PATIENT INFORMATION

Patient's Name _____
First Middle Last

Mailing Address _____

City _____ State _____ Zip _____

Preferred Phone _(_____)_____ (cell, home, work)

Alt Phone _(_____)_____ (cell, home, work)

Email Address _____ Place of Birth _____

Date of Birth _____ Sex: Female / Male Social Security # _____

Ethnicity : (***please circle one***)Hispanic, Non Hispanic, Refuse Race _____

Language spoken at home _____

If Married, Name of Spouse _____If Single, Name of Closest Relative _____

Preferred pharmacy (name & street) _____

Who is your Primary Physician? _____ Phone_____

Is it ok to fax office visit notes and results to your PCP? (Please circle) Yes/No

Who referred you to our office? _____

Have we seen another member of your family? Yes / No

If yes, name _____ Relationship _____

INSURANCE – You are responsible for checking your insurance regarding procedures performed

Primary Insurance_____

Insured Name:_____ DOB:_____

Relationship: Self_____ Spouse_____ Parent____

Social Security(if needed to submit claims): _____

MEDICAL CONSENT AUTHORIZATION

The undersigned does hereby authorize Dr. Elaine Miller to administer such treatment, prescribe medication, and perform such surgery as she deems necessary or advisable in the diagnosis and treatment of the patient's condition. I authorize release of medical information to my insurance company.

Signature _____ Date _____

Patient Authorization for Practice to Release Protected Health Information

THIS DOCUMENT CONTAINS IMPORTANT INFORMATION ABOUT YOUR HEALTH INFORMATION. PLEASE READ CAREFULLY.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations, or for other purposes permitted by law. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

The above mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

The state of Texas allows the charge of copying your medical records to be sent to certain entities, such as life insurance policies.

- Leave a voicemail regarding appointments? **YES or NO**
- Leave a voicemail regarding lab and pathology results or any other health care issues? **YES or NO**
- Contact you at your place of employment regarding appointments, lab and pathology results or any other health care issues? **YES or NO**
- If you wish to receive email notifications of appointment reminders or notices of due for follow ups please be aware our emails are HIPAA compliant so only potential risk of lost information is if we have an incorrect email. Please verify email is correct with the front desk. **YES or NO**
- If the patient is a minor, I allow the minor, once an established patient, to be seen without the accompaniment of a parent or guardian. **YES or NO**
- Please list **NAME, RELATIONSHIP AND PHONE NUMBER** of any person(s) you give permission for our office to speak with regarding your medical condition. parents of minors and spouses) **YES or NO**

  THEY MUST BE LISTED FOR US TO SPEAK TO THEM.

- Name: Relationship: Phone:

  _____

  _____

  _____

Expiration date of this authorization: ONE YEAR FROM DATE OF SIGNATURE

By signing this form, you authorize the Practice to use and disclose Protected Health Information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

This authorization was signed by:_____

Sign Name – Patient or Representative **(18 and older must sign for themselves)**

Date_____

Print Name – Patient or Representative

Print name _____

Relationship to Patient (if other than patient): _____

The Dermatology Spot
Elaine Miller, DO
1841 Martin Drive, Suite 200
Weatherford, Texas 76086
817/609-4114
817/609-4116 fax

Please INITIAL :

____ I give Dr. Elaine Miller permission to take a photograph of my face for identification purposes in my chart.

____ I give Dr. Elaine Miller permission to take a picture of my condition/biopsy site for documentation in the chart.

____ I give Dr. Elaine Miller permission to send a picture of my condition/biopsy site to a referring physician to help further the treatment of my condition.

____ I give Dr. Elaine Miller permission to use my picture for education purposes to help further the treatment of my condition with other doctors and medical institutions in the future.

____ I am a patient of Dr. Elaine Miller. I hereby acknowledge receipt of Dr. Elaine Miller's Notice of Privacy Practices. (Located in binder on waiting room table)

____ We regret patients must sometimes wait a lengthy time to be seen by a physician. Due to the high demand of appointments and in order to be respectful of the medical needs of all of our patients please be courteous and call our office promptly if you are unable to attend an appointment. If you are unable to keep your scheduled appointment, we require 24 hour notice. If you miss 2 appointments without proper notification (as mentioned above) we reserve the right to dismiss the patient from care.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name].

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____Date: _____

The Dermatology Spot
Elaine Miller, DO
1841 Martin Drive, Suite 200
Weatherford, TX 76086
817/609-4114
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24 Hour Cancellation and "No Show Fee"

Recognizing that everyone's time is valuable and the appointment time is limited, we ask that you provide a **24 hour notice** if you are unable to keep your appointment. We do ask if you are going to be late to your appointment to let us know ASAP, if you are going to be 15 minutes late or more we will try our best to accommodate you but we may require you to reschedule for another time since you will have missed your entire appointment time by then. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, The Dermatology Spot reserves the right to charge a fee of **$50.00** for each missed (No Show) **regular** appointment and **$100.00** for a **surgery** that is not canceled within a 24 hour notice. "No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. If you miss 2 appointments without proper notification (as mentioned above) we reserve the right to dismiss the patient from our care.

Thank you for your anticipated cooperation.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____

Printed, Last Name, First Name Date

_____

Signature

The Dermatology Spot
Financial Policy

We are happy and thankful that you have chosen us as one of your healthcare providers. As a partner in our relationship, it is important that you understand and agree on our financial policy.

1. We must first understand that our relationship is with you as our patient. Your insurance is a contract between you and your insurance company and possibly your employer. You are responsible to understand your policy and its terms including referrals and pre-certifications necessary prior to your visit.

2. It is your responsibility to provide us with your most current billing information to include: Insurance I.D. Card, address, all available phone numbers, and contact information. If you fail to provide us with the correct insurance information, or if your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of a claim. Most insurance companies have timely filing restrictions; if a claim is not received within 60 days of the date of service, it can be rendered ineligible for payment and you will be responsible for the balance that remains.

3. If we are a participating provider with your insurance, this does NOT mean that all services provided are covered by your insurance. In many circumstances, most procedures "covered" will apply to your deductible. You are responsible to pay any differences in your insurance estimate and what is contracted by your insurance as these numbers are sometimes different.

4. We accept assignment and participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurer with any questions you may have.

5. If you need a referral for your insurance (HMO plans), it is **your** responsibility to obtain the referral from your primary care physician prior to your appointment. If we do not have the referral prior to your appointment, you may elect to be seen but will be considered a cash pay patient and payment will be due at the time of the visit.

6. We will send you a statement on a monthly basis of balances due. These must be paid in full or you must set up a payment plan with the office. If you have an overdue balance, we will collect payment in full before you are seen.

7. Balances may be paid by cash, check, or credit cards (Visa, MC, and Discover). There is a fee of $30 for any returned check.

8. If your account becomes delinquent and is sent to a collection agency full payment of prior charges will be required in order for you to make an appointment.

I have read and understand this Financial Policy.

Signature _____ Date _____

Elaine Miller, DO

Name _____DOB_____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High blood pressure
HIV/AIDS
High cholesterol
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
MOHS surgery – surgeon _____
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Hysterectomy – ovaries removed
Hysterectomy – uterus only
None
Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Contact Dermatitis due to Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None
Other _____

Do you wear Sunscreen? 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 enter all your prescription medications).

Name	***Dosage***	***How often taken***

___ I am not taking any medications at this time_____

___ I have a list for my medications (please attach)

___ I take supplements

MEDICATION Allergies: (Please enter all **MEDICATION** allergies) **NONE**

_____
_____
_____

Gynecological History: Females ONLY

Date of last menstrual period _____/_____/_____

Social History: **(Please circle all that apply)**

Cigarette Smoking:

Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

Alcohol Use:

Alcohol: none
Alcohol: less than 1 drink a day
Alcohol: 1-2 drinks a day
Alcohol: 3 or more drinks a day
****65 years of age or older (Medicare):** Alcohol: how many times in last year have you had 5 (men) or 4 (women) or more drinks in a day _____**

Safety:

I feel safe at home.
I do not feel safe at home

Occupation (If retired, from what?): _____

Review of Systems: Are you **CURRENTLY** experiencing any of the following?
(please check yes or no for the following)

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
FEMALES ONLY – History of irregular menses		
Immunosuppression		
Hay fever		
Chest pain		
Fever or chills		
Night sweats		
Unintentional weight loss		
Sore throat		
Blurry vision		
Abdominal pain		
Bloody stool		
Bloody urine		
Joint aches		
Muscle weakness		
Neck stiffness		
Headaches		
Cough		
Shortness of breath		
Wheezing		
Anxiety		
Depression		

Other Symptoms: _____

Alerts: Do you currently have any of the following?
(please check yes or no for the following)

Alert	Yes	No
Pacemaker		
Defibrillator		
Allergy to lidocaine		
Allergy to topical antibiotics		
Rapid heart beat with epinephrine		
Premedication prior to surgery		
Artificial joints within the past 2 years		
Artificial heart valve		
History of MRSA		
Taking blood thinners		
Pregnancy or planning a pregnancy		
Allergy to adhesive		
Yeast infection with antibiotics		
GI "stomach" upset with antibiotics		
HIV/AIDS		
Hepatitis B		
Hepatitis C		
Allergy to latex		
History of tanning bed use less than 15 times		
History of tanning bed use greater than 30 times		
Height (approximately)	‘ “	
Weight (approximately)	lbs	
Ebola Risk: Fever >=100.4°(F)/38° (C)		
Ebola Risk: Resided or traveled to country with wide-spread Ebola transmission in the last 21 days		
Ebola Risk: Contact with an Ebola patient without proper protective equipment in the last 21 days		
Ebola Risk: Headaches, weakness, muscle pain, vomiting, diarrhea, abdominal pain, and/or hemorrhage		

Other Symptoms: _____