Patient Information

Name: _____ **D.O.B:** _____

Email: _____

Who is your Primary Care/ Referring Provider? _____

Current/Past Medical Conditions:

___ Anxiety ___ Diabetes
___ Depression ___ Arthritis
___ Cancer ___ Allergies
___ Hypertension ___ Hypotension
___ Hyperthyroid ___ Hypothyroid
___ Heart Condition ___ High Cholesterol
Other _____

Surgical History:

___ Gallbladder
___ Appendix
___ Knee (right, left, both)
___ Hip (right, left, both)
___ Heart
Other _____

Skin Disease History:

___ Acne ___ Eczema
___ Pre-Cancer ___ Rosacea
___ Itchy Scalp ___ Sunburns
___ Keloids ___ Skin Cancer
___ Psoriasis Other _____

Social History:

___ Current Smoker? ___ Current Alcohol Use? ___ Drives daytime
___ Previous Smoker? ___ Previous Alcohol Use? ___ Drives nighttime
___ Packs per day? ___ Social Drinker? ___ Does not drive

Do you exercise? _____
How often? _____
Do you drink caffeinated drinks? _____
How often? _____

Unhealthy Alcohol Use: Screening & Counsel

How many times in the past year have you had 5 (for men) or 4 (for women & everyone over 65) or more drinks in one day? _____

Do you use sunscreen? _____ SPF? _____
History of Melanoma? _____ Self? _____
Family Member? _____ Who? _____

Medications:

Name	Strength	Dosing schedule

Allergies:

_____
_____
_____
_____
_____
_____

Your Pharmacy (Name, Location, Phone) _____

What is your occupation? _____ Employer? _____

Patient Medical Information

Name: _____ **D.O.B:** _____

Immunization History:

Influenza Vaccine (Check One)

___ I HAVE received a flu vaccine this season.

___ I did NOT receive the flu vaccine this year because of medical reasons.

___ I did NOT receive the flu vaccine this year because I did not want one.

___ I did NOT receive the flu vaccine this year.

Pneumococcal Vaccine (65 years & older)

___ I HAVE received a pneumococcal vaccine

___ I did NOT receive a pneumococcal vaccine

Other Vaccines: (Patients who are EXACTLY 13 years old. If you are not currently 13 years old, please skip this question.)

CHECK ALL THAT APPLY:

___ I have received one dose of the meningococcal vaccine on or between my 11th and 13th birthdays.

___ I have received one Tetanus, Diptheria and Pertussis vaccine (Tdap) on or between my 10th and 13th birthdays.

___ I have received at least three HPV vaccines on or between my 9th and 13th birthdays.

Advanced Directives

Advance directives are designed to respect your autonomy and determine your wishes about future life sustaining medical treatments if you are unable to indicate your wishes.

Key interventions and treatment decisions include resuscitation procedures such as Cardiopulmonary Resuscitation (CPR) and Medical Resuscitation (breathing tube).

Which statement best reflects your wishes in advanced care recommendations?

___ I want full cardiopulmonary resuscitation efforts to be made. (Full code)

___ I do not wish to have a breathing tube, even if it is necessary to save my life. (Do not intubate)

___ If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life. (Do not resuscitate)

___ I have a living will.

___ I have a healthcare proxy whose name is, _____, and contact info is,

_____.

Patient Information

Name: _____ **D.O.B:** _____

Race:

___ Decline to specify
___ White
___ Black or African American
___ Hawaiian or other Pacific Islander
___ Asian
___ American Indian
___ Alaska Native
___ Other Race

Ethnicity:

___ Decline to specify
___ Hispanic or Latino
___ Not Hispanic or Latino
___ Unknown

Cancellation and No Show Policy:

Effective March 1, 2016, if an appointment is not cancelled at least 24 hours in advance or you do not show up for your appointment you will be charged a $25 fee; this will not be covered by your insurance.

If you are more than 15 minutes late for yur appointment, we will make every effort to fit you into our schedule. Otherwise, we will have to reschedule your appointment for another day.

(We understand that special, unavoidable circumstances may prevent you from cancelling within the allotted time. Fees in this instance may be waived but only with management approval.)

DO YOU GIVE PERMISSION TO LEAVE A DETAILED MESSAGE WITH MEDICAL RESULTS ON YOUR VOICE MAIL BOX? _____

Which number would you like us to call you at with medical results? _____

Patient Signature: _____ **Date:** _____

Information will be updated every 3 months. Please sign and date on follow up appointments that there are NO changes to any of the information listed on this information sheet. If you need to update or change medications, address, phone numbers or any other information please let us know at this time.

Review all information & Sign	Date	Review all information & Sign	Date
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Nassau Bay Dermatology
Dr. Jeanne Paz
390 E. Medical Center Blvd.
Webster, TX 7759

281-286-4455 281-286-3366

HIPPAA CONSENT FORM

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a *Patient Rights* section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor the agreement.

THE PATIENT UNDERSTANDS THAT:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has the right to review the Notice.
- The Practice reserves the right to change the Notice of Privacy Practices. The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon execution of this Consent.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability Accountability Act of 1996 (HIPPAA)

_____ _____

SIGNATURE OF PATIENT or REPRESENTATIVE DATE

Nassau Bay Dermatology
Dr. Jeanne Paz
390 E. Medical Center Blvd.
Webster, TX 7759

281-286-4455 281-286-3366

GENERAL TREATMENT AND FINANCIAL POLICY

Most insurance carriers implement multiple surgery logic when paying claims. Therefore, we may perform only one procedure per visit. In addition, your insurance may not pay for an office visit on the same day that a procedure is performed. For this reason, your initial visit may be a consultation only. This applies to new patients as well as established patients being seen for a new problem. Please feel free to discuss with Dr. Paz all of the problems you are having during your office visit. She will set up a treatment plan and we will schedule additional appointments accordingly.

COMMERCIAL PLANS:

If we are contracted with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for any covered, medically necessary services rendered. We will bill both your primary and secondary insurance plans for contracted plans.

You will be responsible at the time of service for payment of:

- Annual deductibles
- Co-payments
- Charges for non-covered or cosmetic services

  In the event that you, as the patient, or we, as the physicians, are not aware of a charge that is not covered by your insurance plan, you will be billed the balance after we obtain a denial from your insurance carrier.

NON-CONTRACTED COMMERCIAL PLANS:

For patients who have insurance coverage with an insurance carrier which we do not have a contractual relationship, please note the following:

- We will file both your primary and secondary insurance if you have it.
- If you have primary insurance only, you will be asked to prepay and estimated amount not covered by your insurance. Any remaining balance not covered by your insurance company will be billed to you. Please understand that since we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits. The entire amount remaining after your primary carrier has paid is your responsibility and you will be billed for the entire balance.

NO INSURANCE COVERAGE: For patients with no insurance coverage, payment is due at the time of service.

Due to government guidelines, we are unable to waive co-pays or extend discounts.

I give my voluntary consent for diagnostic, medical and surgical procedures required under the general and specific instructions of Nassau Bay Dermatology/ Jeanne Paz, M.D. or designee, as is necessary for my treatment and care. I also acknowledge that the practice of medicine is not an exact science and no guarantee has been made to me as to the result of treatments and examination.

I authorize direct payment of any insurance benefits, not to exceed my indebtedness, to be made to Nassau Bay Dermatology/ Jeanne Paz, M.D. I permit a copy of this authorization to be used in place of the original.

_____ _____

SIGNATURE OF PATIENT or REPRESENTATIVE DATE