DERMATOLOGY ASSOCIATES OF DENISON Patient Demographics Form

E-mail address (Optional)_____

Patient Name _____**DOB**_____**Age**_____**SSN**_____

Mailing Address_____**City/State**_____**Zip**_____

Home Phone_____**Cell Phone**_____ **M / F Married Single Divorced Widowed**

Employer_____**Occupation**_____**Address**_____**Phone**_____

Spouse Name (if applicable) _____**Employer**_____**Occupation**_____

Nearest Relative/Friend (not living with you) _____**Phone**_____

Responsible Party Self OR Other (If other please state relationship)_____

PRIMARY INSURANCE_____**Claims Address**_____

Insurance Phone_____ **Policy/Identification #**_____**Group #**_____

Policy Holder_____**Relationship**_____**DOB**_____**SSN**_____

SECONDARY INSURANCE_____**Address**_____

Insurance Phone_____**Policy/Identification #**_____**Group #**_____

PolicyHolder_____**Relationship**_____**DOB**_____**SSN**_____

PCP/Family Physician_____**City/State**_____**Phone**_____

How were you referred to us?_____**City/State**_____**Phone**_____

Pharmacy_____**City/State**_____**Phone**_____

Patient Consent for Use and Disclosure of Protected Health Information

☐ **I give permission** / ☐ **I do not give permission for** DAOD to leave messages regarding my medical care, which may include lab and pathology results on my: ☐ Home Answering Machine ☐ Cell Phone ☐ Work Voicemail ☐ Other: _____

With this consent, DAOD may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment options, such as appointments, reminder calls or cards and billings statements. By signing this form, I am consenting to allow DADO to use and disclose my Private Health Information to carry out treatment options. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, DAOD may decline to provide me treatment.

The patient/responsible person hereby acknowledges and agrees that DAOD and any affiliates or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any telephonic number I have provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify DAOD if I have given up ownership or control of any such telephone number.

HIPAA CONSENT

The patient understands that:

1. Protected health information may be disclosed or used for treatment, payment, or health care operations.
2. The practice has a Notice of Privacy Practices and that the patient has the right to ask for this notice.
3. The practice reserves the right to change the Notice of Privacy Practices at any time.
4. The patient has the right to restrict the uses of their information, but the practice does not have to agree to those restrictions.
5. The patient may revoke this consent in writing at any time and all future disclosure will cease.
6. The practice may condition receipt of treatment upon execution of this consent.
7. Please indicate any person/s to whom you would like information released to

(INFORMATION WILL NOT BE RELEASED TO ANY PERSON NOT LISTED ON YOUR HIPAA CONSENT. NO EXCEPTIONS)

Name/Relationship/Phone Number_____

Name/Relationship/Phone Number_____

Name/Relationship/Phone Number_____

Name/Relationship/Phone Number_____

This consent was signed by:

_____ _____

Printed name of patient/Legal Representative **Relationship (if other than patient)**

_____ _____

Signature **Date**

IMPORTANT NOTICE REGARDING PRESCRIPTIONS

If your prescription requires a prior authorization, it could take up to 72 hours for our office to ***start*** the process for prior authorization once we have received this request from your pharmacy.

Once the authorization is submitted from us to your insurance **it can take up to 30 days for your insurance to approve or deny the medication.** Unfortunately, we have no control over how long it takes for the insurance to respond.

Our office does try to provide patients with samples, when available, to help until the request has been approved or denied.

Once an answer is received from your insurance company, we will contact your pharmacy with their decision.

Please sign below to acknowledge that you have been advised of this process.

_____ _____

Patient/Guardian Signature Date

DERMATOLOGY ASSOCIATES OF DENISON
SUMMARY OF STANDARD OFFICE POLICIES

Thank you for choosing Dermatology Associates of Denison for your dermatology needs. We respect your decision to choose your healthcare provider and want you to have a satisfying experience in our office. We have developed the following office policies in an effort to provide you, our patient, with outstanding service. As a part of our professional relationship, it is important that you understand and adhere to the office policies set forth below.

INSURANCE

We cannot file your insurance unless all of your insurance information is given at the time of your visit. It is imperative that a current copy of your insurance card is provided for accurate billing. If your insurance company has not paid within 90 days, you may receive notification in the mail requesting assistance by you in determining if there is a problem, or if additional information is required in processing the claim. Insurance benefits will be obtained by our verification clerk. All patients will be responsible for their portion due at the time of service. Example: If your insurance pays at 80%, you must pay 20% at the time of service. Co-pays and deductibles are required at the time of service with no exceptions. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Our office accepts cash, check, Visa, MasterCard, American Express, Discover, PayPal, and Care Credit for your convenience.

*It is extremely important for you to educate yourself about your individual insurance benefits. Your insurance is a contract between you, your insurance company, and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company. We cannot guarantee payment of your claims by your insurance company. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. If you are scheduled for a procedure that could be considered a surgery, like a biopsy, cryotherapy, excision, etc., you could be responsible for these charges. To protect yourself, contact your insurance company prior to any procedure to be certain of your benefits and coverage.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

I hereby assign all medical and/or surgical benefits to include Medicare, private insurance and any other health plans to: **DERMATOLOGY ASSOCIATES OF DENISON**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all services not paid for by my insurance company; including co- payments, deductible amounts, or services that are not a covered benefit by my plan. I hereby authorize said assignee to release all information necessary to secure the payment. I authorize **DERMATOLOGY ASSOCIATES OF DENISON** to release any information acquired in the course of my exam or treatment to my insurance company, primary care physician, pediatrician or another physician. I recognize that I am responsible for all charges incurred whether or not paid by my insurance company. I also recognize and agree that I will pay any amount not paid by my insurance company within 30 days. In the event I fail to comply with this financial policy, I understand that my account will be turned over to a collection agency which charges a collection fee, accrual of interest and credit reporting. I UNDERSTAND and agree that (REGARDLESS OF MY INSURANCE STATUS), I am ultimately responsible for the balance on my account for any professional services rendered. I will notify you of any changes in my health status or health insurance. If I am a member of an HMO or PPO group and the insurance company has not paid the claim within 90 days of the visit, I understand I am responsible for the balance due. A photostatic copy hereof is as valid as the original.

NON-COVERED SERVICES

All cosmetic services are not covered by insurance and these services must be paid in full at the time of the visit. Any service that is denied by your insurance carrier due to benefit descriptions or limitations, policy exclusions, or pre-existing waiting periods will be the responsibility of the patient. Skincare products sold in office are also not covered by insurance.

LABS

If you are aware that your insurance carrier requires you to utilize certain labs for blood work or biopsies, it is your responsibility to inform our office prior to the lab being performed. Our office sends your insurance card information with the specimen to an outside facility for processing. Lab charges are separate charges from our office visit and/or procedure charges. Depending on your benefits, you may be billed separately for any lab charges incurred. Any bills received by you from lab companies will need to be discussed with the lab company directly should you have any questions. We do not do billing for the labs and do not have any access to their records or statements.

REFERRALS

If your insurance company requires a referral from your primary care physician in order to see a specialist, it is your responsibility to make sure that it has been received by our office before your scheduled appointment. If we do not have a current referral on file before your appointment you will be responsible for the total estimated charges incurred on the day of your appointment. Our office makes every effort when verifying benefits to notify PCP's and/or patients if an updated referral is needed but it is ultimately the patient's responsibility to ensure that a required referral is on file with us before their appointment.

INSURANCE AND DEMOGRAPHIC CHANGES

You are required to notify our office if your insurance terminates or changes. You will be held financially responsible for any charges incurred if you are without insurance coverage or if we are not able to file your claim in a timely manner. Please also notify us of any address or phone number changes. Our ability to contact you is vital to our ability to provide you care. We require patients to update new patient paperwork and rescan insurance cards and photo ID every 3 years even if your demographics or insurance hasn't changed due to the fact that we need to make sure that we have the most up to date and accurate information on file, especially medical history, and if there are any changes to our office policies, the patient has been made aware.

MEDICAL PAPERWORK

Disability, cancer policy forms, or other paperwork requiring physician review and completion is subject to a $15.00 fee per form. Payment must be made prior to forms being completed. In most cases, cancer policies will accept a printout of charges and services rendered by our office in lieu of form completion. There is no charge for FMLA paperwork. Please allow up to 1 week for paperwork to be completed.

APPOINTMENTS

We understand your time is valuable and we do our best at keeping the schedule running smoothly and on-time. As a courtesy to our providers and other patients, we ask that you arrive on time to your appointment. Any patient who is more than 15 minutes late to their appointment will be considered a no-show and you will need to reschedule your appointment. If you know that you may possibly be late to your appointment, please call the office as soon as possible so that we may try to work with you so you can still be seen. Our office provides an automated courtesy call and text reminder for appointments 2 business days in advance. This is a courtesy only; it is still your responsibility to keep up with your appointments. Not getting a reminder call/text is not a valid reason for no-showing an appointment. If you need to cancel or reschedule an appointment, we ask that you give us 24 hours' notice. Any patient who provides less than 24 hours' notice (same day cancels or no shows) 3 times or more will be required to pay a $50.00 No-Show Deposit. This fee is not covered by insurance and will need to be paid before any subsequent appointments are made.

RETURNED CHECKS

In the event that you submit a payment by check that is returned by the bank for any reason, we will add a $35.00 NSF fee to the original balance due. In addition, we may seek all legal remedies provided to us under Texas law. If you have a returned check, we will no longer be able to accept checks from you for payment of services.

MEDICAL RECORDS

All medical records must be requested in writing. We are able to provide a copy of your medical records to another physician as a professional courtesy with a completed medical records request on file from the requesting physician along with your signature. If you are needing to obtain medical records for yourself there is a charge of $25.00 for the first 20 pages and $0.50 per page thereafter. We can also provide records on a disc or email them in a secure file for a flat fee of $25.00. The fee must be paid before medical records are provided. Please allow up to 1 week for records to be completed.

MINORS

We assign all financial responsibility to the parent/legal guardian that completes and signs the new patient paperwork. Any amount due at the time of service is expected from the parent/legal guardian accompanying the minor to the visit. In the event that a divorce decree assigns distinct financial responsibility for medical bills to another individual, we still hold the registering parent/legal guardian responsible. We will provide you with receipts showing payment to assist you in the recovery of such payment, however we do not get involved in separation/divorce disputes.

Minors who are established patients will not be seen in the office without a parent/legal guardian present unless a signed minor consent form is on file with our office before the appointment. However, the parent/legal guardian takes full responsibility for any decisions the minor makes without the parent/legal guardian present. Payments will still be due at the time of service regardless if the parent/legal guardian is not present in the office.

If a minor is being accompanied to an appointment by a legal guardian, we may need to obtain a copy of guardianship paperwork for our records. If we do not have this info on file, we may have to cancel/reschedule the appointment until it is received.

ESTIMATES/QUOTES

Any estimates/quotes given for surgical procedures are simply estimates only and nothing more and are based on the information your insurance company provides at the time, which may or may not be accurate. Regardless of the accuracy of said estimates/quotes you are ultimately responsible for any amount not paid by your insurance company once the claim has been submitted for confirmation.

REFUNDS

Should your insurance company process your claim differently than quoted or expected and you have a credit with us, we will be happy to issue you a refund once all outstanding claims for our office have been processed if you request a refund. This policy is designed to reduce the administrative work associated with refunding money and subsequently billing for new balances. Credits can be used for future visits with the same provider as well. In most cases we cannot transfer credits between providers or other patients in the same household unfortunately.

NON-DISCRIMINATION POLICY

Dermatology Associates of Denison prides itself on being a welcoming and safe office for anyone seeking medical care. We comply with all federal laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We also do not exclude people or treat them differently because of race, color, national origin, age, disability, gender identity, or sex. While in our office, we expect all patients and visitors to treat our staff, other patients, and any visitors to our office with mutual respect and courtesy. We will not tolerate any racist, homophobic/transphobic, sexist, or otherwise abusive language or behavior while you are our patient. We reserve the right to terminate our professional relationship should this policy be violated.

PATIENTS COVERED BY A TEXAS MEDICAID HEALTH PLAN

Texas Medicaid will only pay for one (1) in office physician visit per day.

By signing this acknowledgement, you agree that you:

- Have not had another office visit with another physician on the same day
- Will not be seeing another physician in office on same day
- Understand that in the event that you incur more than one physician office visit per day and Dermatology Associates of Denison is denied payment from your Medicaid payer, that you (Patient or Responsible Party) are fully responsible for the cost of the denied visit.

Patient or Responsible Party Signature: _____ Date: _____

I HAVE READ THE ABOVE INFORMATION AND AGREE TO ABIDE BY THE POLICIES SET FORTH BY DERMATOLOGY ASSOCIATES OF DENISON.

Signature: _____ Date: _____

MEDICARE PATIENTS ONLY

DERMATOLOGY ASSOCIATES OF DENISON

2022 Quality Reporting for Medicare/Railroad Medicare Patients

Patient Name:	Date of Birth:	Date of Service:

(Measure 47)
Do you have an Advanced Care Plan (Living Will)? ☐ YES ☐ NO *(1123F/8P)*

IF YES: Please name your Surrogate Decision Maker? _____ *(1123F)*

☐ Please check this box if you are unable to or choose not to name your Surrogate Decision Maker. *(1124F)*

(*Measure 110)*
Have you received an Influenza Immunization this year (*October 2021-March 2022*)?
☐ YES *(G8482)* ☐ NO *(G8484)*

(Measure 111)
Have you EVER (in your entire life) received a Pneumococcal Vaccination?
☐ YES *(4040F)* ☐ NO *(4040F/8P)*

(Measure 128)
Please list your HEIGHT: _____ AND WEIGHT: _____
For Internal Use Only:
BMI Score: _____ ___*Normal (G8420)* ___*Abnormal (G8419)* ___*Not Calculated (G8421)*

(Measure 130)
Have you provided our office with a list of current medications? ☐ YES *(G8427)* ☐ NO *(G8428)*

(Measure 226)
Do you use Tobacco products?
(4004F)☐ YES *(PLEASE NOTIFY THE PROVIDER IF YOU WOULD LIKE INFORMATION OR COUNSELING ON STOPPING THE USE OF TOBACCO PRODUCTS)*
(1036F)☐ NO

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DERMATOLOGY ASSOCIATES OF DENISON
MEDICAL HISTORY FORM

Patient: _____ **Date:** _____ **Age:** _____ **Height:** _____ **Weight:** _____

Reason for today's visit: _____

LIST CURRENT MEDICATIONS (Include prescriptions, over the counter, vitamins, herbs, and supplements)			

Allergies: _____

Do you take aspirin or blood thinner?	**Do you smoke?**	**Do you drink alcohol?**

Family History (Please circle all that apply)
Skin Cancer: Basal cell carcinoma / Squamous cell carcinoma / Melanoma / Other: _____
Psoriasis / Asthma / Eczema / Other: _____

Past Medical History (Please circle all that apply to YOU personally)	Lupus / Rheumatoid Arthritis / Other
Multiple Sclerosis / Fibromyalgia / Chronic Fatigue	Artificial Joint Replacement
Eczema / Psoriasis	Herpes / Cold Sores / Keloids / Hives
Ear / Nose / Throat / or Mouth Disease	Organ Transplantation
Stroke / TIA's / Seizures / Headaches	Menstrual Irregularities
Diabetes / Thyroid Disease	Pregnant? Yes No Due Date:
Heart Disease / Heart Attack	Depression / Bipolar / Anxiety / Other_____
Mitral Valve Prolapse / Heart Murmur	Cancer: Type_____
Pacemaker / Defibrillator	Radiation Therapy / Chemotherapy
Heart Valve Replacement	Bleeding Disorder / Anemia
Asthma / Tuberculosis	Hepatitis / AIDS / HIV Positive
Allergies / Hay Fever	High Blood Pressure

Any other diseases or conditions not listed above:_____

Have you been told to take oral antibiotics before dental or other procedures? Yes No **Do you use sunscreen?** Yes No

Past Surgical History:			

Skin Cancer History: (Please circle all that apply): Basal cell carcinoma / Squamous cell carcinoma / Melanoma / Other: _____

Location on Body and Date Treated:_____