The Skin Center of San Antonio

Welcome to Our Office!

Patient Information

☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

Patient Name: Mr. Mrs. Ms. Dr._____ **Date** ___/___/_____

Age _____ **DOB** _____/_____/_____ **Gender:** F M

Marital Status: S M W D **Driver's Lic. #** _____ **SSN:** _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

Phones: home: ____/____/_____ cell: ____/____/_____

Email: _____

Occupation: _____ Employer / School: _____

Employer's address: _____

City: _____ State: _____ Zip: _____ work phone: ____/____/_____

Guardian / Emergency Contact: _____ Relation: _____

Phone: home: ____/____/_____ cell: _____/_____/_____ work: _____/_____/_____

Preferred Pharmacy: _____ at _____ Phone or Fax: _____

Personal Physician

Physician's Name: _____

Address: _____ Phone: ____/____/_____ Fax: ____/____/_____

Referral required: Yes No

How did you hear from us?

☐ Doctor: _____
☐ Friend / Family: _____
☐ Community Newsletter: _____
☐ Insurance : _____
☐ Magazine: _____
☐ Internet / Website: _____
☐ Newspaper: _____
☐ Other :

How can we reach you?

If we need to contact you regarding appointments, results, medications and/ or any other general information about our practice, we may:

Call or leave a message on answering machine or voicemail	YES	NO	Call Work	YES	NO
Contact you by email	YES	NO	By mail	YES	NO

Besides your emergency contact, with whom may we share your medical information? _____

Relation: _____ phone: _____/_____/_____

At **The Skin Center of San Antonio** we strive for excellence and we want to keep our patients well informed on the most current information.

Will you like us to send you information or notifications about?

New medical treatments?	YES	NO	New Aesthetic products and services?	YES	NO
New information on medical condition?	YES	NO	Office specials or special events?	YES	NO
Clinical Trials?	YES	NO	Office Surveys or questionnaires?	YES	NO

Insurance Information

Patient's Name: _____ **DOB:** ____/____/_____ **Date:** ____/____/_____

Primary Insurance: _____

Policy Number: _____ Group Number or Name: _____

Subscriber's Name: _____ DOB: ____/____/_____ SSN: _____/_____/_____

Subscriber's Relationship to patient: _____ Employer: _____

Secondary Insurance: _____

Policy Number: _____ Group Number or Name: _____

Subscriber's Name: _____ DOB: ____/____/_____ SSN: _____/_____/_____

Subscriber's Relationship to patient: _____ Employer: _____

Preferred Pharmacy: _____ at _____

Phone: _____/_____/_____

Please complete ONLY if someone other than the patient is financially responsible:

Responsible party: _____ **Relationship to patient:** _____

DOB: ____/____/_____ Gender: F M Marital Status: S M W D SSN: _____

Driver's License: _____ Home Address: _____

City: _____ State: _____ Zip: _____

Phone: Home ____/____/_____ Cell: ____/____/_____ Email: _____

Occupation: _____ Employer: _____

Employer's address: _____

City: _____ State: _____ Zip: _____

Work phone: ____/____/_____

The Skin Center of San Antonio

Welcome to Our Office!

Patient Name _____ Age _____ Date _____/_____/_____

Conulting Physician:. _____

Main reason for today's visit: _____

When and where did it first start? _____

Have you or your doctor tried anything? NO YES explain _____

Skin History

Do you or family member has or ever had the following: ***(check all that apply; if checked, please explain briefly)***

	Self	Relative	Explain Briefly
Basal Cell Carcinoma	☐	☐	_____
Squamous Cell Carcinoma	☐	☐	_____
Melanoma	☐	☐	_____
Abnormal or changing mole	☐	☐	_____
Psoriasis	☐	☐	_____
Eczema, allergies, asthma	☐	☐	_____
Excessive sweating	☐	☐	_____
Acne or Rosacea	☐	☐	_____
Accutane (isotretinoin)	☐	☐	_____
Slow healing	☐	☐	_____
Thick scars/ keloid	☐	☐	_____
Nail or hair problems	☐	☐	_____
Other	☐	☐	_____

Patient's Medical History and Medications (include **all** prescription, over the counter, herbs/supplements):

Do the patient has or ever had the following:

- ☐ Heart problem _____
- ☐ Irregular heartbeat _____
- ☐ High blood pressure _____
- ☐ Heart murmur _____
- ☐ Blood clots / phlebitis _____
- ☐ Artificial heart valve _____
- ☐ Pacemaker/ defibrillator _____
- ☐ Epilepsy/ Seizures _____
- ☐ Stroke _____
- ☐ Frequent or severe headache _____
- ☐ Bleeding problems _____
- ☐ Anemia _____
- ☐ Kidney problems _____
- ☐ Hemodialysis _____
- ☐ Liver problems / hepatitis _____
- ☐ Lung problems _____
- ☐ Sun sensitivity _____
- ☐ Cancer _____
- ☐ Chemo/ Radiation _____
- ☐ Depression, Bipolar Disorder _____
- ☐ Anxiety, Hyperactivity _____
- ☐ Lupus/ Sjogrens _____
- ☐ Stomach/ bowel problems _____
- ☐ Reflux / stomach ulcer _____
- ☐ Difficulty swallowing _____
- ☐ Urologic / Genital problems _____
- ☐ Cyst in Ovaries _____
- ☐ Endometriosis _____
- ☐ High blood sugar / diabetes _____
- ☐ High Cholesterol / Triglycerides _____
- ☐ Thyroid problems _____
- ☐ Arthritis/ Joint pain/ Gout _____
- ☐ Artificial joint _____
- ☐ HIV / AIDS _____
- ☐ Sexual Transmitted disease _____
- ☐ Fingers turn color when cold _____
- ☐ Difficulty swallowing _____
- ☐ Nasal allergies / Sinus / Asthma _____
- ☐ Eye problem _____
- ☐ Faint / Dizzy spells _____
- ☐ Transplant _____
- ☐ Cold sores _____
- ☐ Recurrent Infections/ MRSA _____
- ☐ Other:

MEDS:

Allergies & Skin Reactions (include medications, supplements, foods, plants, pollen, creams, perfume, bandages, latex, animals, etc..)

_____

_____

Surgeries / Hospitalizations (please include cosmetic and elective surgeries and procedures)

Reason	Dates
_____	_____
_____	_____
_____	_____
_____	_____

Any bad reactions to anesthesia?	YES	NO
Nausea, vomiting, diarrhea or yeast infections when taking antibiotics?	YES	NO
Need for antibiotics prior to dental procedures?	YES	NO

Female Patient History

Currently pregnant?	YES	NO	Breastfeeding?	YES	NO	Postmenopausal?	YES	NO
Trying to conceive?	YES	NO				Had hysterectomy?	YES	NO
Regular periods?	YES	NO	Date of last period: ____/____/_____			Had tubal ligation?	YES	NO
Using contraceptives or hormones?	YES	NO				Husband had vasectomy?	YES	NO
Which one _____								

Patient Social History

Do you...			How much or often per week?
Smoke/ use tobacco?	YES	NO	_____
Use recreational illegal drugs?	YES	NO	_____
Use a tanning bed?	YES	NO	_____
Use sunscreen?	YES	NO	_____
Alcohol?	YES	NO	_____

Present work or occupation? _____

Types of work done in the past? _____

Any hobbies?	YES	NO	Which?	_____	
Play any sports?	YES	NO	Which?	_____	
Exposed to any pets, animals?	YES	NO	Which?	_____	
Lived abroad or traveled in the last 2 years?	YES	NO	Where?	_____	
How many household members live with you?	0	1	2	3	4 or more
Are you a caregiver?	YES	NO			

Any other skin problem you will like to address at a later date? YES NO _____

Dermatologists recommend at least a **yearly** skin cancer check. Will you like to schedule for a skin cancer check at a later date? YES NO

Are you interested in learning more about our dermatology **aesthetic** services? YES NO

Botox	Fillers	Collagen stimulation	Sculptra	Skin Tightening	Chemical Peels	Microdermabrasion
Scar Improvement		Under-Eye Circles	Enlarged Pores	Facial Veins	Leg Veins	Cellulite
Laser Rejuvenation		Liquid Facelift	Fat Reduction			

The above information is accurate and complete to the best of my knowledge.

X _____ _____

Name of Patient or Guardian Signature

Update: / / By:

Update: / / By:

Update: / / By:

The Skin Center Of San Antonio

ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information (PHI). It discusses your rights as a patient and The Skin Center of San Antonio's duties with respect to your PHI. Our *Notice of Privacy Practices* is available on our website and is also prominently displayed in our reception area. You will be furnished with a printed copy upon request. If we change our *Notice*, you may obtain a revised copy by contacting our office or downloading it from our website: ***www.skincentersa.com*** ***I have received the Notice of Privacy Practices and have been provided with an opportunity to review it.***

X_____ _____ _____

Signature of Patient or guardian **Date of Birth** **Date**

_____

Printed name of Patient or guardian (attach supporting documentation)

CONFIDENTIAL COMMUNICATIONS NOTICES

We highly value your right to privacy. Please be aware that it is our policy to call both your home and cell phone numbers in order to:

1. Confirm Appointments
2. Leave medical instructions and information
3. Leave messages pertaining to laboratory and biopsy results
4. Return your calls

Use of email: The Skin Center of San Antonio, as my Health Care Provider, may use the e-mail address provided and consented by you on the attached patient registration form, to contact me concerning products, services, therapies, results, procedures or treatments. I understand that my e-mail address may be considered individually identifiable health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and as such could be used to identify me as patient of The Skin Center of San Antonio. I release The Skin Center of San Antonio from any liability that may be incurred from the use of my e-mail address to contact me concerning health-related products, services, therapies, results, procedures and treatments. This authorization is effective from the date of its signing and terminates upon the first to occur: (1) my death or, (2) upon my written revocation actually received by The Skin Center of San Antonio. By signing this authorization, I acknowledge that the information used or disclosed pursuant this authorization may be subject to re-disclosure and thus no longer protected by the HIPAA rules.

FINANCIAL, PAYMENT AND REFERRAL POLICY

Your clear understanding of our Financial, Payment and Referral Policy is important to our professional relationship; please understand that payment for services is an integral part of that relationship. Do not hesitate to ask a member of our staff for clarification regarding payment, fees, benefits and eligibility. Please read and sign at the end to acknowledge that you have read, understand and agree to comply with each of our office's policies.

☐ **Payment policy:** As a courtesy to our patients we will submit your insurance on your behalf, but regardless of insurance coverage, payment responsibility for services rendered by The Skin Center of San Antonio ultimately belongs to the patient (parent, guardian, insured, etc.).

☐ **Insurance Claims:** Please remember that your insurance policy is a contract between you and your insurance company, therefore it is the patient's responsibility to know how their benefits work. Please make sure that our office has a copy of all current primary and secondary insurance cards and, as a courtesy, we will file your insurance claims for you. At the time of your visit we will collect any applicable co-pay, coinsurances and/or deductibles. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits.

☐ **Patients without Insurance Coverage or Out-of-Network Coverage:** You will be responsible for services not payable by your insurance company. For your convenience we accept many forms of payment, including cash, checks, debit cards, VISA, MasterCard, American Express and **CareCredit** financial. Patients with no insurance are personally responsible for full payment of medical care at the time service is rendered.

☐ **Labs/Outside Testing:** In the event that your visit includes biopsies, lab tests, or cultures, the specimen(s) will be sent out for processing and or testing. You may receive separate billings from the laboratory performing the service; any questions regarding this bill should be directed to the billing department at the lab where services were rendered.

☐ **Outstanding Balance:** It is your responsibility for all invoices being payed in a timely manner. It is our office policy that all past due accounts be sent two statements. If payment is not made on this account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to a collection agency and it is possible that the doctor may not continue to provide you with medical services.

☐ **No Show and Late Cancellation:** Your appointment represents an amount of time set aside specifically for you. We understand that at times it is necessary to change an appointment; please give our office as much advanced notice as possible so we are able to change your schedule accordingly. It is our office policy that a cancellation fee will be charged from any ***procedure*** deposit amount if you no-show, cancel or reschedule your procedure with less than 48 hours notice. We may reserve the right to terminate a patient that habitually no-shows, reschedules and/ or cancels appointments.

☐ **Minors, Incompetent Adults and Adult Students covered by Parent's insurance:** A parent or legal guardian must accompany all children under the age of 18. In case of a legal guardian consenting for a minor or incompetent adult, he must bring supporting documentation in order to render services. In the case of divorced parents, the parent bringing the child in for service is responsible for the bill. However, if the patient is over 18, you are responsible for your bill unless any other arrangements were made *prior* to the appointment.

☐ **Termination:** We are happy to serve all our patients regardless of gender, race, religion or financial means but The Skin Center of San Antonio reserves the right to terminate any patient showing disruptive and/ or disrespectful conduct, non-compliance with medical advice and / or treatment, or non-compliance with our office policies.

☐ **Referral Policy:** If you have an insurance plan that requires a referral, ***it is your responsibility to obtain an up-to-date referral from your primary care physician before your appointment.*** If you are an established patient,it is your responsibility to notify us of any changes in your insurance status so that a proper referral can be obtained. If a referral has not been received by the time of your appointment, there are two options available to you:

1. Reschedule your visit until a current referral can be obtained.
2. Pay privately for the visit and we will reimburse you if a referral is received after your visit.

If you are unsure about your benefits or our referral policy, please ask our receptionist who will gladly help you.

☐ **Authorization, Assignment and Financial Responsibility:** I authorize the release of any medical information to process insurance claims on my behalf. I understand that I am financially responsible for all charges and that I am responsible for obtaining referrals as stated above. I request that my medical insurance carrier make any payment directly to The Skin Center of San Antonio, PLLC for services rendered to me. As a courtesy, my charges will be filed with my insurance carrier; however, I will be billed if the claim is denied or is not paid in a timely manner.

I authorized the payment of medical or other benefits for all such services to be paid to The Skin Center of San Antonio, PLLC. My signature below indicates that I have read and I am in agreement with the above mentioned office policies.

X_____ _____/_____/_____

Signature of Patient or legal guardian **Today's Date**

_____

Printed name of Patient or Legal guardian (attach supporting documentation)

Rev 8-2010

General Consent to Treatment *(if patient is a minor or is legally incompetent fill the appropriate consent)*

I consent to the performance of those examinations, diagnostic procedures, laboratory tests and rendering of treatment by the medical provider and her designated medical office staff as deemed necessary in the medical provider's judgment. I consent to treatment in the event the physician finds routine dermatologic treatment necessary (i.e. skin biopsy, destruction, clipping, injections, etc.). As with any treatment, I am aware that complications and side effects can occur (i.e. bleeding, infections, scarring, pain, recurrence, etc.). I authorize Skin Center of San Antonio to take photographs / videos as deemed necessary for documentation and medical record completion purposes only and will not be released without my prior authorization. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees can be made or implied as to the outcome of treatment.

_____ _____ ____/____/____

Patient or legal guardian name **Signature** Date

Consent to Treat Minors

I, the undersigned parent / legal guardian of **(patient name)** _____ listed above authorize the physician and assistants of Skin Center of San Antonio, PLLC to provide health services to this minor in the absence of a parent or legal guardian. This health service may include, but is not limited to, examinations, diagnostic procedures, laboratory tests, and rendering of treatment by the medical provider and her designated medical office staff as deemed necessary in the medical provider's judgment. I consent to treatment of this minor in the event the physician finds routine dermatologic treatment necessary (i.e. skin biopsy, destruction, clipping, injections, etc.). As with any treatment, I am aware that complications and side effects can occur (i.e. bleeding, infections, scarring, pain, recurrence, etc.). It is understood that this consent is given in advance of any specific diagnosis or treatment being required and is given to encourage and allow the physician to exercise her best judgment as to the requirements of such diagnosis or medical treatment in my absence. I authorize The Skin Center of San Antonio, PLLC to take photographs / videos as deemed necessary for documentation and medical record completion purposes only and will not be released without my prior authorization. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees can be made or implied as to the outcome of treatment. The consent shall remain in effect until revoked in writing by parent or legal guardian or until child may legally consent for himself or herself.

_____ _____ ____/____/____

Name of Parent or legal guardian **Signature** Date

Practice Policies Consent

I have Read, Understood, Acknowledge & Consent to the following:

Notice of Privacy Practices
Confidential Communication Notice
Financial, Payment & Referral Policy
Authorization for Release of Records
Authorization for Use & Release of Photographs Yes No

_____ _____ ____/____/____

Name of Patient or legal guardian **Signature** Date

The
Skin Center
Of San Antonio

SkinCenterSA

Authorization for Release of Records

Patient Name: _____ DOB: _____ / _____ / _____

Release records:

☐ To Skin Center of San Antonio
☐ From 10007 Huebner Rd Suite 102
San Antonio TX 78240

FAX : 210-695-7730

☐ To Organization/ Name: _____
☐ From Address: _____
_____
_____
Phone: _____ Fax: _____

Records to release:

- ☐ Complete record
- ☐ Lab reports
- ☐ Biopsy results
- ☐ Progress notes
- ☐ Specific portion
  From _____ / _____ / _____
  To _____ / _____ / _____
- ☐ Other

Reason to release:

- ☐ Consultation
- ☐ Continue medical care
- ☐ Personal
- ☐ Insurance
- ☐ Second Opinion
- ☐ Legal purposes
- ☐ Social Security / Disability (provide copy of SSA letter)
- ☐ Emergency / Acute Care
- ☐ Other / Specify: _____

Method of release:

- ☐ Call me when records are ready to pick up
  Phone: _____
- ☐ Mail records to above address
- ☐ Please fax my records
- ☐ Other: _____

Fax to SCSA: 210-695-7730

I understand that the information released may include information related to communicable disease, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV), genetic testing or screening, treatment or history of drug or alcohol (substance) abuse, behavioral or mental or psychiatric care, or any such related information. I understand that this authorization is voluntary and I may refuse to sign. I also understand that to the extent any recipient of this information, as identified above, is not a "covered entity" under Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the recipient and, therefore may be subjected to re-disclosure by the recipient. I further understand that my health care and the payment of my health care will not be affected by my completion of this form. I may inspect or copy the information to be used or disclosed.

The Skin Center of San Antonio, PLLC may charge a processing fee for this service. This authorization is valid by law for 6 months from the date of this authorization unless I otherwise specify. This authorization will be in effect until _____ (date or event). I may revoke this authorization at any time by notifying The Skin Center of San Antonio, PLLC in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____ ____ / ____ / ____
Printed name of Patient or representative **Signature of Patient or representative** **Date**

_____ **or** _____
Relationship to Patient **Legal Authority (attach supporting documentation**

Rev 11-2014