



HOUSTON INSTITUTE OF DERMATOLOGY

PATIENT REGISTRATION

Welcome and thank you for visiting our office today! My staff and I are committed to providing you with quality care. Please make yourself comfortable and let us know if we may assist you with anything.

Today's Date: ____ / ____ / ____ Name: _____
 Address: _____
 City/State/Zip: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 Email Address: _____ Preferred Contact: Cell Home Work
 Date of Birth: ____ / ____ / ____ Age: ____ Sex: M F Marital Status: _____
 Social Security Number: ____ - ____ - ____ Drivers License #: _____
 Referring Physician's Name: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Primary Insurance: _____	Secondary Insurance: _____
Insured's Name: _____	Insured's Name: _____
Social Security Number: _____	Social Security Number: _____
Policy #: _____	Policy #: _____
Group #: _____	Group #: _____
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured's Employer: _____	Insured's Employer: _____
Insured's Date of Birth: ____ / ____ / ____	Insured's Date of Birth: ____ / ____ / ____

Pharmacy Name and Phone Number: _____

Patient's Employer: _____

Occupation: _____ Full-Time Student? Yes No

Emergency Contact: _____ Phone Number: _____

Relationship of Emergency Contact: _____

Name of Parent or Guardian (if patient is a minor): _____

How did you hear about us? Physician Family member Friend

Employer Insurance Company Google/Internet Search Magazine/Phonebook

Other: _____

I understand that office visit charges are payable on the day service is rendered. I authorize Houston Institute of Dermatology to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner.

Signature: _____ **Date:** _____



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MEDICAL HISTORY

Today's Date: ____ / ____ / ____ Name: _____

Please list the reason for your visit: _____

Height: _____ Weight: _____ Age: _____

Are you interested in treating wrinkles, skin texture, skin tone, reversing sun damage, or facial rejuvenation? Yes No

Medical History: (Please check)

- | | |
|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypercholesterolemia (High Cholesterol) |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Benign Prostatic Hyperplasia | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> COPD (Emphysema) | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> GERD (Acid Reflux) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Valve Replacement |
| <input type="checkbox"/> Other: _____ | |

Please list any previous surgeries: _____

Skin Disease History: (Please check)

- | | |
|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Hay Fever/Allergies |
| <input type="checkbox"/> Actinic Keratoses | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Poison Ivy |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Pre-cancerous mole |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> None |
| <input type="checkbox"/> Flaking or itchy scalp | <input type="checkbox"/> Other: _____ |

For Women: Are you currently pregnant, actively trying to get pregnant OR breastfeeding?

Yes No

Do you wear sunscreen regularly? 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)? _____

Any other family history? _____

Medications (please list all current medications): _____

Medication Allergies (please list all allergies): _____

Social History:

Do you smoke cigarettes? Yes No

If yes, how much? _____

Do you drink alcohol? Yes No

If yes, how much? _____

How often do you exercise?

Once a day

Few times weekly

Sometimes

Never

What is your caffeine use?

Several times a day

Once a day

Few times a week

Never



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NOTICE OF PRIVACY AND HIPAA

Today's Date: ____ / ____ / ____ Name: _____

You may be contacted by the practice to remind you of appointments, healthcare treatment options or other health services that may be of interest to you.

Leave a message on your preferred contact number regarding medical results? Yes No

Home Phone: _____ Mobile Phone: _____

Do we have permission to confirm your appointment via email? Yes No

Do you authorize emails pertaining to appointment reminders, specials, events, etc? Yes No

Do we have permission to discuss your medical condition with a family member? Yes No

If yes, who? _____ Relationship: _____ Telephone: _____

Houston Institute of Dermatology has provided me with a copy of my rights (find a copy on our web site or ask for a copy in the office) as a patient under the HIPAA act. I have been provided the opportunity to read and understand my rights and ask questions regarding my rights and receive answers to my satisfaction. If you have any questions, please address them with the physician during your visit.

I acknowledge that Houston Institute of Dermatology has made the Notice of Privacy Practices available to me. I authorized release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physicians.

Signature: _____ **Date:** _____



FINANCIAL POLICY

Houston Institute of Dermatology is committed to providing you with quality care. As a patient of Houston Institute of Dermatology, you are financially responsible for all medical services. Your clear understanding of our financial policy is important to our professional relationship. Our office will be pleased to discuss our professional fees with you at any time.

PATIENT/INSURANCE/VERIFICATION INFORMATION: As a patient, you are responsible for providing accurate and complete insurance information. Your health insurance is a contract between you and your insurance company. It is your responsibility to contact your carrier to verify if provider is in network, coverage and payment obligations. At the time of scheduling your appointment, you will be asked to provide your insurance information. Our office reserves the right to contact your health insurance carrier to verify your coverage and payment responsibilities. This is not a guarantee of payment. If we are providers with your insurance carrier, as a courtesy to you, we will file a claim with your insurance carrier. Again, your health insurance is a contract between you and your insurance company. We are not a party to your contract. Therefore, Houston Institute of Dermatology cannot become involved in disputes between you and your insurance company regarding deductibles, non-covered charges, co-insurance, secondary insurance, coordination of benefits, pre-existing conditions, or “reasonable and customary” charges other than to supply factual information as necessary. You are responsible for timely payment of your account. At check-in you will be asked to provide your insurance identification card, social security number, and state-issued identification. This is for your protection as well as to ensure that no changes in coverage have occurred.

REFERRALS: If you have a health plan that requires a referral from your primary care physician it is your responsibility to obtain this information prior to your appointment. It is also your responsibility to verify that you do not exceed the number of visits authorized by your primary care physician/health care plan. If you exceed your authorized visits you will be billed for all services rendered. If you are unable to obtain a referral, your appointment will be rescheduled or you will be expected to pay for charges in full at the time of service.

CO-PAYMENTS/DEDUCTIBLES/COINSURANCE: All co-payments, applicable deductibles and coinsurance amounts will be collected upon patient check-in. In compliance with our contract with your insurance carrier, Houston Institute of Dermatology cannot discount/waive any co-payment, deductible and/or coinsurance amounts.

CANCELLATION POLICY: Our office works very diligently to schedule all appointments in a timely manner; therefore if you request to reschedule or cancel an appointment, we ask for **at least 24 hours notice prior to your appointment date.** Houston Institute of Dermatology reserves the right to charge the patient a **\$50 fee** if the patient does not cancel within 24 hours.



SELF-PAY/NON-CONTRACTED PLANS/NON-COVERED SERVICES/THIRD PARTY CLAIMS: Payment in full will be collected at the time of your office visit.

MEDICARE PAYMENTS: If you have regular Medicare part B and a secondary carrier (Medi-Gap plan) we will not collect any payment at the time of your visit. Our office will bill you for any portion of your bill not paid by Medicare and your secondary carrier. If you have regular Medicare Part B only and have not met your deductible, we will collect the deductible amount along with your 20% coinsurance at the time of your visit. If you have regular Medicare Part B only and have met your deductible, we will only bill your 20% coinsurance at the time of your visit.

OUT OF NETWORK PATIENTS: Any applicable deductible, co-payment, coinsurance, and non-covered services will be collected at the time of your office visit. Please contact your insurance carrier for guidelines pertaining to your coverage.

PATHOLOGY/LABORATORY: Skin samples are sometimes sent to a laboratory for microscopic evaluation to determine or confirm proper diagnosis. I authorize and understand that I am responsible for the cost of any testing or lab services performed for me and that billing of such services may be billed independently by another physician or laboratory if my insurance doesn't pay or I am a self-pay patient.

PATIENT BALANCES: Any patient balance due after your insurance company has processed your medical charges will be billed: this balance is due upon receipt. If the balance is not paid or payment agreement established, your account will be forwarded to an outside collection agency within 90 days of the first billing statement. Upon arrival for an appointment, any outstanding balance due will be collected at check-in.

METHODS OF PAYMENT

Our office accepts cash, Debit, VISA, Discover, MasterCard and American Express.

- I have read the Financial Policy of Houston Institute of Dermatology.
- I understand that I am personally responsible for payment on my account
- In the event my insurance company deems a service to be "non-covered", I understand that I am personally responsible for payment.

LATE PATIENT POLICY: Patients that are late for their appointments will have to wait until all other on-time patients are seen by the doctor. We will do our best to get you in as quickly as possible, but cannot guarantee that there will not be a lengthy wait time. Please call the office if you are going to be late.

Signature: _____

Date: _____

Printed Name: _____