TEXAS DERMATOLOGY ASSOCIATES, P.A.

PATIENT REGISTRATION

PATIENT INFORMATION

Last Name:	First Name:	DOB:	
Home Address:	City:	State:	Zip:
Preferred Phone: _____ ☐Home ☐Work ☐Cell	2nd Phone: _____ ☐Home ☐Work ☐Cell	Consent to text message ☐**Yes** ☐**No**	
E-Mail Address: _____	Sex:	Marital Status: _____	Spouse Name: _____
Employer: _____	Emergency Contact:_____		
Preferred Pharmacy: _____	Location: _____		

RESPONSIBLE PARTY INFORMATION (if patient under 18)

Last Name: _____ First Name: _____ DOB: _____

Relationship to Patient: _____ Marital Status: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Preferred Phone: _____	☐Home ☐Work ☐Cell	2nd Phone: _____	☐Home ☐Work ☐Cell	Other Phone: _____	☐Home ☐Work ☐Cell

INSURANCE INFORMATION

Primary Insurance Company: ID NUMBER		
Who Holds This Insurance?	DOB:	Rel. To Patient: _____
Secondary Insurance Company: ID NUMBER		
Who Holds This Insurance?	DOB:	Rel. To Patient: _____

REFERRING PHYSICIAN'S INFORMATION

Physician's Name: _____

I hereby authorize the release of any medical information required by my insurance carrier for services rendered to me in order to process claims on my behalf, I request that payments of authorized medical benefits be made to my provider. I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered.

Signature of Patient (or Legal Representative)	**Date**

GENERAL CONSENT

GENERAL CONSENT FOR TEXAS DERMATOLOGY ASSOCIATES PATIENTS

FINANCIAL

___initial	**We ask for payment in full at the time of service.** By initialing the box you are giving us your general consent to file your insurance claim for you. Our physicians have agreed to accept many insurance plans. You will be responsible to make your appropriate co-payment **at the time of service.** If your visit includes a procedure, you may be required to pay the amount of deductible owed also **at the time of service.**

Returned checks will have a service charge of $25.00. If this is not handled in a timely manner, the returned check will be handled by a collection agency. We will make every effort to establish a payment plan if the situation requires this service.

COSMETIC PROCEDURES

___initial	**At times, procedures are considered by your insurance company as "not medically necessary".** We will make an attempt to alert you before the service is rendered if we are aware of this possibility. Our office will not file these claims with your insurance carrier, although you may submit information to them on your own. Examples may include: removal of benign lesions, treatments with fillers, treatments including peels, microdermabrasion, sclerotherapy or laser surgery.

MEDICATION HISTORY

☐ Yes ☐ No	Texas Dermatology has joined a pharmacy hub network which will enable us to receive your last two years' of medication history for drugs prescribed to you through electronic processing. It will not include every medicine you take - over the counter items, and items not paid through your pharmacy insurance benefit are omitted. This service will improve your health records and will speed up your patient visits with us **If you agree to have us request this information, please mark "yes". If not, please mark "no".**

I have read and understand the content of this patient consent and agree to comply with financial policies of Texas Dermatology Associates, P.A.

I voluntarily authorize the rendering of medical care, including examination, diagnostic procedures and medical treatment by the staff of Texas Dermatology, its designees, as may, in his/her professional judgment, be deemed necessary or beneficial. I acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition. I understand that I have the right to make decisions concerning my health care, including the right to refuse medical and surgical procedures. I understand residents and others in professional training programs, under the direct supervision of my provider, may be among the individuals who provide care to me.

Signature of Patient (or Legal Representative)	**Date**

TEXAS DERMATOLOGY ASSOCIATES

PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

PRACTICES AND HIPAA ACCESS FORM

Thank you for choosing Texas Dermatology Associates for your healthcare needs.

I understand that it is the policy of Texas Dermatology Associates to restrict access to my Protected Health Information. In addition to the caregiver(s) providing health services, and my insurance company(ies) for payment of my claim, I would like for the following person/people to have access to my Private Health Information:

Name(s) {Please Print)	DOB	Information Access Preferences
1.		List any restriction to providing your Private Health Information.
2.		
3.		
4.		
5.		

Restricted information may include issues such as: Sexually Transmitted Disease(s), Mental/Behavioral Health, Pregnancy, Terminal illness, Billing Information, etc.

Communication: Please check all that apply

- ☐ You may leave confidential clinical information on my answering machine.
- ☐ I would like to receive information about special offers, coupons, and events at Texas Dermatology Associates and Menter Cosmetic Institute.
- ☐ I have Psoriasis and would like to be considered for a clinical trial, you may be offered compensation for your time and travel.
- ☐ For more information you may visit www.menterderm.com

We are required by law to provide you a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of this Notice.

Signature of Patient (or legal Representative) **Date**

Signature of Staff Member **Date**

Comments:

Dear Patients,

Your medical provider is participating in a government program that encourages the adoption of electronic health records. This technology will lead to reduced health care costs but it will improve the quality of your care and our ability to communicate with you, our patients.

As a part of this program, the government requires us to record the following demographic information about you:

Preferred Language	Race	Ethnicity	Date of Birth	Gender

The U.S Center for Disease Control and Prevention (CDC) provides the options for the race and ethnicity fields that match the data collection standards defined by the U.S. Office of Managements and Budget (OMB) and the U.S. Bureau of the Census (BC). We maintain secure records and assure you that this information will remain confidential.

You can help us by reviewing the list of options below and providing your preferred language, race and ethnicity information during registration or check-in. If you do not wish to provide this information, you may simply decline.

Thank you for your assistance!

Texas Dermatology Associates, P.A.

Please select your Preferred Language from the following CDC-defined options:

☐ English ☐ Spanish ☐ Other _____

Please select your Race from the following CDC-defined options:

White	Black	Declined	
African	Cambodian	Korean	Okinawan
African American	Chinese	Laotian	Other Pacific Islander
Alaska Native	Dominica Islander	Madagascar	Other Race
American Indian	Dominican	Malaysian	Pakistani
Arab	European	Maldivian	Polynesian
Asian	Filipino	Melanesian	Singaporean
Asian Indian	Haitian	Micronesian	Sri Lankan
Bahamian	Hmong	Middle Eastern or	Taiwanese
Bangladeshi	Indonesian	North African	Thai
Barbadian	Iwo Jiman	Native Hawaiian or	Tobagoan
Bhutanese	Jamaican	Other Pacific Islander	Trinidadian
Burmese	Japanese	Nepalese	Vietnamese
			West Indian

Please select your Ethnicity from the following CDC-defined options:

Not Hispanic or Latino	Hispanic or Latino/Spanish	Mexican	Declined
Central American	Latin American/Latin, Latino	Spaniard	
Cuban	South American	Puerto Rican	
Dominican			

Signature of Patient or Legal Guardian | **Date**

TEXAS DERMATOLOGY ASSOCIATES, P.A.

M. Alan Menter, MD
John C. O'Brien, Jr., MD
John Griffin, MD
Caitriona Ryan, MD
Cynthia Trickett, PA-C

We are pleased to introduce our new internet Service

Communicator

Our Patient Portal!

Communicator is a secure web patient portal on our website home page that gives you, our patient, a new and efficient internet-based method of communicating with our practice. Patients can log on to our website **www.texasderm.com** and:

- Exchange messages with our practice
- Review and pay billing statements
- Request appointments
- Research health topics
- Retrieve Test Results
- Review Personal Health Information
- Complete and update medical forms
- Update your profile and contact information
- View a summary of your most recent office visit

It's simple and easy to access your patient portal:

1. Log onto our web site at **www.texasderm.com**
2. Click on the Existing Patient link
3. Register: The phone number you enter must match the primary number we have on file for you at Texas Dermatology. This would be the phone number (home or mobile) that you provided for us to call as your primary contact number. For security purposes, you will receive a phone call from Athena at your primary contact number before you will be able to complete your registration. Therefore, you should have this phone accessible when you start the registration process.
4. Log in and follow the directions.

If your experience difficulty when registering, please call our office during normal business hours for assistance:

Baylor, Dallas	(972) 386-7546
Toll Free:	(866) 510-8592