Spicewood Dermatology, P.A.

Experts in Skin Health

PATIENT INFORMATION

Patient Name: (Last, First, Middle Initial)			Date of Birth:
Address: (apt/unit #)	City:	State:	Zip Code:
Primary Phone Number: ( )	Secondary Phone Number: ( )		
Gender: O Male O Female O MtF O FtM Other _____	Marital Status: O Married O Single O Other	Social Security Number: - -	
Email Address: (for patient portal access and specials)	Race: O Asian O African Am. O Caucasian O Hispanic O Other		
Language: O English O Spanish O Other: _____	Preferred Pharmacy: (name, location and phone number)		

PARENT/LEGAL GUARDIAN INFORMATION *(If patient is a minor)*

Name: (Last, First, Middle Initial)	Relationship to Patient:		
Address:	City:	State:	Zip Code:

INSURANCE INFORMATION *(Please fill out this section if you are NOT the primary policy holder)*

Insurance Name:	
Primary Insured's Name: (Last, First, Middle Initial)	Primary Insured's Social Security Number: - -
Relationship to Patient: O Self O Spouse O Parent O Other: _____	Date of Birth:

DOES YOUR INSURANCE PLAN REQUIRE YOU TO HAVE A REFERRAL TO SEE A SPECIALIST?
O YES O NO
Note: It is the patient's responsibility to get required referrals. Failure to do so may result in denied claims and the patient will be responsible for all services rendered.

HOW DID YOU HEAR ABOUT US?

O Dr._____ O Family / Friend_____ O Insurance O Internet O Radio O Location / Drove by O Other

EMERGENCY CONTACT

Name:	Relationship:	Phone Number: ( )

OFFICE VISIT POLICY

Copays or deductibles are payable on the day of service. Verification of insurance benefits is a courtesy, not a guarantee of benefits. Please refer to your insurance policy or contact your insurance company for detailed explanations. I agree to pay all charges for medical and healthcare services not covered by my insurance company or other third-party payer and agree to make payment as requested by SPICEWOOD DERMATOLOGY, P.A.

Signature of Patient or Parent/Guardian:	Print Name:	Date:

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MEDICAL HISTORY

Patient Name:	Primary Care Physician:
Reason for Visit:	
Areas Involved:	Duration:
Medication Allergies:	
Current Medications:	

Do you have or have you ever had any of the following? (Please check all that apply)	O None
O Skin Cancer: what kind?	O Stomach or Peptic Ulcers
O Other Cancer: what kind?	O Hepatitis or Liver Disease: what kind?
O Seasonal Allergies / Hay Fever	O Chronic Kidney Disease
O Lung Disease	O Arthritis
O Tuberculosis	O Lupus Erythematosus
O Heart Disease, murmurs, mitral valve prolapse or rheumatic fever	O Pacemaker/Defibrillator
O Bleeding Tendency	O Anemia
O Diabetes	O Thyroid Disease
O HIV or AIDS	O Tendency to scar or keloid
O Mood/ Nervous/ Mental Disorders	Other Medical Problems:
Past Surgeries:	
O Are you currently Pregnant, Nursing or Trying to conceive? Please circle. If pregnant, when is your due date?	

SOCIAL HISTORY

Occupation:	Smoking history: O never smoked O former smoker O current smoker
Do you drink? O Yes O No How much?	

FAMILY HISTORY

Family history of Melanoma: O Yes O No If Yes, who in your family? _____
Other medical problems in your family:

Signature of Patient or Parent/Guardian:	Print Name:	Date:

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AUTHORIZATION / ACKNOWLEDGEMENT

CONSENT TO TREATMENT: I consent to the performance of these diagnostic procedures, examinations and rendering of treatment by SPICEWOOD DERMATOLOGY, P.A. medical providers and designated medical staff as is deemed necessary in the medical provider's judgment. I understand that no guarantee has been made to me as to result or cure.

CONSENT FOR TREATMENT OF A MINOR: If the patient is under 18 years of age, he/she must be accompanied by one or both parents at the time of visit. To appoint a responsible party (must be 18 years or older) to act as a guardian in the parent's place, additional paperwork must be completed.

RELEASE OF INFORMATION:

O Yes O No I authorize SPICEWOOD DERMATOLOGY, P.A. to release and/or disclose medical and billing information to:

Spouse: _____ Parent: _____ Other: _____
Name Name Name

O Yes O No I authorize SPICEWOOD DERMATOLOGY, P.A. to leave a detailed message regarding billing and medical information to the following phone number:

_____

SPICEWOOD DERMATOLOGY, P.A. may disclose all or any part of my medical record (including oral information) and may provide bills/invoices to : 1)any person, corporation or agency (or their authorized representative) which is or may be liable under a contract to SPICEWOOD DERMATOLOGY, P.A. including but not limited to hospital or medical service companies, insurance or third-party payers, or my employer; and 2) any individual or entity designated by me as a guarantor, my insurance policy, or party responsible for payment of fees for health care services provided to me.

I understand and agree that the information I am authorizing to be released may include 1) AIDS/HIV test results, diagnosis, treatment and related information; 2) information about drug and alcohol use and treatment; and 3) mental health information.

I give permission to my medical provider at SPICEWOOD DERMATOLOGY, P.A. to send a visit summary to my referring physician.

RELEASE FROM LIABILITY: I release and agree to hold harmless SPICEWOOD DERMATOLOGY, P.A. and its agents, representatives, and employees from any and all liability associated with the release of confidential patient information in accordance with this authorization. I understand SPICEWOOD DERMATOLOGY, P.A. cannot be responsible for use or redisclosure of information by third parties.

Acknowledgement - Notice of Privacy Practices (see clipboard)
I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. In addition, I agree to the office visit policy of SPICEWOOD DERMATOLOGY, P.A.

Signature of Patient/Other Legally Authorized Person:	Date/Time:

CANCELLATION POLICY

To allow our practice to continue to offer the highest level of service possible to all of our patients, we require a 24 hour cancellation notice. If less notice (or no notice) is given, a fee for the reserved time will be billed directly to the patient's account.

We will attempt to call you at least 24 hours before your scheduled appointment. This is a courtesy. We still expect that you will remember your appointments. Please leave us phone numbers that have a voicemail so we can leave a message.

We realize, of course, that emergencies do happen. However, we cannot overemphasize our appreciation to our patients who keep their scheduled appointments.

Please provide at least 24 hours advance notice
for scheduling changes in order to avoid a cancellation fee.

CANCELLATION FEES	
Office Visit	$50
Surgery/Biopsy	$100
Cosmetic Procedure with Provider (ex; Botox, Radiesse, Juvederm)	$100
Chemical Peels, Microdermabrasion, Laser Treatments & all other Aesthetic services	$50

LATE ARRIVAL POLICY

If you arrive after your scheduled appointment time, you may have to be rescheduled.

Signature of Patient or Parent/Guardian:	Print Name:	Date:

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FINANCIAL POLICY

Full payment is due at the time of service. We accept cash, check, Visa/Mastercard/Discover/AmEx and Care Credit. There is a fee for all visits, even to discuss cosmetic procedures. There are no free consultations. They payment today is for our providers' knowledge, time and judgment. **In general, surgical procedures are not done on the day of the initial visit.**

If you have private insurance, then this insurance policy is a contract between you and your insurance company. We are not a party to that contract. All charges are your responsibility whether your insurance company pays or not. Please be aware that some of the services provided may not be covered under the Medicare program and/or other medical insurances.

If you are on an insurance plan for which we are a PARTICIPATING PROVIDER, all copays and deductibles are due at the time of service. **If you do not have your insurance card with you for us to verify and make a copy, you will be asked to pay in full of that day's visit or you may reschedule your appointment.**

If an insurance company, whether private, HMO or PPO, is waiting on more information from the insured (you) before they pay us and if the balance is past 45 days, the balance will be your responsibility and will be payable in full at that time.

If for any reason, your insurance company deems "after the fact" that something we did was not covered, or you needed a referral, or somehow you didn't come here under the right circumstances as dictated by them, you are expected to pay SPICEWOOD DERMATOLOGY, P.A.'s fee in full within thirty days of the receipt of your bill. Some insurance companies do not cover the treatment of acne or removal of benign moles. It is your responsibility to know your insurance coverage. Please contact your insurance company if you have any questions.

Monthly statements are not routinely sent. On overdue accounts, after three bills have been sent with no response from the patient or no attempt at payment, the account may be transferred to our collection agency.

I have read the above Financial Policy. I understand and agree to this Financial Policy. SPICEWOOD DERMATOLOGY, P.A. will not be responsible for any communication for a patient by email, pager, fax or voicemail. All communication should be sent through the clinic staff during normal business hours**. I WILL BE RESPONSIBLE FOR ANY UNMET DEDUCTIBLES AND APPLICABLE COPAYS.**

Signature of Patient or Parent/Guardian:	Print Name:	Date: