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Thank you for choosing U.S. Dermatology Partners! We appreciate the opportunity to care for your health.

REQUIRED ITEMS NEEDED FOR YOUR APPOINTMENT

- ✓ Completed New Patient Packet (see below)
- ✓ Valid Government Issued Photo ID
- ✓ Insurance Card(s)
- ✓ Form of Payment
- ✓ Written Insurance Referral provided by your PCP (if applicable)

NEW PATIENT PACKET includes the following forms:

- ☐ New Patient Registration Form
- ☐ Acknowledgement of Office Policies
- ☐ Patient Consents
- ☐ Financial Policies
- ☐ PHI Communication Preferences
- ☐ Notice of Privacy Practices
- ☐ Medical History

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# NEW PATIENT REGISTRATION

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Print Legal Name: | | DOB: | |
| Patient Nickname: | | | |
| Address: | | | |
| Home Phone: | (  ) | Cell Phone: | (  ) |
| Email: | | | |
| PCP Name: | | PCP Phone Number: | (  ) |
| How did you hear about our office? | | | |

## COMMUNICATION PREFERENCES

Preferred communication method for appointment reminders, patient surveys, office notifications, etc.

| | | |
|---|---|---|
| Email | Yes | No |
| Phone Call | Yes | No |
| SMS (Text) Message | Yes | No |
| Voice Reminders | Yes | No |

## SPOUSE, PARENT, LEGAL GUARDIAN, EMERGENCY CONTACT INFORMATION

| | | | |
|---|---|---|---|
| Printed Name: | | Relationship: | |
| Address: | | | |
| Home Phone: | (  ) | Cell Phone: | (  ) |

## PRIMARY INSURANCE

| | | | | |
|---|---|---|---|---|
| Insured's Full Name: | | | Insurance Company: | |
| Insured's DOB: | | Sex: M / F | Member No: | |
| Relationship to Patient: | | | Group No: | |
| Insured's Address: | | | | |

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# NEW PATIENT REGISTRATION

**SECONDARY INSURANCE**

| | | | | |
|---|---|---|---|---|
| Insured's Full Name: | | | Insurance Company: | |
| Insured's DOB: | | Sex: M / F | Member No: | |
| Relationship to Patient: | | | Group No: | |
| Insured's Address: | | | | |

**RESPONSIBLE FINANCIAL PARTY** (fill out if other than self)

| | | | |
|---|---|---|---|
| Printed Name: | | Relationship: | |
| Address: | | | |
| Home Phone: | (  ) | Cell Phone: | (  ) |

By signing below, I certify that the information above is true and correct to the best of my knowledge.

| | |
|---|---|
| Patient Printed Name: | |
| Patient DOB: | |
| Parent/Legal Guardian Printed Name: | |
| Relationship to Patient: | |
| Signature: | |
| Date: | |

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# ACKNOWLEDGEMENT OF OFFICE POLICIES

**Notice of Privacy Practices**
I have read a copy of the Notice of Privacy Practices which explains how my medical information will be used and disclosed. I authorize the release of any medical information necessary to evaluate and/or treat my condition. I further authorize the release of any medical information necessary to process insurance claims on my behalf. I understand that I am entitled to receive a copy of the Notice of Privacy Practices.

**Cancellation Policy for Medical Appointments**
It is my responsibility to call the office to cancel at least 24 hours prior to the scheduled appointment. *U.S. Dermatology Partners* reserves the right to charge a fee if the appointment is not cancelled at least 24 hours in advance. Additionally, the office reserves the right to reschedule appointments for which I am more than 15 minutes late.

**Cancellation Policy for Cosmetic Appointments**
Some types of cosmetic procedures or surgeries require a down payment to reserve the procedure date. *U.S. Dermatology Partners* reserves the right to charge a fee if the appointment is not cancelled at least 72 hours in advance.

**Cosmetic Retail Sales**
All retail sales are final. Due to the nature of the cosmetic products, no exchanges/refunds are allowed.

**Payment Policies**
Payment is due at the time of service. This amount includes any co-pay as well as the insurance deductible or co-insurance. I understand that I am financially responsible for all charges for services rendered on my behalf or on behalf of my dependent, whether or not they are covered by my insurance.

**Appointment Reminders**
I understand that I will receive appointment reminders and information on services via telephone, email and/or text message based on the contact information I have provided. I further understand that I will have the option to opt out of future reminders.

By signing below, I certify that I have read the above information and have had any questions answered. My signature also certifies my understanding and agreement with the above information.

| | |
|---|---|
| Patient Printed Name: | |
| Patient DOB: | |
| Parent/Legal Guardian Printed Name: | |
| Relationship to Patient: | |
| Signature: | |
| Date: | |

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# PATIENT CONSENTS

**Consent for Treatment**

I authorize *U.S. Dermatology Partners* to provide any healthcare services that my provider deems necessary for diagnosis and/or treatment. If a biopsy is performed, I authorize the dermatopathologist to send my specimen for a second opinion and/or obtain special tests, if medically necessary to ensure an accurate diagnosis. I understand that additional costs may result and that I will be responsible for any remaining balance that is not covered by my insurance company, Medicare and/or supplemental policy.

**Consent for Filing Insurance Claims**

I understand that in order to file claims and release medical information to any insurance companies I have listed in my financial record, *U.S. Dermatology Partners* is required to keep my signature on file. I hereby authorize *U.S. Dermatology Partners* to receive benefits directly from my insurance company when an assigned claim is filed. I also authorize *U.S. Dermatology Partners* to appeal any denials to my insurance companies on my behalf and authorize the release of any medical information to my insurance companies that is necessary for the processing of claims.

**Consent for Electronic Prescription History**

I understand that in order to offer the best patient care, *U.S. Dermatology Partners* will retrieve my prescription history that has been ordered and filled through Surescripts. I authorize *U.S. Dermatology Partners* to import the prescription history obtained through Surescripts into my electronic chart.

**Consent for Photos**

I understand that in the course of treatment photographs may be taken for clinical and educational purposes. No audio taping, videotaping, or photography is allowed by non-staff members.

By signing below, I certify that I have read the above information and have had any questions answered. My signature also certifies my understanding and agreement with the above information.

| | |
|---|---|
| Patient Printed Name: | |
| Patient DOB: | |
| Parent/Legal Guardian Printed Name: | |
| Relationship to Patient: | |
| Signature: | |
| Date: | |

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# FINANCIAL POLICIES

**Payment is required at the time services are rendered.** We are allowed by contract with your insurance company to collect your co-payment(s) and/or co-insurance and any unmet deductible at the time of service. For patients with private insurance where we have no contract, you will be required to pay for your services in full at the time of service.

- I understand I will be responsible for any remaining balance not covered by my insurance company, Medicare and/or my supplemental policy. This also includes the full amount of any cosmetic services. Please contact your insurance company to verify benefits and coverage information.
- I understand that if I have a surgical procedure or biopsy performed, there are two charges: (1) a charge by the provider for collecting the Biopsy; and (2) a charge to examine the specimen by a Pathologist (who is chosen by my Rendering Provider). I understand that I will be billed separately by the Pathologist (also a medical doctor) who performs the reading.
- I understand that my insurance company may have a preferred laboratory for blood work. It is my responsibility to know which preferred laboratory I need to use. It is also my responsibility to inform my provider of this at the time services are rendered.
- I understand that a $25 returned check fee will be assessed to my account for any checks returned by my financial institution.

By signing below, I certify that I have read the above information and have had any questions answered. My signature also certifies my understanding and agreement with the above information.

| | |
|---|---|
| Patient Printed Name: | |
| Patient DOB: | |
| Parent/Legal Guardian Printed Name: | |
| Relationship to Patient: | |
| Signature: | |
| Date: | |

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# PHI COMMUNICATION PREFERENCES

I authorize *U.S. Dermatology Partners* to disclose any and all details of my medical diagnoses, treatment, and billing/claims information to the individuals listed below. This authorization is voluntary and I understand that I have the right to revoke this authorization by submitting a written request to the office. I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is released. I understand that the below list may not be exhaustive and that my protected health information (PHI) may be disclosed to additional individuals based on my written authorization or as indicated in our Notice of Privacy Practices. This authorization shall remain in effect indefinitely unless revoked in writing by me.

| **I elect not to authorize disclosure to any individuals at this time** | | | Check all that apply | |
|---|---|---|---|---|
| **First and Last Name:** | **Relationship:** | **Telephone Number** | **Medical** | **Billing** |
| | | (  ) | | |
| | | (  ) | | |
| | | (  ) | | |
| | | (  ) | | |
| | | (  ) | | |

| **Communication for benign (non-cancerous) test results** | **Telephone Number** |
|---|---|
| I hereby allow all benign (non-cancerous) test results to be put in a voice message on the phone number indicated in the box. | (  ) |

By signing below, I certify that I have read the above information and have had any questions answered. My signature also certifies my understanding and agreement with the above information.

| | |
|---|---|
| Patient Printed Name: | |
| Patient DOB: | |
| Parent/Legal Guardian Printed Name: | |
| Relationship to Patient: | |
| Signature: | |
| Date: | |

# NOTICE OF PRIVACY PRACTICES

**As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

**A. OUR COMMITMENT TO YOUR PRIVACY**

Our practice is dedicated to maintaining the privacy of your individually identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your protected health information (PHI). By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights regarding your PHI
- Our obligations concerning the use and disclosure of your PHI

**The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.**

**B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:** U.S. Dermatology Partners
Compliance/Privacy Officer or Surgery Center Administrator
5310 Harvest Hill Rd, Ste. 290, Dallas, TX 75230
compliance@usdermpartners.com

**C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:**

**1. Treatment**. Our practice may use your PHI to treat you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment.

**2. Payment**. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us.

**3. Health Care Operations**. Our practice, and its affiliated entities and management company, may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct costmanagement and business planning activities for our practice.

**4. Appointment Reminders**. Our practice may use and disclose your PHI to contact you and remind you of an appointment. We will notify you about your appointment utilizing an automated phone system, a personal call, text or by mail. This notification may involve leaving a message on an answering machine or other automated or electronic equipment for such purposes, which could (potentially) be received or intercepted by others.

**5. Sign In Sheet**. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

**6. Treatment Options**. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

**7. Health-Related Benefits and Services**. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

**8. Release of Information to Family/Friends**. Our practice will routinely disclose to your responsible party(ies) the PHI directly relevant to his/her involvement with your health care, PHI related to payment of your health care, and PHI used for notification purposes. Our practice may release your PHI to another responsible party(ies) you identify, that is involved in your care.

**9. Marketing.** We may contact you to give you information about products or services related to your treatment, or care. We will not otherwise use or disclose your medical information for marketing purposes, without your prior written authorization.

**10. Sale of Health Information.** We will not sell your health information without your prior written authorization.

**11. Disclosures Required By Law**. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

**12. Breach Notification.** In the case of a breach of unsecured protected health information, we will notify you as required by law.

**D. USE AND DISCLOSURE OF PHI IN SPECIAL CIRCUMSTANCES**

The following categories describe unique scenarios in which we may use or disclose your protected health information:

**1. Public Health Risk Reporting**. Our practice may disclose your PHI to public health authorities that are authorized by law. For example, we are required to report certain communicable diseases to the state's public health department.

**2. Law Enforcement.** Your health information may be disclosed to law enforcement agencies, military, and national security without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

**3. Workers' Compensation**. Our practice may release your PHI for workers' compensation and similar programs that provide benefits for work-related injuries or illnesses.

**E. YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding the PHI that we maintain about you. These include:

- The right to request restrictions on the use and disclosure of your protected health information, including to request that a health plan not be informed of treatment for which patient paid entirely out of pocket.
- The right to prohibit the sale of your protected health information, its use for marketing purposes, or participation in research.
- The right to request to receive confidential communications concerning your medical condition and treatment in a specific manner.
- The right to inspect and obtain copies of your protected health information.
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed outside of our practice if not for treatment, payment, or health care operations.
- The right to file a complaint if you believe your privacy rights have been violated. Please file your complaint in writing. You will not be penalized for filing a complaint.
- The right to receive a printed copy of this notice.

All requests must be in writing and directed to U.S. Dermatology Partners, Compliance/Privacy Officer at 5310 Harvest Hill Rd, Ste. 290, Dallas, TX 75230. Our practice may charge a fee for the costs associated with any request.

**F. RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES**.

Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

If you believe your privacy rights have been violated, you may complain to the secretary of the U.S. Department of Health and Human Services or to the Compliance/Privacy Officer listed below. There will not be retaliation against you for filing a complaint. Again, if you have any questions regarding this notice or our health information privacy policies, please contact:

**U.S. Dermatology Partners**
**Compliance/Privacy Officer**
**5310 Harvest Hill Rd, Suite 290, Dallas, TX 75230**
**compliance@usdermpartners.com**

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# PATIENT MEDICAL HISTORY

| | | | |
|---|---|---|---|
| **Patient Name:** | | **Patient DOB:** | |
| **Pharmacy Name:** | | **Pharmacy Location:** | |
| **PCP Name:** | | **PCP Phone:** | ( ) |

**PATIENT MEDICAL HISTORY:** (Please **check** any of the following conditions that you have had or currently have.)

| | | | |
|---|---|---|---|
| ☐ None | ☐ Colon Cancer | ☐ Hepatitis | ☐ Lupus |
| ☐ Anxiety | ☐ COPD | ☐ Hypertension | ☐ Lymphoma |
| ☐ Arthritis | ☐ Coronary Artery Disease | ☐ HIV/AIDS | ☐ Prostate Cancer |
| ☐ Asthma | ☐ Depression | ☐ Hypercholesterolemia | ☐ Radiation Treatment |
| ☐ Atrial Fibrillation | ☐ Diabetes | ☐ Hyperthyroidism | ☐ Seizures |
| ☐ Bone Marrow Transplantation | ☐ End Stage Renal Disease | ☐ Hypothyroidism | ☐ Strokes |
| ☐ BPH | ☐ GERD | ☐ Leukemia | ☐ Other |
| ☐ Breast Cancer | ☐ Hearing Loss | ☐ Lung Cancer | |

**PATIENT SURGICAL HISTORY:** (or attach surgery list)

| | | | |
|---|---|---|---|
| Surgery / Year: | | Surgery / Year: | |
| Surgery / Year: | | Surgery / Year: | |

**PATIENT SKIN DISEASE HISTORY:**

| | | | |
|---|---|---|---|
| ☐ None | ☐ Dry Skin | ☐ Hair Loss | ☐ Precancerous Moles |
| ☐ Actinic Keratosis | ☐ Eczema | ☐ Hay Fever/Allergies | ☐ Psoriasis |
| ☐ Blistering Sunburns | ☐ Flaking or Itchy Scalp | ☐ Poison Ivy | ☐ Other:_____ |

| | | | | | |
|---|---|---|---|---|---|
| Do you wear sunscreen? | ☐ YES | ☐ NO | If yes, what SPF? | | |
| Do you tan in a tanning salon? | ☐ YES | ☐ NO | If yes, for how many years? | | |
| Do you have a family history of melanoma? | ☐ YES | ☐ NO | If yes, which relative? | | |

**PATIENT SKIN CANCER HISTORY:**

| **Diagnosis** | **Skin Location** | **Date Diagnosed** |
|---|---|---|
| ☐ Basal Cell Carcinoma | | |
| ☐ Squamous Cell Carcinoma | | |
| ☐ Malignant Melanoma | | |
| ☐ Other: _____ | | |

**PATIENT CURRENT MEDICATIONS:** (or attach medication list)

| | | | |
|---|---|---|---|
| Medications: | | Dosage: | |
| Medications: | | Dosage: | |
| Medications: | | Dosage: | |

**PATIENT ALLERGIES:** (or attach allergy list)

| | | | |
|---|---|---|---|
| Drug/Food: | | Reaction: | |
| Drug/Food: | | Reaction: | |

**If over 65, have you had the Pneumonia vaccination? ?** ☐ No ☐ Yes (If yes, when: _____)

**Do you have a pacemaker?** ☐ No ☐ Yes

**Do you have a defibrillator?** ☐ No ☐ Yes

**Are you pregnant or planning pregnancy?** ☐ No ☐ Yes

**Are you allergic to Latex?** ☐ No ☐ Yes (If yes, what is the reaction: _____)