BELLAIRE DERMATOLOGY

6565 West Loop South #800 | Bellaire, TX 77401 | P: 713.661.4383 | F: 713.661.4346

Patient Registration Form

Please provide the following information if you are a new patient, your information has changed since your last visit, or if it has been 12 months or longer since your last visit. Thank you for your time and cooperation.

Last Name _____ First Name _____ Middle Initial _____

Street Address _____ City _____ State _____ Zip Code _____

Social Security Number _____ Date of Birth _____ Marital Status (circle one): Single / Married / Other

Home Phone Number _____ Cell Phone Number _____ Work Phone Number _____

Email Address _____ **Referred by** _____

Gender (circle one): M / F

Preferred Language (circle one): English / Spanish / Other _____

Ethnicity (circle one): Hispanic or Latino / Not Hispanic or Latino

Race (circle one): Not Disclosed / White / Black or African American / Asian / American Indian / Multi-Racial

I understand that by signing this form, I certify that all information provided is accurate to the best of my knowledge. I have been provided a copy of the HIPAA Privacy Practices and have read and understood the policy. I have also been provided a copy of the Financial Policy Practices and agree to the terms.

I understand that my contact information will not be shared with any other third parties for solicitations, but that I will receive reminders about upcoming appointments.

Patient or Guarantor's Signature _____ **Date** _____

BELLAIRE DERMATOLOGY

Patient Communication Consent Form

Patient Name: _____

Date of Birth: _____

I agree to allow Bellaire Dermatology to contact me in the following methods regarding my private health information, evaluation, and treatment. This includes appointment information, biopsies, tests or lab results. I authorize Bellaire Dermatology to leave messages for me when I am unavailable.

	Method	Number/Address	MESSAGES?			
	Cell Phone			YES		NO
	Altern Phone			YES		NO
	Text Messages			YES		NO
	Email			YES		NO
	Portal			YES		NO

EMERGENCY CONTACT ONLY

NAME: _____ PHONE: _____

By my signature below I acknowledge that I have read and understand the Guidelines to Patient Communication and information provided on this consent form. I understand the risk associated with the different methods of communication, especially e-mail and texting, and consent to the conditions, restrictions and patient responsibilities outlined within the Guideline as well as any other instruction that Bellaire Dermatology may impose.

Printed Name: _____ Relationship to Patient: _____

Signature _____ Date: _____

Patient Name: _____ Account #_____

PRACTICE FINANCIAL POLICY

In order to establish optimal relations with our patients and avoid misunderstandings and confusion regarding payment guidelines, our staff is trained to consistently inform you of the financial policies of our office.

PROVIDING QUALITY MEDICAL CARE FOR OUR PATIENTS IS OUR PRIMARY CONCERN. We will be more than happy to provide that care within the guidelines of your contract with your insurance company; however, it is your responsibility to understand your benefits and to call your insurance company for clarification of questions relating to your coverage. **Payment for non-covered charges and balances not paid by your insurance company is ultimately your responsibility.**

Please read and initial each policy below:

As a courtesy, we will obtain in-office benefits for patients with whom our providers are Preferred Providers (contracted health plans). Once these benefits have been determined, payment of any co-pays, annual deductibles, co-insurances and/or non-covered or cosmetic procedures is required at the time services are rendered.

If you are scheduled for a visit for either a cosmetic or aesthetic service including laser treatments, cosmetic injectables or consultation which are cash pay and medical concerns arise which are covered under your insurance benefits, additional charges such as an office visit copay may be incurred.

HMO patients and some managed care patients are responsible for obtaining the necessary referrals prior to their appointment. Please call your insurance company to determine if a referral is required from your Primary Care Physician. Appointments may be rescheduled if our office does not receive the required referral by the time of your visit. In addition, unauthorized (referrals not obtained) and non-covered services are the patient's responsibility and full payment for these services are expected at the time of visit.

Patients with health insurance with whom our providers are not contracted are expected to pay the full charges at the time of the visit. An Attending Physicians' Statement will be provided to you to submit to your insurance company for reimbursement. We do not file insurance claims for non-contracted health plans. This includes non-contracted secondary plans as well.

If a small sample of growth on your skin is removed, your sample may be sent to our Dermapathologist, Dr. Howard Gerber, or an independent pathologist, who examines the sample under a microscope and determines the type of growth or disease present. This helps your provider determine the best possible treatment for you. Thus, there may be a pathology charge for preparation and evaluation of the tissue sample, in addition to your provider's charge for removal of the tissue.

If a cosmetic consultation is scheduled, A non-refundable fee will be collected at the time of scheduling. The fee is $150 for providers and $75 for Aesthetician. If a cosmetic treatment is performed because of the consultation, then the fee will apply to the service. If a patient cancels appointment within 24 hours, no shows or no treatment is performed the fee is non-refundable.

Patients requesting an appointment for cosmetic fillers will be required to place a deposit of $100 when making an appointment. This deposit will be applied to the total treatment cost and is non-refundable should the patient fail to cancel their appointment 48 hours in advance of the scheduled appointment.

At our discretion, there will be a $50.00 charge for missed appointments not cancelled within 24 hours and for changes made to an appointment without informing our office beforehand.

There will be a $150 nonrefundable deposit for MOHS surgical procedure paid at time of appointment scheduling. If surgery is cancelled within 24 hours prior to surgical date scheduled or patient does not show for surgery, a charge will be assessed in the amount of $150, and patient notified.

There is a $150 deposit fee for all surgical procedures. If a patient cancels within 24 hours or no shows the deposit because non-refundable.

There will be a $35.00 surcharge for all checks written and returned by the bank due to insufficient funds.

I UNDERSTAND AND AM WILLING TO COMPLY WITH ALL THE ABOVE POLICIES.

Patient Signature: _____ Date:_____

BELLAIRE DERMATOLOGY

NAME: _____ OCCUPATION: _____ PREFERRED NAME: _____
AGE: _____
REFERRED BY: _____ HOBBIES: _____

GENERAL MEDICAL HISTORY: Do you have or have you ever had any of the following?

Y	N	ANXIETY/DEPRESSION	Y	N	GERD	Y	N	PACEMAKER/DEFIB
Y	N	ARTHRITIS	Y	N	HEARING LOSS	Y	N	RADIATION TREATMENT
Y	N	ASTHMA	Y	N	HEPATITIS A B C	Y	N	SEIZURES
Y	N	ATRIAL FIBRILLATION	Y	N	HEART DISEASE/ARRYTHEMIA	Y	N	STROKE
Y	N	ANEMIA	Y	N	HIV/AIDS	Y	N	THYROID DISEASE
Y	N	AUTOIMMUNE COND TYPE_____	Y	N	HIGH CHOLESTEROL	OTHER:_____		
Y	N	BONE MARROW/ORGAN TRANS	Y	N	HIGH BLOOD PRESSURE	_____		
Y	N	CANCER/TYPE_____	Y	N	KIDNEY DISEASE			
Y	N	COPD/EMPHYSEMA	Y	N	LUPUS	_____		
Y	N	DIABETES	Y	N	MIGRAINES			

SURGERIES:

Y	N	APPENDIX	Y	N	HYSTERECTOMY/TUBAL LIGATION	Y	N	SPLEEN
Y	N	BLADDER	Y	N	JOINT REPLACEMENT TYPE_____	Y	N	TRANSPLANT SURGERY
Y	N	BREAST RECONS: R L B	Y	N	MASECTOMY/LUMPECTOMY R L B	Y	N	VALVE REPLACEMENT
Y	N	DENTAL IN LAST 6 MONTHS	Y	N	MELANOMA	OTHER:_____		
Y	N	GALLBLADDER	Y	N	PROSTATE			
Y	N	HEART SURGERY/STENT	Y	N	PROSTATE BIOPSY/CANCER	_____		
						_____		

SKIN TYPE:

If exposed to the sun in the summer without sunscreen, would you: 1. always burn, never tan; 2. always burn, sometimes tan; 3. sometimes burn, always tan gradually; 4. burn minimally, always tan well; 5. rarely burn, tan profusely; 6. never burn, deeply pigmented.

Y	N	ACNE	Y	N	ECZEMA	Y	N	KELOID
Y	N	ACTINIC KERATOSIS	Y	N	FLAKING OR ITCHY SKIN	Y	N	MELANOMA
Y	N	BASAL CELL CANCER/SCC	Y	N	HAY FEVER/ALLERGIES	Y	N	PRECANCEROUS MOLES
Y	N	BLISTERING SUNBURNS	Y	N	HSV	Y	N	PSORIASIS

OTHER:_____

SKIN CANCER LOCATION: _____ TYPE: _____ TREATED BY: _____
Do you wear sunscreen? Y / N If yes, what SPF? _____
Did you tan in tanning salons? Y / N

FAMILY HISTORY: Circle any conditions affecting a blood relative and specify who is affected below.
Melanoma Basal cell or squamous cell skin cancer Psoriasis Eczema Hay fever / allergies Asthma Acne
Which relative(s)?
_____
Any other family history?
_____
Are you pregnant or breastfeeding? Y / N If no, method of birth control: _____Are you contemplating pregnancy? Y / N
Yeast infections when taking antibiotics? Y / N
Allergies to medications and type of reaction: _____
Medications (Prescription, Non-Prescription, Vitamins): _____
_____\

SOCIAL HISTORY: Please circle all that apply.

MARITAL STATUS	Single / Married / Divorce / Widow
CIGARETTE SMOKING	Never smoked / Quit (former smoker) / Smokes less than daily / Smokes daily
ILLICIT DRUG USE	None / Drug Use / IV drug use
ALCOHOL USE	None / Less than 1 drink a day / 1-2 drinks a day / 3 or more drinks a day
SAFETY	I feel safe at home / I do not feel safe at home
BLOOD THINNER	Y N
ASPIRIN	Y N
RECENT VACCINATIONS:	_____

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HIPAA CONSENT

Patient Name: _____DOB: _____Account: _____

I understand that as part of my health care, Bellaire Dermatology Associates (BDA), creates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A tool to notify me of various events, clinical studies, and ongoing opportunities for medical care related to my medical history.
- A basis for planning my care & treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis, medical and surgical information to my bill
- A means by which a third-party payer can verify that services billed were provided, and
- A tool for routine healthcare operations such as assessing quality and the competence of healthcare professionals.

I hereby consent to the clinic's use and disclosure of my individually identifiable health information for the purposes listed above and other purposes relating to my treatment, the payment of my health care, and other health care operations of the clinic. In addition, I acknowledge that I received, on the date indicated below, a copy of the clinic's ***Notice of Privacy Practices***, which describes the obligations of the clinic regarding its use and disclosure of my individually identifiable health information and my rights regarding this information.
Bellaire Dermatology Associates is authorized by this form to disclose and/or discuss my protected health information with the following named people (identified by relationship, date of birth, and phone number):

Name: _____ DOB: _____ Phone: _____
Relationship to Patient: [ ] Spouse [ ] Child [ ] Parent [ ] Other

Name: _____DOB: _____ Phone: _____
Relationship to Patient: [ ] Spouse [ ] Child [ ] Parent [ ] Other

I understand that I have the right to revoke anyone listed above on this authorization by completing a new copy of this form. All revocations must be sent to the clinic address to the attention of the ***Privacy Officer, Bellaire Dermatology Associates, 6565 West Loop South, Suite 800, Bellaire, Texas, 77401,*** and are not effective until received by such.

Photographic Release
I, the undersigned, hereby give Bellaire Dermatology Associates and its clients or agents permission to use the photographs that they have taken of me.

1. To copyright in their name or any other name that they may choose.
2. To use and publish the same in whole or in part, individually or in conjunction with other photographs, in any medium for any purpose including art, illustration, promotion, advertising, or trade.
3. It is understood that the use of the photographs is for illustrating the medical procedure and demonstration of treatment outcomes.

I hereby release Bellaire Dermatology Associates and its agents from any and all claims and demands arising out of, or in conjunctions with, the use of the photographs. _____(initial)

Patient Signature: _____ Date:_____