Welcome to Ross Dermatology

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

LAST NAME **FIRST NAME** **MI**

ADDRESS **APT#** **CITY** **STATE** **ZIP**

HOME PHONE **WORK PHONE** **CELL PHONE**

DATE OF BIRTH **AGE** **SEX** **SOCIAL SECURITY#**

MARITAL STATUS **EMPLOYER** **EMAIL**

RESPONSIBLE PARTY

ADDRESS **APT#** **CITY** **STATE** **ZIP**

DATE OF BIRTH **SOCIAL SECURITY#** **RELATIONSHIP**

EMPLOYER **WORK PHONE**

PRIMARY INSURANCE **ID#** **GROUP#**

INSURED NAME AND ADDRESS **DOB** **EMPLOYER** **RELATIONSHIP TO PATIENT**

SECONDARY INSURANCE **ID#** **GROUP#**

INSURED NAME AND ADDRESS **DOB** **EMPLOYER** **RELATIONSHIP TO PATIENT**

METHOD OF PAYMENT FOR TODAY'S VISIT: ___ CASH ___ CHECK ____ VISA ____ MASTERCARD

****COPAYS AND DEDUCTIBLES DUE AT TIME OF VISIT!!****

PLEASE READ AND SIGN THE FOLLOWING:

I authorize the release of any information including the diagnosis and the records of any treatments or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual billed for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

SIGNATURE: _____ DATE: _____

MEDICAL HISTORY AND INTAKE FORM

Patient Name: _____ **Date of Birth:** _____

Reason for visit, location of problem, duration of problem: _____

_____

_____

Past Medical History: (Check all that apply)

_____ Allergies	_____ Heart Valve Replacement	_____ Lumpectomy
_____ Asthma	_____ High Blood Pressure	_____ Lupus/RA
_____ Bleeding Disorder	_____ High Cholesterol	_____ Mastectomy
_____ Cancer: _____	_____ HIV/AIDS	_____ Organ Transplant
_____ Coronary Art. Bypass	_____ Joint Replacement	_____ Thyroid Disease
_____ Depression	_____ Kidney Transplant	_____ Diabetes
_____ Liver Disease	_____ Fever Blister	_____ NONE

Do you have a history of skin cancer or skin disorders? (Examples: acne, actinic keratosis, basal cell, melanoma, psoriasis, squamous cell) _____Yes _____No If Yes, please indicate condition or disorder:

_____

Family history of skin cancer including melanoma? _____ Yes _____No if yes whom: _____

Medications: (Enter all current medications including non-prescription and birth control; if none write N/A)

_____

_____

_____

Allergies: (Please enter all allergies including allergies medications; if none write N/A) _____

_____

Social History:

Do you smoke? _____ Yes _____No If yes, how much? _____

Do you drink? _____Yes _____No If yes, How much? _____

Review of Systems: (check all that apply)

_____ Problems with bleeding	_____ Night sweats	_____ Problems with healing
_____ Unintentional weight loss	_____ Problems with scarring/keloids	_____ Joint Pain
_____ Fever or chills		

Alerts: (Check all that apply)

_____ Allergy to adhesive	_____ MRSA	_____ Allergy to Lidocaine	_____ Pacemaker
_____ Allergy to Topical Antibiotics	_____ Require antibiotics prior to a surgical procedure		
_____ Artificial Heart Valve	_____ Rapid Heartbeat with Epinephrine		
_____ Artificial Joint Replacement	_____ Are you pregnant or currently trying to get pregnant?		
_____ Blood Thinners	Notify your provider verbally		
_____ Defibrillator	_____ NONE		

Preferred Pharmacy: _____ Telephone (if known): _____

Address (or cross streets) _____ City: _____

Ross Dermatology

HIPAA CONSENT FORM

This consent form describes how Ross Dermatology and Laser Clear of S.A. will use and disclose protected health information about you to carry out treatment, payment, and healthcare options. You have the right to review the Notice of Privacy Practices prior to signing this consent form.

Ross Dermatology and Laser Clear of San Antonio reserve the right to revise its Notice of Privacy Practices at any time. A copy of the Notice of Privacy Practices may be obtained by requesting a copy from our office.

When contacting you for appointment reminders, insurance items, or any calls regarding your care. May we leave a message or state who is calling on your:

Home Phone: ____ Yes ___NO Work Phone: ___ Yes ____NO

Due to confidentiality regulations, should a family member, friend, or relative contact our office, we are not at liberty to discuss your situation. Unless we have permission from you the patient or your guardians.

___ I **DO NOT** Authorize the practice to release any of all information concerning my medical care to any individual except as set forth above.

__ I **AUTHORIZE** the practice to verbally release any or all information concerning my medical care to the following individuals.

Please list below with whom we may discuss your health information:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone: _____ Phone: _____

By signing this form, I am consenting that Ross Dermatology & Laser Clear of San Antonio can use and disclose my protected health information to carry out treatment, billing, and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures because of my prior consent.

_____ _____

Printed Name & Signature/Date Relationship to Patient / Date

_____

Witness/Office Representative / Date

Ross Dermatology
Patient Responsibility

☐ **To ensure benefits coverage for any services rendered, we ask that you provide our office with a copy of your insurance card and current identification/driver's license card at each office visit.**

☐ **If the patient's insurance plan (HMO) requires a referral from the patient's primary care physician (PCP), it is the patient's responsibility to secure the referral authorization number.**

☐ **Due to time constraints we are unable to call your employer, insurance company or primary care physician for verification of coverage or copies of cards.**

☐ **If insurance verification and coverage cannot be determined prior to the visit, payment will be requested at the time of service.**

☐ **Please be advised that the eligibility and benefit information supplied by your insurance company is only an estimate and is not a guarantee of payment by the insurer. Actual benefits are subject to all plan terms, definitions, limitations and exclusions in effect on the date of service.**

☐ **Ross Dermatology will submit your claim to your insurance company for services performed by our medical providers; however, if we are unable to collect from the insurance company, it is the patient's responsibility to pay for any and all services provided.**

☐ **Please notify our office if your insurance has changed at least 24 hours prior to your appointment.**

☐ **If Ross Dermatology does not accept your new insurance, you will be treated as a cash patient and the bill is your responsibility and payment is due in full at the time of service.**

_____
Patient Printed Name

_____ _____
Patient signature Date:

Ross Dermatology
Financial Policy

Co-pays, co-insurance, deductibles and procedures not covered by insurance and/or cosmetic procedures are due in full at the time of service.

We accept cash, check, credit care (MasterCard/VISA/Discover/American Express), and Care Credit.

If your claim has not been paid within 90 days, we require that you pay the balance using one of the approved payment methods.

Cancellations and Missed Appointments: We request that you give our office a minimum of **24 hour notice** if you need to cancel or reschedule an appointment. Failure to do so will result in a missed appointment fee, which is NOT covered by insurance. The **missed appointment fees** are as follows:

- **Medical - $35.00**
- **Surgery / Cosmetic – $50**

Medical Records Release Fee: In accordance with the Texas Medical Board, we will charge a $25 fee for the first 20 pages of medical records requested for release, and .50 cents for each additional page. The fee for electronic records is $25.00 for 500 pages.

Returned Check Fee: There will be a $35.00 fee for all returned checks.

Collections: Failure to pay your balance within 90 days will result in your account being turned over to a collection agency. You will be responsible for any fees charged to us by the agency, in addition to your outstanding balance.

I have read and understand the financial policy of the practice, and I agree to be bound by its term. I also understand and agree that such terms may be amended from time to time by the practice. In the event my insurance company is billed, I authorize payment of medical benefits to be paid directly to my physician. A photocopy and/or scanned copy of this agreement shall be considered as effective and valid as the original.

_____

Patient Printed Name

_____ _____

Patient signature Date