location: _____
3. _____ Duration:_____Location:_____

Do you need a gown? ☐ Yes ☐ No

ROS (Please check any present medical conditions pertaining to the patient)

	MRSA		Skin Problem(s)
	Unexplained weight loss/ fever/ chills		Headache, Seizure, or muscle weakness
	Vision Changes		Depression
	Problems w/ ears, nose, throat, and mouth		Heat/Cold Intolerance
	Chest pain		Easy bruising/ prolonged bleeding/ Anemia
	Shortness of breath/ Cough		Problems in School or Work? ☐ Yes ☐ No
	Nausea, Vomiting, Diarrhea, Abdominal Pain, bloody or black stool		Additional Concerns:
	Bloody Urine		
	Joint or Bone pain		

Past Medical History (Please check any past/present medical conditions pertaining to the patient)

	Anxiety		Depression		Leukemia
	Arthritis		Diabetes		Lymphoma
	Asthma		End Stage Renal Disease		Prostate Cancer
	Atrial Fibrillation		GERD		Radiation Treatment
	Bone Marrow Transplant		Hearing Loss		Seizures
	Benign Prostatic Hyperplasia		Hepatitis		Stroke
	Breast Cancer		Hypertension		Lung Cancer
	Colon Cancer		HIV/AIDS		Other:
	COPD		Hypercholesterolemia		
	Coronary Artery Disease		Hyperthyroidism		
	COVID-19		Hypothyroidism		None

Past Surgical History (Please list any past/present medical conditions pertaining to the patient) ☐ None

1. _____Date: _____
2. _____Date: _____

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Skin Disease History

	Acne		Flaking/Itchy Scalp		Psoriasis
	Actinic Keratoses		Hay Fever/ Allergies		Other:
	Blistering Sunburns		Melanoma		
	Dry Skin		Poison Ivy		
	Eczema		Precancerous Moles		

Do you have a **history of Skin Cancer**? ☐ Yes ☐ No If Yes, what type? _____
Date Diagnosed_____Treating Physician:_____Phone: _____

Current Medications and Dosage (Please list **Current** Medications). Use back of sheet if more space is needed.

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

Do you have any **Drug Allergies**? ☐ Yes ☐ No
If yes, please list name of medication and reaction: _____

Social History
Do you use/previously use **Nicotine products**? ☐ Yes ☐ No Type/Frequency: _____

Family History (Immediate Family Medical History)
Condition(s):_____Relation:_____
Condition(s):_____Relation: _____

Have you received the **Flu Shot** this season? ☐ Yes ☐ No
Have you received the **Pneumococcal** vaccine? (65 years +) ☐ Yes ☐ No
Have you received the **COVID-19** vaccine? ☐ Yes ☐ No If Yes, have you received the **booster**? ☐ Yes ☐ No

Female Patients: Are you pregnant or trying to get pregnant? ☐ Yes ☐ No

Do you have an **Advanced Care Plan**? ☐ Yes ☐ No
Health Care Proxy Name:_____Relationship to patient: _____

Is it okay to leave a detailed message on the contact number provided? ☐ Yes ☐ No
With whom can we leave message with? Name_____Phone number _____

Are you interested in cosmetic procedures/establishing a skin care regiment? ☐ Yes ☐ No

Are you interested in eliminating underarm sweat? ☐ Yes ☐ No

Do you suffer from urinary incontinence? ☐ Yes ☐ No

I hereby state that the information listed above is accurate and complete to the best of my knowledge. By my signature below, I have read the financial policy of Texas Dermatology, including services rendered,including co-pays, deductibles, and Cosmetic services.

Signature of Patient/ Guarantor:_____Date: _____

Printed Name of Patient/ Guarantor:_____Date: _____

TEXAS DERMATOLOGY

Allergy Wellness

Name: _____ **Date of Birth:** ____/____/____ **Date:** ____/____/____

Do you experience any of these symptoms?	Yes	No
Runny Nose		
Itchy Nose		
Stuffy Nose		
Itchy Eyes		
Watery Eyes		
Frequent Sneezing		
Itchy Mouth/Lips/Throat		
Post Nasal Drip (drainage down the back of the throat, clearing throat)		

How often do you experience these symptoms?

- ☐ Occasionally (2-3 times per year)
- ☐ Over 3 times a year
- ☐ A few long periods of time per year (Spring, Summer, Fall, Winter)
- ☐ Most of the year

Do you take prescription or over-the-counter (OTC) medications for the management of your allergy symptoms? ☐ Yes ☐ No

Please indicate below symptoms/conditions you've experienced during the last 1- 2 years

- ☐ Sinus related issues (sinus pressure/pain, headaches, sinusitis)
- ☐ Re-occurring Seasonal Colds
- ☐ Chronic colds (lasting longer than 2 months)
- ☐ Migraine Headaches
- ☐ Restless sleep, challenges sleeping through the night, snoring
- ☐ Consistent or Re-occurring coughing
- ☐ Feeling of fatigue, irritability, & restlessness
- ☐ Asthma
- ☐ Skin conditions (dry and/or itchy skin, etc.)

Are you interested in Allergy Testing? ☐ Yes ☐ No

Patient/Guardian Signature: _____ Date: ____/____/____

We are excited to offer you simple and secure 24/7 access to your personal health information through our EMA Patient Portal.

Get 24/7 access from any computer, smartphone or tablet! Why call when you can click?

- Communicate with your physician
- Request a medication refill
- Review your lab results
- Obtain information about your diagnoses and treatments
- Update your medical history, demographics and much more

Your health, in your hands. Get started… It's as easy at 1, 2, 3!

1. Check your email for the portal invitation and click the link. If you did not receive this email, please check your spam folder, or email us at **scheduling@texasdls.com**. ***Please note that the email invitation link will expire after 72 hours.***
2. Verify your identity and create a password.
3. To log into the patient portal once you have activated it, simply click the patient portal link from our website www.texasdls.com.

Questions or feedback? Email us!

- **scheduling@texasdls.com** for scheduling questions or to request a patient portal invite.
- **ma@texasdls.com** for medical questions or refill requests, please allow 24 hours.
- **billing@texasdls.com** for billing questions.
- For questions regarding insurance coverage, please contact your insurance provider.
- **Pay your bill online @ Texasdls.com**

Pathology (if applicable): *Charges for these services are in* ***addition*** *to your regular physician charges. Pathology charges may come directly from the following labs: Aurora Diagnostics (South Texas Dermatopathology), Quest Diagnostics, and Pathology Reference Lab. Please note that if any of these services are denied as out of network, not covered by the terms of your insurance policy, not medically necessary, as requiring a deductible or co-payment, or other related issues, the patient or responsible party will be billed.*

Texas Dermatology
San Antonio, Texas
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