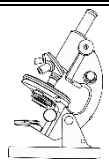


SKIN CANCER SURGERY CENTER
AT PLANO DERMATOLOGY

NEW PATIENT INFORMATION FORM

Date: _____ Date of Birth: _____ / ____/ _____

Name of Patient: _____ **Sex**: □ Male or □ Female
Last First MI

Home Address: _____
Street City / State Zip

Home (____) _____ **Cell** (_____) _____ **Work** (_____) _____

Call preference: □ Home □ Cell □ Work **Email Address**: _____

SS# _____ / _____ / _____ **Marital Status**: □ Minor □ Single □ Married □ Divorced □ Widowed

Driver's License #: _____ **State**: _____
Occupation:_____ **Work #:** (_____)_____

Race: □ American Indian / Alaska Native □ Asian □ Black / African American □ White
□ Native Hawaiian / Other Pacific Islander □ Other: _____

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino Language: □ English □ Spanish □ Other

Name of Dermatologist referring you: _____ Phone #: _____

In the event of an emergency, whom should we contact?

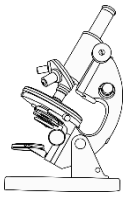
Name: _____ Relationship: _____

Phone #: _____ Cell #: _____

INSURANCE INFORMATION

Primary Insurance: _____
Insurance Address: _____
_____
Ins. Phone #: _____
ID #: _____
Group #: _____
Policy Holder: _____
Insured's Address: □ same as above
_____
_____
D.O.B.: _____
SS#: _____
Relationship to patient: _____
Sex: Male or Female
Employer: _____

Secondary Insurance: _____
Insurance Address:_____
_____
Ins. Phone #: _____
ID #: _____
Group #: _____
Policy Holder: _____
Insured's Address: □ same as above
_____
_____
D.O.B.: _____
SS#: _____
Relationship to patient: _____
Sex: Male or Female
Employer: _____



Name: _____

SKIN CANCER SURGERY CENTER
AT PLANO DERMATOLOGY

D.O.B.: _____

HEALTH HISTORY FORM

What is the purpose of your visit today? _____

Preferred Pharmacy Name: _____ Phone: _____

Pharmacy Location: Address or intersection: _____

Please check yes or no if you have or have had any of the following:

	Yes	No		Yes	No
COPD	□	□	Diabetes	□	□
Kidney Problems	□	□	Organ Transplant: _____	□	□
Dementia	□	□	Bone Marrow Transplant	□	□
Psychiatric care	□	□	Hypertension	□	□
HIV/AIDS	□	□	Chest Pain / Angina	□	□
Hepatitis B	□	□	Cardiac Stent Date: _____	□	□
Hepatitis C	□	□	**Defibrillator**	□	□
Keloids / Hypertrophic Scars	□	□	**Pacemaker**	□	□
Skin Cancer: (*prior to this time*)	□	□	Blood Clots	□	□
Basal Cell Carcinoma	□	□	DVT	□	□
Squamous Cell Carcinoma	□	□	Stroke	□	□
Melanoma	□	□	TIA	□	□
Other	□	□	Requires Oxygen	□	□
Women: Are you pregnant?	□	□	**Artificial Joints Date(s): _____**	□	□
Are you nursing	□	□	Heart Valve problems	□	□
Low platelets	□	□	Artificial heart Valve	□	□
Bleeding disorder	□	□	Cirrhosis	□	□
Rheumatic Fever	□	□	Shingles	□	□
Asthma	□	□			

Have you had Mohs Surgery before: □ Yes □ No By Dr. _____ Date(s):_____

Family history of Skin Cancer: _____

Other medical problems / Previous Surgeries: _____

_____

_____

Medications, vitamins, and herbal supplement taken: _____

_____

_____

Circle if you are taking: *Aspirin Plavix Effient Pradaxa Ticlid Ibuprofen Heparin Lovenox Coumadin (Warfarin)*

(last INR: _____ Date: _____)

List Medication Allergies: _____ **Are you allergic to latex? Yes NO**

Height: _____ **Weight:** _____

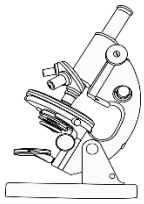
Do you live in a nursing home or assisted living facility? □ Yes □ No Name of facility: _____

Phone #:_____ Do you live alone? □ Yes □ No

Do you smoke? □ Yes □ No **Do you use smokeless tobacco?** □Yes □ No

Do you drink alcohol: □ Yes □ No **(Drinks / day: _____)**

Is the patient able to give informed consent? □ Yes □ No If no, Name / Phone of P.O.W.: _____



SKIN CANCER SURGERY CENTER
AT PLANO DERMATOLOGY

Name: _____
D.O.B.: _____

PATIENT FINANCIAL POLICY

PATIENT FINANCIAL POLICY

Thank you for choosing our office for your care. In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any question regarding this policy, please discuss them with our Insurance Specialist. We are dedicated to providing the best possible care and service to you and regard your complete understanding of the policy as an essential element of your care and treatment.

Your insurance policy is a contract between you and your insurance company only. If you fail to notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company.

If you have out-of-network benefits, we will be happy to assist you with filing the claim. Therefore, our charges for your care and treatment are due at the time of service. In the event your health plan determines a service is "not covered," "not medically necessary" or a "cosmetic procedure" you will be responsible for the complete charges.

Although benefits may be verified at time of service, please note this is not this is not a guarantee of payment.

Patient balances are due within 30 days of receipt of statements. At that point, additional charges may be applied. We will work with you to make payment arrangements. If these efforts do not result in resolution of the account, the account may be referred to a collection agency; you will be responsible for any and all fees charged by the collection agency. These fees will be added to your account.

If your insurance plan denies payment for any reason, you will be responsible for payment. It is your responsibility as the patient to pay the denied amounts in full.

If you need laboratory services (pathology, wound culture), you will receive a separate bill from the pathology laboratory for said tests.

PAYMENT POLICY: *It is my responsibility to confirm that the physician is a covered provider under my insurance plan.* I hereby authorize the assignment of benefits (payments) directly to **Eric S. Hollabaugh, MD, Edward L. Parry, MD, Gunjan M. Modi, MD, and Michael J. Wells, MD., for** all my insurance claims related to services received. I understand that I am financially responsible for services provided which are to be paid on the day services are rendered. This includes co-payments / deductibles with any managed care contract and non-covered services. I have read, understood, and agree to the financial and cancellation policies above.

Signed (insured person) _____ Date _____

AUTHORIZATION TO PAY BENEFITS PHYSICIAN: I hereby authorize Skin Cancer Surgery Center at Plano Dermatology to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit to insurance companies.

Signed (insured person) _____ Date _____

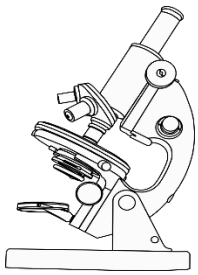
MEDICARE PATIENTS ONLY:

MEDICARE RELEASE: I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf. Photocopy shall be valid as original.

Signed (insured person) _____ Date _____

SECONDARY INSURANCE RELEASE: For patient with SECONDARY insurance, a separate signature is needed. I request benefits be made on my behalf for services rendered. I authorize to be released to my Insurance carrier any information needed to determine benefits.

Signed (insured person) _____ Date _____



Name: _____

SKIN CANCER SURGERY CENTER
AT PLANO DERMATOLOGY

D.O.B.: _____

COMMUNICATION RELEASE AND NOTICE OF PRIVACY PRACTICES:

May we leave personal medical information on your answering machine or cell phone? □ **Yes** **or** □ **No**

If yes, please list the best number _____

May we email personal medical information to you? □ **Yes** **or** □ **No**

Email Address: _____

If you checked email regarding medical communications, you authorize us to send you information that is not encrypted.

Do you give our office permission to discuss your medical information with family members or friends? □ **Yes** **or** □ **No**

If yes, please provide their names below.

I authorize **Skin Cancer Surgery Center at Plano Dermatology** to disclose my medical information pertaining to my diagnosis and / or treatment, laboratory results, medical history, or any other such related information to these listed below (physician, family members, and friends):

Name	Phone #	Relationship
Name	Phone #	Relationship
Name	Phone #	Relationship

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand and authorize release of this information to other health care providers associated with my care to facilitate further health care treatment. I further understand that requests for medical information from persons not listed above will require specific authorization prior to the disclosure of my medical information.

Privacy Policy:

Eric S. Hollabaugh, M.D., Gunjan M. Modi, M.D., Micheal J. Wells, M.D., and Edward L. Parry, M.D., maintain complete compliance with all HIPAA regulations regarding privacy and protection of patient medical and financial information. In accordance with HIPAA guidelines, presentation of your insurance card as payment for your services, allows **Eric S. Hollabaugh, M.D., Gunjan M. Modi, M.D., Michael J. Wells, M.D., and Edward L. Parry, M.D.** permission and authorization to file claims electronically and to release private medical information concerning your claims to your insurance company. You will be presented with a copy of our HIPAA privacy policy at your first visit to our office.

_____

Signature of Patient / Legally authorized representative **Date** **Relationship**

_____

Print Name **Date**