Word Dermatology Patient Information

*E-mail address (Optional):*______________________________

Patient Name:___________________________________DOB:__________________Age:_________SSN:_________________________

Street Address:____City/State:______________________________Zip:________________

Home Phone:(______)______-__________Cell Phone: (______)______-__________ Sex: M / F __Married __Single __Divorced __Widowed

Employer:______________________Occupation:________________Address:____________________________Phone:_________________

Spouse Name:__________________________________Phone Number:________________________Employer:________________________

Nearest Relative/Friend (not living with you):____Phone: (______)______-__________

Responsible Party: SELF **OR** Other (If other please state relationship):____

PRIMARY INSURANCE COMPANY:_________________________________Address:____

Insurance Phone:____________________Policy/Identification#:_______________________Group Name & #:___________________________

Insured Name (if other than self):______________________________DOB:__________________SSN:______________________________

SECONDARY INSURANCE COMPANY:______________________________Address:____

Insurance Phone:____________________Policy/Identification#:_______________________Group Name & #:___________________________

Insured Name (**if other than self**):______________________________DOB:__________________SSN:______________________________

PCP/Family Physician Name:__________________________________City/State:____________________Phone: (______)______-__________

How were you referred to this clinic?:____________________________City/State:____________________Phone: (______)______-__________

★ Pharmacy:_____________________City/State:___________________Phone#:_______________

How did you hear about our office? (if not referred by physician):

- ☐ Friend/Family: ______________
- ☐ Google (Internet Search)
- ☐ Yellow
- ☐ Pages
- ☐ Facebook
- ☐ Ellis County Living
- ☐ Now Magazine
  - ☐ Waxahachie
  - ☐ Midlothian
  - ☐ Ennis
  - ☐ North Ellis County
  - ☐ Southwest
  - ☐ Other: ________________

Patient Consent for Use and Disclosure of Protected Health Information

_____I GIVE permission / _____I DO NOT give permission for Word Dermatology 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, Word Dermatology, PLLC 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 Word Dermatology, PLLC 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, Word Dermatology, PLLC may decline to provide me treatment.

HIPPA 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:_________________________________ Name/Relationship:_________________________________

Phone Number:_________________________________ Phone Number: _________________________________

This consent was signed by: _________________________________ _________________________________

Name of Patient/Legal Representative Relationship (if other than patient)

_________________________________ _________________________________

Signature Date

Andrew P. Word, M.D.
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Office (972) 736-DERM (3376) • Fax (972) 736-3375
www.WordDermatology.com

WORD DERMATOLOGY

PATIENT MEDICAL HISTORY FORM

Patient: ______________________________ **DOB:** _______ **Today's Date:** _______ **Age:** _____ **Height:** ______ **Weight:** ______ **Male / Female**

Reason for today's visit: ____

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

Allergies: ____

Do you take aspirin or blood thinner? Y / N	**Do you smoke?** Y / N	**Do you drink alcohol?** Y / N
Have you been told to take oral antibiotics before dental or other procedures? Y / N		**Do you use sunscreen?** Y / N

Family History (please circle all that apply)
Mother: Living / Deceased   Father: Living / Deceased
Skin Cancer: Basal cell carcinoma / Squamous cell carcinoma / Melanoma / Other: ____
Psoriasis / Asthma / Eczema / Other: ____

Past Medical History (circle all that apply to <u>YOU</u> personally):

Artificial Joint Replacement	Lupus / Rheumatoid Arthritis / Other	
Bleeding Disorder / Anemia	Multiple Sclerosis / Fibromyalgia / Chronic Fatigue	**HIV Positive**
High Blood Pressure	Organ Transplantation	
Eczema / Psoriasis	**Cancer**: (Y / N) Type: ______________________________	**AIDS**
Herpes / Cold Sores / Keloids		
Asthma / Allergies / Hay Fever / Hives	Radiation Therapy / Chemotherapy	**Tuberculosis**
Menstrual Irregularities	Stroke / TIA's / Seizures / Headaches	
Pregnant? (Y / N) Due Date:	Heart Disease / Heart Attack	**Hepatitis**
Depression / Bipolar / Anxiety / Other:	Mitral Valve Prolapse / Heart Murmur	
Diabetes / Thyroid Disease	Heart Valve Replacement	
Ear / Nose / Throat / or Mouth Disease	Pacemaker / Defibrillator	
***Other diseases or conditions:** ____		

Past Surgical History:

Skin Cancer History (circle all that apply): Basal cell carcinoma / Squamous cell carcinoma / Melanoma / Other: ______________________________
Location and Date Treated: ____
____

FINANCIAL POLICY

The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. Payment for services rendered is due at the time they are provided. For your convenience, we accept cash, checks, VISA, MasterCard, and Discover Card.

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.

*It is extremely important for you to educate yourself about your individual insurance benefits. 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.

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.

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. You will receive an explanation of benefits from your insurance carrier. Lab charges are separate charges from our office charges. I have read the financial policy, and I understand and agree to this financial policy.

____ ________________________

Signature of patient or responsible party Date

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILTY

I hereby assign all medical and/or surgical benefits to include Medicare, private insurance and any other health plans to: WORD DERMATOLOGY, PLLC. 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 WORD DERMATOLOGY, PLLC 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, (REGUARDLESS 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 photo static copy hereof is as valid as the original. I hereby state that all information provided is true and correct to the best of my knowledge.

____ ________________________

Signature Date

IF YOUR INSURANCE REQUIRES REFERRALS

We are unable to make sure we have everyone's referral all the time. You are responsible for making sure that we have your referral. You are either to bring the referral with you to your appointment or call ahead to make sure we have it in our office before your appointment. Please do not ask our receptionists to call your primary care physician to obtain the referral for you. I have chosen ____to be my primary care physician. I understand that if the above is not true, if I am not eligible under the terms of Medical Insurance Agreement, or my referral is not valid for this date of service, I am liable for all charges for the services rendered and if billed, I agree to pay in full for all services rendered within 30 days of receiving the bill. PCP's phone number:___________________________________.

____ ________________________

Signature of insured, member or guardian Date

WORD DERMATOLOGY

CONSENT FOR RELEASE OF MEDICAL RECORDS

I hereby authorize________________________ to release the following information from the health records of:

Patient Name:____ DOB:_______________

Patient Address: ____

☐ COMPLETE MEDICAL RECORDS
☐ EXCLUDING INFORMATION RELATED TO HIV AND/OR RESULTS
☐ HISTORY AND PHYSICAL ONLY
☐ OTHER:____

The reason for this request is: ☐ Transfer of care to another healthcare physician
☐ 2nd Opinion
☐ Social Security/Disability
☐ Other:____

Please release requested information to:

☐ Word Dermatology, PLLC
2460 North I-35E, Suite 285
Waxahachie, TX 75165
Phone (972) 736-3376
Fax (972) 736-3375
www.worddermatology.com

☐ Other: ________________________________
____
____
____
____

I understand that this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. The facility, its employees, and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

____ __________________
Patient/Legal Guardian Signature Date

____ __________________
Witness Signature Date