SKIN SPECIALISTS
ALLEN | ADDISON

PATIENT INFORMATION AND ACKNOWLEDGEMENT OF PRIVACY NOTICE RECEIPT

1. Patient's Name _____
Last First MI

_____
Address Street & Apt # City State Zip

_____
Home Phone Cell Phone Other Phone

Email Address: _____

Age _____ Birthdate _____/_____/_____ SS# _____-_____-_____ Pt.'s Gender: · Female · Male

Marital Status: Married - Single - Divorced - Partnered - Widowed

Primary Care Physicians name & phone: _____

How were you referred: _____

2. Patient's or Parent's Employer_____ Occupation_____

Work Phone_____ Ext:_____ Is it okay to call you at work? · Yes · No

3. Emergency Contact
_____ Relationship to Patient_____ Home Phone_____

_____
Address: Street & Apt # City State Zip

4. Primary Insurance _____ _____
Subscriber/ Member ID #

_____ _____ _____ _____
Group/ Account ID # Ins. Phone **PO Box # for claims (back of card)

5. Primary Policy Holder's Name: _____ DOB _____/_____/_____

Address: _____Telephone _____
Street City State Zip

Social Security #_____ -_____ -_____**Policy Holder's Relationship to Patient:** _____

6. Secondary Insurance_____

_____ _____ _____
Subscriber/ Member ID # **Group / Account ID #** **Insurance Phone**

Secondary Policy Holder's Name: _____ DOB _____/_____/_____

Address: _____ Telephone _____
Street City State Zip

Social Security #_____ -_____ -_____ **Policy Holder's Relationship to Patient:** _____

7. AUTHORIZATION FOR INSURANCE TO PAY

I hereby authorize payment of medical benefits billed to my insurance company to be paid directly to Skin Specialists PA, the office of Tanya Reddick Rodgers, MD, FAAD. I hereby agree to promptly pay for any service(s) provided to me not covered by my insurance policy. I agree to pay all co-payments, deductibles, coinsurance, and for cosmetic services and/or products sold through Skin Specialists PA.

I also understand that I may change my emergency contact information at any time, by asking for and completing a new emergency contact form.

8. PATIENT ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I understand that as part of the provision of healthcare services, Skin Specialists PA, the offices of Tanya Reddick Rodgers, MD, FAAD, creates and maintains health records describing my health information. This includes, but is not limited to, my health history, symptoms, diagnoses, examinations, test results, treatment and any plans for treatment. I have read and been provided with a copy of the Notice of Privacy Practices which provides a complete description of the uses and disclosures of certain healthcare information. By signing below, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment, and healthcare operations. I have the right to revoke this consent in writing except where disclosures have already been made in reliance on my prior consent.

FINANCIAL AND OFFICE POLICIES

We would like to welcome you to our office and are happy that you have chosen us for your dermatology needs. Our goal is to provide the best possible medical care for you and your family. In order to meet this goal, we need your assistance and understanding of our Financial and Office policies. Our Financial Policy is a necessary part of assuring the financial resources needed to maintain this healthcare facility for our patients.

Office Visits - Private Pay Patients

Full payment of services is due at the time of your visit. We accept cash, checks, Visa, MasterCard, Discover, and debit cards.

Cosmetic Procedure & Products

As we are all aware, cosmetic procedures and skin care products are not covered benefits under medical insurance. Therefore, payment is due at time of service or product purchase.

Insurance Companies

We cannot guarantee how your insurance company processes and pays your claims. Your insurance is a contract between you and your insurance company. We are unable to provide you with exact costs of professional procedures performed by our providers due to the fact that insurance companies deduct contractual adjustments (contract between the insurance company and Skin Specialists PA), prior to applying any co-payments, coinsurances and or deductibles. **Although we are participants in your plan, you will be responsible for all charges the insurance company deems patient responsibility.**

Office - Visits Insured

Most health plans require you to make a co-payment with each visit. Co-payment amounts cannot be billed and will be collected at the time of your visit. We accept cash, checks, Visa, MasterCard, Discover, and debit cards. In order to be consistent with insurance regulations, **you are required to pay your co-payment or deductible before your office visit, after services are rendered if there is more owed it is due at check out**. We accept checks, cash, credit and debit card payments. **There may be several Treatments required for full resolution of your issue.**

_____ _____

Signature of Patient (if over 18) or parent/legal guardian **Date**

_____ _____

Patient Name **Patient DOB**

Non-Covered Services
It is important to understand that some services provided to you may not be covered under your current insurance plan. Therefore, it is important that you check with your insurance company to verify your benefits. You will be responsible for full payment of any services not covered by your insurance at the time of your visit.

Surgery
Some minor surgical procedures are performed in our office. Most insurance carriers put these in the category of "surgery", meaning that the procedure may be applied to a surgical deductible or coinsurance. Therefore, you may be billed for an amount over and above the usual visit co-payment. This may also mean that the procedure will need to be pre-certified. If the procedure is not covered by your insurance we will require 100% payment at the time of the surgery.

Laboratory Services
When you have a skin biopsy or culture done, we will send the specimen to an outside lab. Please note that we DO BILL your insurance for specimen collection, BUT the laboratory will bill your insurance/you separately for processing and diagnosis of the specimen.

Appointments
It is our goal to provide services to you in the most comfortable and timely manner possible. In order to achieve this, we ask that you be on time for your appointments. We realize your time is valuable and we endeavor to keep on schedule, while providing each patient with personalized care. However, emergencies do occur, and may cause delays in our schedule. We will try to keep you informed of these delays should they arise. **Cancellation/No Show Fees:** There is a **$50 non-refundable fee ($100 for surgery) $50 All Cosmetic procedures** for each no show occurrence or untimely cancellation (**untimely cancellation - any cancellation that is not provided 24 hours before scheduled appointment.**)

Patient Services
We are happy to offer the following services to our patients for a nominal fee: **Medical Record Copies up to 20 pages $6.50 and $0.50 for every page after.** Completion of Disability, Insurance, FMLA, Medical LOA, Social Security forms or dictated letters may incur a **$25 fee**. Please **allow at least 5-7 business day to process**.

Prescription Refills
Prescription refill or change requests will be handled within 24 hours of the receipt of the request during regular office hours. Please contact your pharmacy so that a written request can be faxed to our office. No prescription refill or change requests will be handled after regular office hours or on the weekend.

Children
Of course we all love to see children; however, we ask that you monitor them at all times while you are in our office. If you are uncomfortable having them with you in the exam rooms, please make other arrangements for their care during your office visit. **All minors under the age of 17 have to be companied by a Parent/Legal Guardian unless a permission to treat a minor authorization is signed.**

Notification of Changes
In order for us to maintain accurate financial records, we ask that you notify us in writing of any changes regarding your insurance information and/or personal information, i.e., address, name changes, phone numbers and all other relevant information that may affect your financial status.

Thank you for choosing us for your dermatology needs. If you have any questions regarding these policies, please notify a member of our business office during regular hours. We will do our best to ensure your understanding of our policies so that we may concentrate on you and your care. I acknowledge that I have read and understand the contents of the financial and office policies for Skin Specialists PA.

_____ _____

Signature of Patient (if over 18) or parent/legal guardian **Date**

_____ _____

Patient Name **Patient DOB**

AUTHORIZATION TO COMMUNICATE HEALTH INFORMATION

Who to Contact:

I hereby authorize and give permission to Skin Specialists PA, the offices of Tanya Reddick Rodgers, MD, FAAD, to disclose and discuss any information related to my medical condition(s) to/with the following persons:

_____ _____
Name Relationship

_____ _____
Name Relationship

☐ **CONTACT ME ONLY**

I Wish To Be Contacted In The Following Manner:

Home Phone:_____ Cellular Phone:_____

Check All That Apply

__ Ok to leave message with detailed information __ Leave message with call-back number only

Work Phone:_____

__ Ok to leave message with detailed information ___ Leave message with call-back number only

Written Communication:

__ Ok to mail to my home address

__ Ok to mail to my work/office address

__ Ok to fax to this number_____

The duration of this authorization is indefinite unless I revoke it in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

X **Patient or Parent's Signature** _____ **Date** _____

Patient Name: _____ **Patient DOB:**_____

Office Staff Only Below Line

Signature of Witness_____ Date _____

Physician Assistant/Nurse Practitioner Consent to Treat

This facility has on staff a physician assistant and/or a nurse practitioner to assist in the delivery of medical care. A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. A nurse practitioner is not a doctor. A nurse practitioner is a registered nurse who has received advanced education and training in the provision of health care. Under the supervision of a physician, a physician assistant and a nurse practitioner can diagnose, treat and monitor acute and chronic disease as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of the supervising physician, but rather overseeing the activities of an accepting responsibility for the medical services provided. A physician assistant and a nurse practitioner may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Perform surgeries and biopsies as needed for proper treatment
- Perform cosmetic procedures to include fillers, peels, and, onabotulinumtoxins
- Monitoring the effectiveness of medical treatment
- Offering counseling and education
- Making appropriate referrals

I _____have read the above, and hereby consent to the services of a physician assistant and/or nurse practitioner for my health care needs. I understand that this provider bills under the provider and no refunds or credits will be given after services are rendered. I understand that the practice of dermatological medicine may not be an exact science; not all conditions are curable; and at times more than one visit may be required to treat my condition. I understand that at any time I can refuse to see the physician assistant and/or nurse practitioner and request to see a physician.

_____ _____

Signature of Patient (if over 18) or parent/legal guardian **Date**

_____ _____

Patient Name **Patient DOB**

Cosmetic Interests

Skin Specialists of Allen/Addison wants to provide you with *complete* dermatologic care. In order to serve you better, please place a check next to any concerns or interests.

Concerns

- ○ Body Contouring/Fat Reduction
- ○ Uneven Skin Tone
- ○ Aging Hands
- ○ Unwanted Hair
- ○ Facial and Leg Veins
- ○ Cosmetic Facial Redness
- ○ Facial Wrinkle Fine Lines
- ○ Thinning Hair
- ○ Brown Spots
- ○ Facial Folds
- ○ Double Chin
- ○ Volume Loss of Lips
- ○ Sunken Cheeks/Temples
- ○ Dark Circles Under Eyes
- ○ Sagging Facial and Neck Skin
- ○ Drooping Eyelids
- ○ Tattoo Removal
- ○ Daily Skin Care

Specific Interests

- ○ Fillers & Injectables
- ○ Chemical Peels
- ○ Ultherapy®
- ○ Coolsculpting®
- ○ Photofacial / IPL

○ DO NOT CONTACT (check here): We will regularly communicate with you via email. Please inform us if you would NOT like to receive a monthly newsletter and special offers via e-mail.

_____ _____

PRINT – Patient Name **Date**

_____

E mail address

History and Intake Form

Patient Name: _____ **DOB:** _____ **Ht:** _____ **Weight:** _____ **Phone number:** _____

Reason For Your Visit Today: _____

How did you hear about our office: _____

Primary Care Provider: _____

Preferred Language: _____ **Race:** _____ **Ethnic Group:** _____

Preferred Pharmacy Name: _____

Pharmacy Phone#: _____

Pharmacy City or Zip code: _____

Past Medical History: (please circle all that apply)

Anxiety	Colon Cancer	Hepatitis	Prostate Cancer
Arthritis	COPD	High Blood pressure	Radiation Treatment
Asthma	Coronary Artery Disease	HIV/AIDS	Seizures
Atrial fibrillation	Depression	High Cholesterol	Stroke
Bone Marrow	Diabetes	Thyroid Problems	NONE
Transplantation	End Stage Renal Disease	Leukemia	
BPH	GERD	Lung Cancer	
Breast Cancer	Hearing Loss	Lymphoma	

Other _____

Appendix Removed	Colectomy: IBD	Joint Replacement, Hip (Rt, Lt, Bilat)	Ovaries Removed: Ovarian Cancer
Bladder Removed	Gallbladder Removed	Joint Replacement (last 2 yrs)	Prostate Removed: Prostate Cancer
Mastectomy -(Rt, Lt, Bilat)	Coronary Artery Bypass	Kidney Biopsy (Nephrectomy)	Prostate Biopsy
Lumpectomy -(Rt, Lt, Bilat)	Mechanical Valve Replacement	Kidney Removed (Rt, Lt)	TURP (Prostate Removal)
Breast Biopsy -(Rt, Lt, Bilat)	Biological Valve Replacement	Kidney Stone Removal	Spleen Removed
Breast Reduction	Heart Transplant	Kidney Transplant	Testicles Removed (Right, Left, Bilateral)
Breast Implants	Joint Replacement, Knee - (Right, Left, Bilateral)	Ovaries Removed: Endometriosis	Hysterectomy: Fibroids
Colectomy: Colon Cancer Resection		Ovaries Removed: Cyst	Hysterectomy: Uterine Cancer
Colectomy: Diverticulitis			
NONE			

Other _____

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Patient Name: _____ **Patient DOB:**_____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratosis
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
NONE

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** **If yes, which relative(s)?** _____

Medications: (Please enter all current medications)

_____

_____

Allergies to medications: (Please enter all allergies)

_____

Have you had a Pneumonia Vaccine in the past five years? **Yes/No**
Have you had your flu shot within one year? **Yes/ No**
Do you have a living will/durable power of attorney for health care? **Yes/ No**

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

Other _____

Family History of Skin Cancer: (Only first degree relatives)

_____

_____

ALERTS: (please circle all that apply)

Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Pacemaker
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Rapid heartbeat with epinephrine?
Require antibiotics prior to a surgical procedure?
Are you pregnant or currently trying to get pregnant?
OTHER _____