TRINITY DERMATOLOGY

Patient Demographics

Name, Last:_____ Name, First_____ MI _____

Do you go by a nickname?:_____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Div. ☐ Wid.

Birth Date:_____ Soc. Sec. #:_____ Driv. Lic. #:_____

Race:_____ Ethnicity:_____ Language :_____ Height:_____ Weight :_____

Home Address:_____ City:_____ State____ Zip:_____

Phone, Home: (____)_____ Phone, Mobile (_____)_____ Phone, Bus.: (_____)_____

Email: _____

Insurance Information

Insurance Company:_____ Insur. Type (PPO, HMO, etc.):_____ Policy #: _____

Secondary Insurance Company (Medicare Only):_____ Policy #: _____

Responsible Party or Guarantor

(This is the primary insurance policy holder or the employee of the company providing insurance. Only fill this out if the Guarantor is a different person than the patient.)
Guarantor is same as patient ☐

Name:_____ Relation to Patient: _____

Birth Date:_____ Soc. Sec. #:_____ Driv. Lic. #:_____

Home Address:_____ City:_____ Zip:_____

Phone, Home: (____)_____ Phone, Mobile (_____)_____ Phone, Bus.: (_____)_____

Occupation:_____ Employer: _____

Business Address:_____ City:_____ State____ Zip:_____

Primary Care Physician: Dr _____ Phone: (____)_____

Pharmacy Information

Pharmacy Name:_____ Phone: (____)_____

Pharmacy Address or Location (Number & Street or Intersection) _____

Nearest Relative Not Living With You

Name:_____ Relationship: _____ Phone: (____)_____

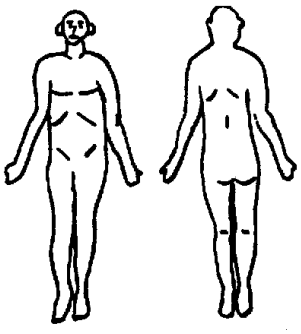
Address:_____ City:_____ State:_____ Zip:_____

Clinical Information

What is your skin problem?_____

When did it start?_____

Where is your skin problem? (circle or shade):



What are your symptoms?

☐ itching ☐ painful ☐ changing ☐ bleeding ☐ spreading ☐ not healing

What have you used for your skin problem?

Prescription_____
Nonprescription _____

Are you ALLERGIC to any medications? _____

Please list all other medicines that you are taking (<u>everything</u>, even vitamins, aspirin, etc.)

_____	_____	_____
_____	_____	_____

Any FAMILY medical history of skin problems? (especially melanoma or skin cancer)_____

WOMEN: Are you pregnant or trying to become pregnant? ☐ yes ☐ no
Are you nursing? ☐ yes ☐ no

Have you ever had (check all that apply):

☐ Melanoma	☐ High blood pressure	☐ Angina
☐ Other skin cancer _____	☐ Diabetes	☐ Arthritis
☐ Other cancer _____	☐ Stomach ulcer	☐ Hepatitis/liver disease
☐ Recent surgery _____	☐ Tuberculosis	☐ HIV/ AIDS
☐ Easy bleeding/blood thinners/anticoagulants	☐ Asthma	☐ Mental disorder
☐ Heart pacemaker	☐ Hay fever	☐ Other_____

Social History

☐ Significant sun exposure ☐ Blistering Sunburns ☐ Alcohol use ☐ Tanning bed use (past or present) ☐ Smoking (past or present)

It is very important to have a total body exam on your first visit to detect skin cancers or other problems of which you may not be aware. For this it is necessary for you to disrobe and put on one of our lovely gowns.

☐ Yes, I want a total body skin exam. ☐ No, I don't want a total body skin exam.

Patient Information

Occupation:_____ Employer: _____

☐I was referred by a doctor office: Dr._____Phone:_____

☐I was referred by one of your patients: _____☐ Family member is a patient at this office_____

Our goal is to address all of your skin care needs and help you look and feel your best. Do any of the following concern you? (Check all that apply).

☐ Fine lines/wrinkles	☐ Dark under eye circles	☐ Sagging/laxity of skin	☐ Redness/Flushing
☐Acne Scars/Scar Revision	☐ Age Spots/Brown Spots	☐ Spider Veins	☐ Uneven Skin Tone/Texture

Would you like to learn more about the following:

☐Skin Care Regimens	☐ Sunscreen Advice	☐ BOTOX® Cosmetic	☐ Cosmetic Fillers
☐ Chemical Peels	☐ SkinPen	☐ Laser Resurfacing	☐ IPL/Photofacial
☐ Hair Removal	☐Sculptra Aesthetic	☐ Other, Please Specify_____	

Would you be interested in a complimentary consultation with our aesthetician to discuss the above? ☐Yes ☐No

TRINITY DERMATOLOGY

Our Fee Policy

Due to the overwhelming number of insurance plans, it is impossible for our front desk staff to guarantee any coverage by any individual insurance plan. Everyone's insurance is different-even those with the same employer and insurance company! Each patient is responsible for knowing their own insurance coverage including the deductible and coinsurance and the amount met, the copay amount, and the coverage policies for procedures. Each patient is also responsible for obtaining their referral and knowing the number of visits, the effective date and the expiration date of that referral. Our office attempts to verify each patient's insurance benefits with your insurance company prior to their visit. At check out, each patient is charged according to the insurance benefit information and fee schedules that we receive from their insurance company. Once the insurance claim has been processed and an explanation of benefits (EOB) is received, a bill or a credit will be issued if necessary. Most insurance companies require the payment of a deductible for any in-office procedure. Procedures include things such as the destruction of warts and actinic keratoses, the injection of psoriasis and scars, and the excision of cysts, skin tags and skin cancers. These procedures are very seldom covered under the copay alone! All deductible charges and co-payments must be paid at the time service is rendered. If you are unable to comply with this policy, please reschedule your appointment for another time. Trinity Dermatology, PA is a specialist office and as defined by the insurance companies, is not a primary care provider (PCP). The fee schedule for each procedure has been predetermined by each participating insurance company by contract with Trinity Dermatology, PA. We will file all claims for all plans in which we participate. For all others, we will provide you with a computer generated insurance form.

Please be advice that our cancellation policy requires a 24-hour notice; we reserve the right to bill a patient $35.00 administration fee for cancelation under 24-hours and no-shows appointments.

Patient Financial Acknowledgement

I understand and agree that I am ultimately responsible for meeting my obligation of the balance of my account for any professional services rendered to myself and/or my dependents. I understand that it is my responsibility to verify that Trinity Dermatology, PA is a provider of my insurance plan before I present to the office for treatment. I agree to obtain a referral from my primary care physician if this is required by my insurance company. I understand that I am ultimately responsible for knowing the specifics of my insurance plan including copays, deductibles, and excluded treatments. Any charges from Trinity Dermatology, PA not paid by my insurance company will be my sole responsibility. In the event this office files medical insurance on my behalf, I authorize the release of medical information necessary to process claims. I also authorize payment of medical benefits to the Doctor for services provided. A photocopy of this assignment is as valid as an original. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. **I agree to pay any deductible or copay required by my insurance company for that day's charges at the time of check out.** My account will be charged $35 for any returned checks.

HIPAA - Patient Consent For Use and Disclosure of Protected Health Information

I hereby give my consent for Trinity Dermatology, PA to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Trinity Dermatology, PA's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Trinity Dermatology, PA reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Trinity Dermatology, PA Privacy Officer at 4340 North Josey Lane, Carrollton, Texas 75010. With this consent, Trinity Dermatology, PA may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. With this consent, Trinity Dermatology, PA may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Trinity Dermatology, PA restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Trinity Dermatology, PA's use and disclosure of my PHI to carry out TPO. 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, Trinity Dermatology, PA may decline to provide treatment to me.

My signature below signifies my understanding and willingness to comply with the above policies.

_____ Date_____

Patient Printed Name

_____

Guarantor Printed Name

_____

Patient or Guarantor Signature

Should you not understand your insurance benefits, please ask our front office.
Please let us know if your insurance has changed in any way!

TRINITY DERMATOLOGY

Patient Preferences Regarding Communication of PHI (Patient Health Information)

Approved HIPAA CONTACTS

Name, Last:_____ Name, First_____ DOB:_____

☐ DO NOT disclose or discuss any information related to my billing account or medical condition with anyone other than myself, except in an emergency situation.

Please list below any person(s) Trinity Dermatology may contact and indicate (by checking the box) if we may discuss any information related to your billing account and/or medical condition. Also, choose the person you would like us to list as your emergency contact in the event an emergency situation was to take place at our office.

Name:_____ Relationship _____ Phone _____

☐ Billing Account Information ☐ Medical Condition Information ☐ Emergency Contact

Name:_____ Relationship _____ Phone _____

☐ Billing Account Information ☐ Medical Condition Information ☐ Emergency Contact

Preferred Method of Communication

☐ I request that communication regarding my medical condition to occur ONLY when I am in the clinic. Please only print and hand me information when I am in the clinic. I DO NOT wish to be notified by any other communication method regarding my medical condition .

My preferred method of communication regarding my medical condition is indicated below (check one):

☐ Home Phone ☐ Work Phone ☐ Cell Phone _____

☐ Mailed Letter ☐ Guardian ☐ Other _____

If the above method of communication is by phone , please check the appropriate box below:

☐ Ok to leave a message with detailed information.

☐ Please leave a message with a call-back number only.

Please note that you are responsible for any charges incurred in receiving our communications.. For example, if you provide a cell phone number as a method of contact, then you are responsible for any charges imposed by your mobile carrier for receiving calls or text messages from the clinic.

Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you want us to call you at a different phone number for a particular test result.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from person not listed on this form will require my specific authorization prior to the disclosure of any medical information

_____ _____

Signature of Patient, Parent or Legal Guardian Date

_____ _____

Name of Legal Guardian Relationship to Patient

TRINITY DERMATOLOGY
Medical, Surgical, Cosmetic and Laser Dermatology

Mark Ray, M.D.
Certified American Board of Dermatology

Jon Pruett, M.D.
Certified American Board of Dermatology

Lisa Guidry Pruett, M.D.
Certified American Board of Dermatology

Julie Nguyen, M.D.
Certified American Board of Dermatology

Sheryl Gyr, P.A.-C.
Certified Physician Assistant

Consent to Obtain External Prescription History

I, _____ , whose signature appears below, authorize The Trinity Dermatology to view my external prescription history via the RxHub service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

_____ _____
Patient Date

_____ _____
Witness Date