

Provider you are seeing: _____

Referring physician: _____

Patient information:

Patient's Name: Last: _____ First: _____ MI: _____ Suffix: _____

Date of Birth: ____ / ____ / ____ Sex: Male / Female Marital status: Child Single Married Widowed

Address: Street: _____ Apartment # _____ City: _____ State _____ Zip Code: _____

Email address: _____ How did you hear about us? _____

Primary Phone #: _____ Is this a mobile, home, or work number? _____

Alternate phone #: _____ Is this a mobile, home, or work number? _____

(Our office will use the primary number to communicate with you and notify you of upcoming appointments)

Insurance information:

1) **Primary medical insurance policy:** _____ Referral required? Yes No
Group #: _____ Member/Subscriber ID #: _____

Claims Address: _____ Customer service #: _____

Subscriber info: (if different from patient) Last: _____ First: _____ MI: _____

Relation to Patient: _____ Sex: Male Female Date of Birth: ____ / ____ / ____

2) **Secondary medical insurance policy:** _____ Referral required? Yes No
Group #: _____ Member/Subscriber ID #: _____

Claims Address: _____ Customer service #: _____

Subscriber info: (if different from patient) Last: _____ First: _____ MI: _____

Relation to Patient: _____ Sex: Male Female Date of Birth: ____ / ____ / ____

Release of information:

Employees of this office must have your permission to relay your medical information to someone you authorize us to communicate with via phone/text/email. If you do not give us permission to speak to a specific person on your behalf, we will be unable to relay any information to anyone other than the patient or legal guardian. Please list below anyone you authorize our office to discuss your medical care and test results with, we will keep this authorization on file and it will remain in effect until you revoke authorization by written notice.

1) Name: _____ Relationship: _____ Number: (____) _____

2) Name: _____ Relationship: _____ Number: (____) _____

May we leave a message on your voicemail/answering machine/text of benign pathology results or normal laboratory results? Yes No

Emergency contact info:

Name: _____ Relationship: _____ Number: (____) _____

Privacy acknowledgement:

I acknowledge that The Woodlands Dermatology/Montgomery Dermatology Associates has provided me with a written copy of his/her Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Patient/ Legal Guardian initials to acknowledge

Assignment and release:

I hereby assign, transfer, and set over to the Woodlands Dermatology/Montgomery Dermatology Associates all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy in regards to all services performed in our office. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether it is a covered benefit by your insurance or not.

(for minors) Legal guardian/Parent Name: _____

Patient/Legal guardian Signature: _____

Today's date: _____

Office & financial policies

Welcome and thank you for choosing The Woodlands Dermatology/Montgomery Dermatology Associates for your dermatology care. We are committed to providing you with the highest quality medical care, in an efficient, and cost-effective manner. We hope that by providing you with our policies in advance, we can prevent any misunderstanding or frustration at the time of your visit.

Insurance: When making an appointment with one of our physicians, it is your responsibility to confirm with your insurance company that our physician is currently under contract with your plan.

Self pay/No insurance: If you have no medical insurance or you are not using your insurance, you will be responsible for the entire cost of the visit upon checking-out.

Patient Payments/Refunds policy: Please be prepared to pay for your estimated cost of today's visit as well as any previous balances unless alternate arrangements are made prior to your visit. Our insurance department will make every effort to obtain your insurance benefits based on the information you have provided us prior to your appointment. Although we try very hard to obtain true and accurate information, your insurance carrier's database may not always be updated at the time of your visit. Therefore, some/all benefit information we obtain may not be factual. We recommend contacting your insurance company to determine your benefits, such as deductible/specialist copay/referral requirements prior to your appointment so you are aware of your requirements and potential out of pocket costs. We will determine and collect the estimated amount due from you at the end of your visit. For your convenience, we accept the following methods of payment: cash, check (VALID ID IS REQUIRED), MasterCard, Visa, Discover, and American Express. In the event you have overpaid or we mistakenly overcharged you for any reason we will promptly refund you by the method in which you paid. (If paid by cash you will receive a check by mail)

Referrals: Some insurance plans require you to obtain a referral prior to seeing a specialist; if your insurance requires a referral to see a specialist, you will be responsible for contacting and obtaining a referral from your primary care physician. Please do this well in advance of your scheduled appointment so you will have it at the time of your appointment. You are responsible for verifying that our office has received your valid referral prior to your appointment. You will also be responsible for obtaining a new referral as needed for additional visits or if your referral expires.

Late arrivals: We normally allow a 15-minute grace period following your scheduled arrival time at **your provider's discretion**. In the event we are able to see you, there may be a longer than usual wait time to allow patients arriving on time to be seen first. In the event that you arrive more than 15 minutes past your scheduled appointment time, you will be asked to reschedule.

No shows/Late cancellations: We require a 24-hour advance notice for all canceled appointments; this is to allow other patients needing an appointment sufficient time to use the canceled appointment slot. As a courtesy, we offer an automated reminder call or text approximately 48 hours prior to your appointment that will allow you to cancel your appointment at that time. When canceling your appointment less than 24 hours in advance (Non-emergent) you will be considered a NO SHOW for that visit. You will then be required to provide a \$50.00 deposit (*Surgical procedures will require a \$150 deposit*), to make a future appointment with our office. In the event you no show or cancel your appointment with less than 24 hours' notice, your deposit will not be refunded to you. Please note: If you have excessive no shows/late cancellations you will be dismissed as a patient in TWDA/MDA practice.

Non-covered procedures: A waiver may be required to acknowledge understanding of your responsibility for paying the entire cost for non-covered services. In dermatology, many procedures are considered cosmetic or medically unnecessary by Medicare and private insurers. These procedures include but are not limited to removal of skin tags, seborrheic keratosis, spider veins, etc. When you have non-covered services performed in our office, be prepared to pay for the service in full on the date the procedure is performed.

Cosmetic procedures: We require a \$75.00-\$150.00 deposit (depending on the procedure and length of your appointment) for all cosmetic procedures. This includes, but is not limited to chemical peels, laser treatments, sclerotherapy, fillers, Botox injections, etc. Cosmetic treatments are not covered by insurance; therefore, we will not file a claim to your insurance company for any treatment deemed as a cosmetic procedure. In the event that you NO SHOW or cancel your appointment with less than 24 hours' notice, we will then keep the deposit used to secure your appointment. In addition, you will also be required to provide a new \$75.00-\$150.00 deposit to schedule a future appointment.

Parent/Legal guardian of minor's: The parent(s) or legal guardian(s) accompanying a minor are responsible for providing current information as well as any payments due on the day of the visit.

Unaccompanied minor: Minors must have a written authorization on file for us to provide treatment for medical conditions. The parent/legal guardian must sign a waiver before any treatment can be rendered. Any unaccompanied minor must also provide any payments due on the day of the visit.

Outside Labs: Please be advised that our office uses an outside lab for processing and diagnosing specimens. Any lab fees and bills you receive are unrelated to your physician charges incurred at the visit. The lab will file your insurance, if applicable and bill you directly for any balances.

By signing below, I am acknowledging that I have read, understand, and have agreed to The Woodlands Dermatology/Montgomery Dermatology Associates office and financial policies. I hereby attest that I have given and agree to provide current demographics, current insurance information, and authorize TWDA/MDA the release of my information necessary for filing claims to my insurance companies and obtaining pre-certification when necessary by signing this statement.

Print patient name: _____

Date of birth: _____

Patient / Legal guardian signature: _____

Today's date: _____

Patient name: _____/Date of birth: _____

Pharmacy name: _____/Pharmacy #: _____

Referring physician: _____/Referring physician #: _____

Past Medical History: (please circle all that apply)

- | | | | |
|--|-------------------------|--|----------------------------|
| Anxiety | Hearing loss | High blood pressure | Valve replacement |
| Artificial joints | COPD | High cholesterol | Seizures |
| Arthritis (type: OA, PSA, RA) | Coronary artery disease | Hyperthyroidism | Stroke |
| Asthma | Depression | HIV/Aids | *Bleeding disorders? Y / N |
| Atrial fibrillation | Diabetes | Hypothyroidism | *Clotting disorders? Y / N |
| Cancer: *what type/treatment:
_____ | GERD/Acid reflux | Organ transplantation:
*what organ: _____ | |
| | Hepatitis | | |

List Surgeries: _____

Skin Disease History: (please circle all that apply)

- | | | |
|-------------------|----------------------|-------------------------|
| Acne | Basal Cell Carcinoma | Psoriasis |
| Actinic Keratosis | Eczema | Rosacea |
| Atypical mole | Melanoma | Squamous Cell Carcinoma |

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 Skin cancer? Yes No
*If YES, what type and which family member? _____

Current Medications: (please list all current medications and dosages including over the counter medications and supplements) *you may continue on reverse side of page or provide a separate list if available

- | | |
|-----------|-----------|
| 1.) _____ | 4.) _____ |
| 2.) _____ | 5.) _____ |
| 3.) _____ | 6.) _____ |

Allergies: _____

Social History:

- Do you smoke tobacco? Yes No *If YES, how many per day: _____
- Do you use IV drugs? Yes No *If YES, which IV drug: _____
- Do you drink alcohol? Yes No *If YES, how many drinks per day: _____
- What is your occupation? _____

Quality Measures:

- Have you received your flu shot for this flu season? Yes No *If NO, please state reason: _____
- Have you received your Pneumonia vaccine? Yes No

Caution:

- Have you ever had difficulty to stop from bleeding? Yes No
- Do you require antibiotics prior to surgical procedures? Yes No
- Do you have an artificial heart valve? Yes No
- Have you had an artificial joint replacement? Yes No
* If yes, when and what body location? _____
- Do you have a pacemaker? Yes No
- Do you have a defibrillator? Yes No
- Are you pregnant or currently trying to get pregnant? Yes No