basin DERMATOLOGY

Name: (Last, First, MI)	Age:	Sex: M F	Birth Date:
Street Address:	City:	Zip	SS#
Mailing Address:	City:		Zip:
Home & Cell Phone:	Email Address:		
Employer:	Address:		Work Phone:
Email Address:	Occupation:		Referred by:
In Case of Emergency (Friend or Relative not listed above. ONE MUST BE LOCAL)			
Name (1): (Last, First)	Address:		
Home & Cell Phone:	Work Phone:		Relation:
Name (2): (Last, First)	Address:		
Home & Cell Phone:	Work Phone:		Relation:

Preferred Language_____ Race_____ Ethnicity_____ Marital Status_____

Assignment of Benefits

I authorize Basin Dermatology to release any medical information that may be necessary to process medical/surgical claims for myself or my dependents. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and other health plans to issue payments on my behalf to Basin Dermatology. I understand that I am responsible for amounts not covered by insurance. This order will remain in effect until revoked by me in writing.

_____ _____

DATE SIGNATURE of PATIENT (or Parent/Legal Guardian if Patient is a minor)

History form

Patient: _____ DOB: _____

Primary Care Provider: _____

Reason for today's visit:

_____

What treatment have you used for the problem? _____

_____

Have you seen a doctor for this before? ____ Yes ____ No When? _____ Treatment_____

Are you allergic to any Medications ____ Yes ____ No If yes, list below:

_____

List all medications you are currently taking (including dosage, prescriptions, over-the-counter, vitamins):

_____

_____

Do you have now, or have you ever had any of the following: (please check yes or no)

Hay Fever	____ Yes ____ No	Hepatitis	____ Yes ____ No
Asthma	____ Yes ____ No	HIV (AIDS)	____ Yes ____ No
Heart Disease	____ Yes ____ No	Diabetes	____ Yes ____ No
Pacemaker	____ Yes ____ No	Thyroid Disease	____ Yes ____ No
Bleeding Tendency	____ Yes ____ No	Kidney Disease	____ Yes ____ No
Artificial Joint	____ Yes ____ No	Seizures	____ Yes ____ No
Depression	____ Yes ____ No	Organ Transplant	____ Yes ____ No

Skin:

Have you ever had Skin cancer? ____ Yes ____ No

Basal Cell carcinoma: Location: _____

Squamous Cell Carcinoma: Location: _____

Melanoma: Location: _____

Has anyone in your family had Melanoma Skin Cancer? ____ Yes ____ No Who _____

Do you have a history of eczema (atopic dermatitis)? ____ Yes ____ No

Do you have a history of any other specific skin diseases? ____ Yes ____ No What _____

Never smoker ___ Former smoker ___ Currently daily Smoker ___ Current someday smoker ___

Have you ever used a tanning parlor? ____ Yes ____ No

What is your Height _____ Weight _____

Have you had pneumonia vaccine ? ____yes ____ No

Have you had the Flu Vaccine ? ___yes ____No

Preferred pharmacy: _____

Do you have a healthcare proxy, power of attorney and/ or a living will?

Yes ___ Name_____ Relashionship_____ Phone_____

No ___

For Women Only: Are you pregnant or trying to get pregnant? ____ Yes ____ No Due Date: _____

I understand that if I am trying to get pregnant or I become pregnant I will stop all oral and topical medications you have prescribed and contract this office. Please initial here _____ sign _____ date_____

SOCIAL MEDIA INFORMED CONSENT

I, _____, hereby give Basin Dermatology permission to take photographs, videos, and testimonials of me for the purpose of marketing on Basin Dermatology's social media sites including Facebook, Instagram, and their clinic website.

I hereby release and discharge Basin Dermatology from any and all claims arising out of use of the photos and videos.

In signing this consent, I give authorization to use my photos and videos.

Patient's printed name:_____
Signature: _____ Date: _____

If patient is a minor:
Parent/Legal Guardian's name: _____
Signature: _____ Date: _____

Financial Policy

Thank you for choosing Basin Dermatology as your healthcare provider. Our offices are committed to providing the best medical care through communication and understanding. Confirmation and updating of personal address and phone/cell numbers for contact will assure our ability to communicate with you. At any time, you have questions or concerns requiring further information, whether it is medical or business, our staff is available to assist you.

The following information outlines our policies regarding payment of your doctor's bill.

The cost of medical care is determined by the nature of complexity of the illness. There is no "flat rate" for examinations and treatment. You are given an **estimated** amount at the time of visit before checkout. After reviewing the physicians/providers documentation for the visit additional services/procedures may be added to the visit.

Out-Of-Network Insurance Patients will be expected to pay the Out-Of-Network deductibles and coinsurance at the time services are rendered. Basin Dermatology will file with your insurance company as a courtesy.

In-Network Insurance Patients at each visit, your current insurance card(s) will require a presentation when "signing in" at the front desk. The patient will be responsible for any co-payments, deductibles, co-insurance or non-covered services at the time of the visit.

Non-Insured Patients will be expected to pay in full the total charges for the services rendered. We do offer a discount for our non-insured patients.

A statement of your unpaid balance plus additional services not covered by insurance will be sent to you for full payment within 30 days. To avoid collections procedures your account must be kept current. If the account is sent to collections, then the physician/patient relationship is terminated.

Patient Name Print_____

Patient or Legal Guardian Signature_____

Date_____

basin DERMATOLOGY

CANCELLATION POLICY/NO SHOW POLICY
FOR DOCTOR APPOINTMENTS & PROCEDURES

1. **Cancellation/No show for Doctor appointment**
    a. We understand that there are times when you miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not canceled at least 24 hours in advance you will be charged a $50.00 fee; this will not be covered by the insurance company. A patient who is a no show more than three(3) times is dismissed from the practice.

2. Scheduled appointments
    a. We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

Patient Name print _____

Patient or Legal Guardian Signature_____

Date_____

Health Insurance Portability and Accountability Act

ACKNOWLEDGEMENT OR RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the acknowledgement and consent

This acknowledgement of notice and consent authorizes **Basin Dermatology** to use and disclose health information for treatment, payment, and health care operations purposes.

Notice of Privacy Practices. **Basin Dermatology** has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

Consent to Treatment. I voluntarily consent to receive medical and health care services provided by **Basin Dermatology**, employees and such associates, assistants, and other health care providers. I understand that such service may include diagnostic procedures, examinations, and treatment. I understand photographs, videotapes, digital and/or images may be made/recorded for treatment and payment purposes only.

I acknowledge that **Basin Dermatology** may use health information exchange systems to electronically transmit, receive and /or access my medical information which may include, but is not limited to, treatment, prescriptions, labs, medical and prescription history, and other health care information.

Please mark if you agree to accept artificial messages by:

Phone calls ☐ Yes ☐ No **Text Messages** ☐ Yes ☐ No **Emails** ☐ Yes ☐ No

Authorization Form For Release of Protected Health Information

We are required by law and regulations to protect the privacy of your medical information. Without this form signed by a patient, or an agent given medical power of attorney, your private health information and/or treatment will not be discussed.

By signing this form, I authorize you to use and disclose the protected health information described below.

The health information you may release subject to this authorization is as follows:

☐ All Medical ☐ All Financial ☐ Other: _____

release my protected health information to the following person(s)/entity:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person: **Basin Dermatology Compliance Office: Tammy Rowell, 4214 Andrews Hwy, Ste 110, Midland, TX 79703 Telephone: 432-689-2491 Fax: 432-699-1158**

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. I have reviewed **Basin Dermatology** Notice of Privacy Practices. **Basin Dermatology** is authorized to use and disclose health information about patients listed below for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practice. **The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure. As a best practice policy for Basin Dermatology we require all forms to be updated annually.**

Patient Name_____ Date of Birth_____ Date_____

_____ _____ _____

Signature of Patient Signature of Personal Representative Relationship to patient

(Basin Dermatology policy we require all information forms be updated annually)