ABILENE DERMATOLOGY
AND SKIN SURGERY CENTER, PC

3190 Antilley Rd., Abilene, TX 79606-5015
Phone: (325) 672-5603 Fax: (325) 672-6570

Welcome to Abilene Dermatology and Skin Surgery Center, PC. Our goal is to provide you with the highest quality of treatment and service.

We appreciate you taking the time to complete these New Patient Forms thoroughly to help us maintain accurate contact and medical records. This information is critical to us in assisting you with the care, treatment and management of your dermatological needs.

There are several pages for you to fill out:

The first is a **PATIENT INFORMATION FORM** requesting patient and insurance information. Your signature and date are required.

Next is a **MEDICAL HEALTH QUESTIONNAIRE**. We must know the details of your current and prior medical condition in order to provide you with quality health care. This form is required to be updated on an annual basis. Your signature and date are required.

Next is a page outlining your **FINANCIAL RESPONSIBILITIES** and your rights concerning privacy of your **PROTECTED HEALTH INFORMATION**. Please read these policies and sign and date in both places.

Another page authorizes persons selected by you to receive information regarding your financial account, appointments, pathology results, treatment and/or other information pertinent to your healthcare. The names of any individuals you wish this information released to, signature and date are required.

If you are on Medicare and/or have a supplemental policy or have Tricare, ChampVA, or Triwest, there is an additional page of statements that you must read and sign.

If the patient is a minor there is an additional page for parents/guardians to give permission for Abilene Dermatology and Skin Surgery Center to treat the minor child if they arrive to the office unaccompanied. **Please be aware that a parent must accompany a minor to their first appointment.**

If you printed these forms from our website, you may fax them to us at (325) 672-6570 prior to your appointment, or bring the completed original forms with you to your appointment along with the other items requested below.

If you need assistance completing these forms, our receptionist will be happy to help when you arrive for your appointment.

REMINDERS OF REQUIRED ITEMS
FOR YOUR VISIT

- **Insurance Cards** If you have health insurance, we cannot see you without making a copy of your insurance card.
- **Written Referral** from your Primary Care Physician if required by your insurance plan.
- **Co-pay** or **Deductible** is collected at the time of visit.
- **Cosmetic procedure fees** are due at time of visit
- **Completed Patient Registration Package**
- **Driver's License** or **State Issued Photo ID**
- **Please bring your current medications you are taking**

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PATIENT INFORMATION

PATIENT NAME (FIRST, MIDDLE, LAST)			NICKNAME
MAILING ADDRESS			HOME PHONE NUMBER
			WORK PHONE NUMBER
CITY	STATE	ZIP CODE	CELL PHONE NUMBER
SOCIAL SECURITY NUMBER	DATE OF BIRTH - MM/DD/YYYY	DRIVERS LICENSE # / STATE	PREFERRED NUMBER TO BE REACHED: ☐ HOME ☐ WORK ☐ CELL
SEX: ☐ MALE ☐ FEMALE	MARITAL STATUS S M W D	PREFERRED LANGUAGE	EMAIL (Optional)

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP TO PATIENT
ADDRESS	TELEPHONE NUMBER

PARENT/LEGAL GUARDIAN (if patient is under 18)

PARENT/LEGAL GUARDIAN (FIRST, MIDDLE, LAST)			NICKNAME
ADDRESS			HOME PHONE NUMBER
			WORK PHONE NUMBER
CITY	STATE	ZIP CODE	CELL PHONE NUMBER
SOCIAL SECURITY NUMBER	DATE OF BIRTH - MM/DD/YYYY	DRIVERS LICENSE # / STATE	PREFERRED NUMBER TO BE REACHED: ☐ HOME ☐ WORK ☐ CELL
SEX: ☐ MALE ☐ FEMALE	MARITAL STATUS S M W D	PREFERRED LANGUAGE	EMAIL (Optional)

INSURANCE INFORMATION (PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST)

POLICY HOLDER'S NAME	RELATIONSHIP TO PATIENT	POLICY HOLDER'S SOCIAL SECURITY	POLICY HOLDER'S D.O.B.
POLICY HOLDER'S ADDRESS	CITY	STATE	ZIP

CONSENT FOR EXAMINATION, TREATMENT AND FINANCIAL RESPONSIBILITY AGREEMENT

I hereby consent to and authorize the providers and employees to provide medical care to the patient identified above. If appropriate, I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I understand it is my responsibility to provide current up-to-date insurance information prior to treatment. I also acknowledge that the filing of any insurance claim(s) is NOT A GUARANTEE OF PAYMENT, and that I AM FINANCIALLY RESPONSIBLE FOR PAYMENT if such claim(s) are unpaid or denied by the insurance company. I authorize payment of medical benefits directly to Abilene Dermatology and Skin Surgery Center, PC for services(s) provided to me. I understand I am ultimately responsible for payment of services rendered. I am at least 18 years of age, or if not, I am accompanied by a legal guardian. Delinquent accounts are subject to a collection fees, and reasonable attorney's fees.

If patient is a minor, I hereby cosent that the Parent / Legal Guardian who brings in the minor child will be responsible for all copays and deductibles. I hereby affirm that I am the legal parent or guardian of patient and have authority to make decisions regarding medical treatment.

I authorize Abilene Dermatology and Skin Surgery Center, PC to fax my records to any physician or pharmacy for the purpose of coordinating or managing my healthcare. I understand that photography may be necessary for planning and evaluating treatment, and hereby authorize the taking of photographs at the direction of the physician and/or delegate, solely for documentation purposes and recognize they will be kept confidential unless otherwise disclosed.

SIGNATURE OF PATIENT OR GUARDI	TODAY'S DATE

Name: ____ Date of Birth: ______/______/______

HISTORY AND INTAKE FORM

Past Medical History: (please mark all that apply):

- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Atrial fibrillation
- □ BPH (Benign Prostatic Hyperplasia)
- □ Bone Marrow Transplant
- □ Breast Cancer
- □ Colon Cancer
- □ COPD (Emphysema)
- □ Coronary Artery Disease
- □ Depression
- □ Diabetes
- □ End Stage Renal Disease
- □ GERD (Acid Reflux)
- □ Hearing Loss
- □ **HIV/AIDS**
- □ Hypertension
- □ Hypercholesterolemia
- □ Hyperthyroidism
- □ Hypothyroidism
- □ Leukemia
- □ Lung Cancer
- □ Lymphoma
- □ Pacemaker/Defibrillator
- □ Prostate Cancer
- □ Radiation Treatment
- □ Seizures
- □ Stroke
- □ Valve Replacement
- □ None
- □ **Artficial Joints If so, year __________**
- □ **Hepatitis C**

Other ____

Past Surgical History: (please list all prior surgeries)

Skin Disease History: (please mark all that apply):

- □ Acne
- □ Actinic Keratoses
- □ Basal Cell Carcinoma
- □ Eczema
- □ None
- □ Melanoma
- □ Precancerous (Dysplastic) Moles
- □ Psoriasis
- □ Squamous Cell Carcinoma

Other ____

Do you have a family history of Melanoma? □ Yes □ No
If yes, which relative(s)? ____
Any other family history: ____
If you checked yes, it is recommended and you will be asked to have a total body skin examination which is a fully disrobed exam.

THIS FORM IS CONTINUED ON BACK

HISTORY AND INTAKE FORM
Page 2

Current Medications: (prescribed, supplements/herbs, non-prescribed)

______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Allergies: (medications, latex, food)

____

____

Hospice:
Are you currently in Hospice? □ Yes □ No
If yes, what is your Hospice diagnosis? ____

Social History: (please mark all that apply)

Cigarette Smoking:
- □ Never Smoked
- □ Quit: Former smoker
- □ Smokes less than daily
- □ Smokes daily – cigarettes
- □ Uses tobacco daily

Alcohol Use:
- □ None
- □ Less than 1 drink per day
- □ 1-2 drinks per day
- □ 3-4 drinks per day
- □ 5 or more drinks per day

Language:
- □ English
- □ Spanish
- □ Other: _______________

Race:
- □ White
- □ Black/African American
- □ Asian
- □ American Indian or Native Alaskan
- □ Native Hawaiian/Pacific Islander

__ How many times in past year have you had 5 (for men) or 4 (for women or adults older than 65 years) drinks per day

Ethnicity:
- □ Hispanic/Latino
- □ Non-Hispanic/Latino

Pharmacy:
Name: ____
Street Location: ____
_
Occupation: ____

Email Address: ____

Patient Name: ___________________________________ Date of Birth _____/_____/_____

ADDITIONAL HISTORY AND INTAKE QUESTIONS
AS REQUIRED BY MEDICARE AND
NEW HEALTHCARE REGULATIONS

Who is your primary care provider ______________________________?

Who is your referring provider if not your primary care provider ______________________________?

Adult COVID-19 Vaccination Status (for patients 18 AND older)
Please check all that apply

- □ I have received a COVID-19 Vaccination during 2025.
- □ I have previously received a COVID-19 Vaccination.

Advanced Directives: (for patients 65 AND older)
Advanced Directives are designed to respect your wishes and determine what future life-sustaining medical treatment you would like, if you are unable to indicate those wishes on your own. Key interventions and treatment decisions are: Resuscitation procedures such as cardiopulmonary resuscitation (CPR), and mechanical respiration (breathing tube).

Which statements **best reflect** your wishes on advanced care recommendations?

- □ I want full cardiopulmonary resuscitation efforts to be made. (Full Codes).
- □ I do not wish to have a breathing tube, even if it is necessary to save my life. (Do Not Intubate)
- □ If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart even if necessary to save my life. (Do Not Resuscitate)
- □ I have a living will. (A living will is a document that you have in place that specifies the type of care that you would like to receive in the event that you are incapacitated or names another person to make those decisions for you.)
- □ I have a health care proxy whose name is ______________________________ and whose contact information is ______________________________.

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OFFICE POLICIES AND PATIENT RESPONSIBILITIES

Updated: December, 2024

Thank you for choosing Abilene Dermatology for your skin care needs. It is our goal to provide you with a positive experience. Over the past few years, the practice of medicine has become more complicated for physicians and patients alike. Because of the growing complexity of the insurance business, we feel that we can no longer assume that patients fully understand the relationship between the insurance company, the physician, and themselves. In an effort to clarify this relationship, we have established a set of guidelines regarding financial responsibility and office policies.

We will file your insurance for you if we are in your network

- When making an appointment with one of our providers, it is your responsibility to confirm with your insurance company that the physician/provider is currently under contract with your plan. If your insurance is a plan for which we are not a contracted provider, we are more than willing to provide care but the total cost of your visit will be your responsibility at the time of service.
- It is your responsibility to understand your insurance plan coverage. If you do not understand your policy, you may wish to contact the number on the back of your insurance card to review and verify your benefits. Not all services are a covered benefit in all contracts. Some insurance companies select certain services or diagnosis codes which they will not cover. Our office never guarantees that your insurance will pay for all services. We will make every attempt to file your claim as straightforward and simple as possible. However, if for any reason your claim is denied, you are responsible for the amount due on your account.

Referrals

- With some insurance plans, you may be required to see a Primary Care Physician (PCP) in order to see a dermatologist or other specialist. If your plan requires authorization by a PCP, you must obtain a referral prior to scheduling your visit. If your plan requires a referral and you or your PCP does not provide one by your scheduled appointment time, please be prepared to pay for your visit in full or reschedule.

Copayments, Deductibles and Coinsurance

- A copayment is a set dollar amount you owe for each office visit. All claims are subject to a deductible if a procedure is performed (i.e., biopsy, cryosurgery, MOHS, excisions, etc.). A deductible is the amount you are obligated to pay before your insurance company starts paying for your healthcare costs. Some insurance plans may also have a coinsurance, in which you may be responsible for a percentage of healthcare costs in addition to your copayment or deductible. It is your responsibility to understand your plan and any associated deductible or coinsurance. Payment will be due at time of service if your deductible has not been met or if your plan requires a coinsurance payment. You may be billed for these amounts should your insurance company notify us that additional payment is due from you.

A valid <u>Picture ID</u> and your <u>Insurance Card</u> are required at the time of your office visit

- Without a valid insurance card, we are unable to file a claim to your insurance company and you will be responsible for the day's charges at the time of service.
- It is your responsibility to notify the staff of any changes in your address, phone number and/or insurance plan, and provide a current up-to-date insurance card at each visit. Failure to do so may cause your insurance claim to be rejected, thus making it your responsibility to pay for the total cost of the visit.

Patients Undergoing Skin Cancer Treatment:

- I understand that if I have a skin cancer and that it is my responsibility to seek follow-up care by Abilene Dermatology and Skin Surgery Center, PC personnel or other dermatology professionals. ***Failure to seek follow-up care is my responsibility and I do not hold Abilene Dermatology and Skin Surgery Center, PC personnel professionally or personally responsible for skin cancer follow-up.***

Not Medically Necessary or Cosmetic Procedures

- Your insurance company may deem certain procedures as not medically necessary, or cosmetic. If you and your doctor/provider decide to continue with a procedure that falls into this category, we require payment in full at the time of service. The following are some examples:
  - Removal of benign lesions (i.e., skin tags, angiomas, sun spots or liver spots, cysts, milia, sebaceous hyperplasia, or seborrheic keratoses, etc.)
  - Botox, fillers such as Restylane and Perlane, scar revisions, cosmetic consults, or cosmetic procedures such as chemical peels, microdermabrasions, and laser hair removal, etc.
  - The cost of any procedure will be a separate fee from an office visit or consultation fee.

Additional Charges

- We do our best to get accurate charges in the billing system at the time of your visit. However, there are times that not all codes get entered during your visit. If we find charges that were inadvertently left off your bill, these charges will be sent to your insurance and/or billed out to you.

Prescription Refill Policy

- Abilene Dermatology requires that you are seen at least once a year in order to maintain any prescription given by our providers. These prescriptions have been written to allow the maximum number of refills the providers feel comfortable giving without having to assess your

condition or review or test for side effects. Please keep your follow-up appointments and plan ahead to avoid being without your medication. We do not give prescription extensions if you fail to keep recommended visits.

Laboratory and Pathology Fees

- At times, it may be necessary to obtain a tissue sample (biopsy) or perform lab tests to confirm a diagnosis or determine a course of treatment. If a biopsy or other lab work is done, you will receive a separate bill from the pathologist or laboratory for these tests. If your insurance plan has a preferred provider for blood work or pathology, please notify our office staff prior to any procedure for special handling. Although the lab will file with your insurance, you are responsible for any bill you may receive from the laboratory or pathologist. Please discuss any billing errors or discrepancies with those institutions.

Medical Record Copies

- There is a $25 flat fee for medical record copies up to 100 pages. There is an additional $25 fee for each additional 100-page increment (any number of pages up to 100). This fee covers the cost of our staff and supplies required to make copies.

Check-In

- Your time is important to us. The first step in keeping your appointment on time is being prepared. This includes filling out all required paperwork prior to your first appointment. It is extremely important that you provide each piece of information that is requested on both the Patient Information and Medical History Questionnaire. This will avoid delays in creating your chart and account at your visit. Please arrive at least 15 minutes prior to your scheduled time so that all paperwork may be completed BEFORE you are scheduled to see the provider.

Missed Appointments, Late Cancellations, Late Arrivals and Non-Compliance

- Please keep in mind that appointments are time-slots reserved specifically for you. We require a 24-hour advance notice if you are unable to keep your scheduled appointment. For your convenience, we send out appointment reminders several times prior to your appointment. This reminder also allows you the opportunity to cancel or reschedule the appointment, which in turn enables us to schedule another patient during that time. Please confirm that we have your correct preferred phone number as well as your email address to ensure you receive these reminders. It is still ultimately your responsibility to keep track of your appointments whether you receive a reminder call or not.
- If you miss an appointment without a 24-hour notice or cancel the same day as your appointment a $25.00 cancellation fee may be assessed to your account. Surgery/cosmetic patients who fail to contact us or no-show may have a $50.00 fee assessed to your account. This fee is not billable to your insurance and must be paid **BEFORE** subsequent appointments can be scheduled.
- We do our best to keep to the schedule. When a patient arrives late, it is impossible to stay on schedule. If you arrive more than 15 minutes past your scheduled appointment time, you may be rescheduled so that other patients are not inconvenienced.
- At times, a surgery may take longer than anticipated or a patient has been worked in for an emergency which may cause our providers to run late. You won't be rushed when you see the doctor and your patience is appreciated if we are running behind.
- **Patients with two no shows or late cancellations may be discharged from our practice.**
- **Please note that noncompliance with treatment plans (including medications and/or lab work) and abusive/inappropriate behavior towards staff and/or patients will result in immediate dismissal of your care from our practice.**

Forms of Payment

- We accept payment in the form of cash, check, MasterCard, Visa, Discover and American Express.
- Any checks returned to us due to insufficient funds are processed by Instacheck. In addition to charges assessed by Instacheck, we will assess a $30 fee for all returned checks.

Collection Fees

- We will send you three statements regarding your balance. The second statement is considered past due. If you should receive a third statement noted "Final", the account balance will be turned over to a collection agency. **If your account is turned over to a collection agency, you will be discharged from the practice.**

Minors

- The parent(s) or guardian(s) of minor patients **MUST** accompany the child for the initial evaluation and sign an informed consent to treat the child. Future visits will be covered under this consent. It is the responsibility of the parent or guardian to provide current insurance information and payment in full for services provided, should the child be unaccompanied at future visits. In cases of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those charges. If the divorce decree requires the other parent to pay all or part of the costs, it is the authorizing parent's responsibility to collect from the other parent.

Policy On Electronic Devices

- In observance of the confidentiality rights of other patients and out of respect for the privacy of our employees and physicians, ***please either turn off your cell phone or place it on silent. Video or audio recordings in this office are strictly prohibited.*** You are welcome to take notes during your visit, and please remember that all medically necessary information is documented in detail in your medical record.

I have read, understand and agree to the above office and financial policies of Abilene Dermatology and Skin Surgery Center, PC. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of information necessary for insurance filing by signing this statement. My signature below states my agreement and understanding of the Abilene Dermatology office and financial policies and also serves as a request and consent for treatment. I authorize and assign all benefit payments to be made directly to Abilene Dermatology and Skin Surgery Center, P.C.

Signature of Patient/Legal Representative: ______________________________ Date: ____/____/____

Name of Patient/Legal Representative: ____

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Patient Name: ______________________ ________ ______________________
First Name **MI** **Last Name**

Patient Address: ___________________________ **Home Number:** ____________________

City, State Zip: ___________________________ **Cell Number:** ______________________

HIPAA PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how Abilene Dermatology and Skin Surgery Center, PC may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. The Notice is available to you on our website at www.abilenederm.com and at the front desk at your request. You may review the Notice before signing this consent. As a patient, you have the right to request restrictions on use and disclosure of your health information.

Disclosures of your health information or its use for any purpose other than those listed in our "Notice of Privacy Practices" and/or consent require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Persons Authorized to Receive Information About Your Care:
I authorize Abilene Dermatology and Skin Surgery Center, PC to release all information regarding my financial account, appointments, pathology results, treatment and/or other information pertinent to my healthcare provided by Abilene Dermatology and Skin Surgery Center, PC over the telephone or in person to the following person(s) (i.e. spouse, family member, etc.):

Name of Person	Relationship to Patient	Telephone Number

I do not authorize the following information to be disclosed to any other parties except to me as the patient. (Please specify):
____

Communication:
I authorize Abilene Dermatology and Skin Surgery Center, PC to leave messages in reference to any items that assist in carrying out healthcare operations including appointment reminders, biopsy results, and billing issues.
Home phone: YES NO Cell phone: YES NO Work Phone: YES NO

By signing this form, you acknowledge that you have read and understand our Notice of Privacy Practices and consent to our use and disclosure of protected health information about you for the purpose of treatment, coverage and payment from your health insurance company and overall health care operations. You have the right to revoke this consent in writing with your signature.

Signature of Patient/Legal Representative: ________________________________ Date: ____/____/____

Name of Patient/Legal Representative: ____

Signature of Staff Member: ____ Date: ____/____/____