Midland Dermatology/Midland Skin Cancer Center-Akin Chandler MD PLLC

Patient Information			Contact Information
Patient Name			Home Phone
Address			Work Phone
			Cell Phone
City	State	Zip Code	Preferred number
SSN	Date of Birth	Drivers License	Email
Sex (circle one) Male Female	Marital Status (circle one) M S D W	Language	Place of Employment

Emergency Contact	
Name(Last, First)	Relationship
Address	Telephone number

Parent /Guardian – if patient is under age 18			Contact Information
Parent/Guardian Name			Home phone
Address			Work phone
City	State	Zip Code	Cell Phone
SSN	Date of Birth	Driver License	Preferred Number
Marital Status	Language		Email

Insurance Information (Please provide card and Driver's License to reception)			
Policy Holders Name	Relationship	Policy Holder SSN	Policy Holder Date of Birth
Address	City	State	Zip Code

Consent for treatment , examination, and financial responsibility

I hereby consent to and authorize the providers and employees to provide medical care to the patient identified above. I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I understand that it is my responsibility to provide current and up to date information prior to treatment. I acknowledge that the filing of insurance claims IS NOT A GUARANTEE OF PAYMENT and that I AM FINANCIALLY RESPONSIBLE FOR PAYMENT IF SUCH CLAIMS ARE DENIED OR NOT PAID BY MY INSURANCE COMPANY. I authorize the payment of medical benefits directly to Akin Chandler MD PLLC for services provided to me. I am 18 years of age or if not, accompanied by legal guardian. I affirm if the patient is a minor that I am a legal parent or guardian and have the authority to sign and make medical decisions regarding medical treatment. I acknowledge delinquent accounts are turned over to collections and that if I do not pay my bills then accounts are subject to collection fees and attorney fees.

I authorize Akin Chandler MD PLLC, to fax or send electronically my medical information to any pharmacy or health care provider for the purpose of coordinating my medical care. I recognize and consent to photography for planning, documentation, and to aid in continued treatment. I authorize the taking of photographs digitally at the direction of the physician or delegate solely for documentation and understand photos will be kept confidential unless otherwise disclosed.

<u>Cosmetic Services and Benign lesion removal</u>

I further understand that some services such as benign mole removal, skin tag removal, and cosmetic procedures, are often not covered by insurance. Akin Chandler MD PLLC physicians and staff provide these services but I understand that they will not be billed to insurance.

I understand that there is a charge for pathology services provided outside of Akin Chandler MD PLLC and that there will be charges from a outside pathology lab if tissue is sent out for diagnosis.

This consent also serves as a consent for treatment of minor procedures in the office including skin biopsy, lesion removal, liquid nitrogen, extractions, wart treatment and other procedures that can result in scar, increase/decreased pigmentation, pain, bleeding or allergic reaction.

Signature Date

Midland Dermatology
Midland Skin Cancer Center
5117 Sunmore Circle
Midland Tx
432-689-2512
Fax 432-689-2108

HIPAA PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how Midland Dermatology and Midland Skin Cancer Center may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. The Notice is available to you on our website at www.midlandskincancercenter.com and at the front desk at your request. You may review the Notice before signing this consent. As a patient, you have the right to request restrictions on use and disclosure of your health information.

Disclosures of your health information or its use for any purpose other than those listed in our "Notice of Privacy Practices" and/or consent require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Persons Authorized to Receive Information About Your Care:
I authorize Midland Dermatology and Midland Skin Cancer Center to release all information regarding my financial account, appointments, pathology results, treatment and/or other information pertinent to my healthcare provided by Midland Dermatology and Midland Skin Cancer Center over the telephone or in person to the following person(s) (i.e. spouse, family member, etc.):

Name of Person	Relationship to Patient	Telephone Number

I do not authorize the following information to be disclosed to any other parties except to me as the patient. (Please specify):

_____

Communication:
I authorize Midland Dermatology and Midland Skin Cancer Center to leave messages in reference to any items that assist in carrying out healthcare operations including appointment reminders, biopsy results, and billing issues.

Home phone: YES NO Cell phone: YES NO Work Phone: YES NO

By signing this form, you acknowledge that you have read and understand our Notice of Privacy Practices and consent to our use and disclosure of protected health information about you for the purpose of treatment, coverage and payment from your health insurance company and overall health care operations. You have the right to revoke this consent in writing with your signature. **"By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me."**

Signature of Patient/Legal Representative: _____ Date: ___/___/___

Name of Patient/Legal Representative: _____

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OFFICE POLICIES AND PATIENT RESPONSIBILITIES

Thank you for choosing Midland Dermatology and Midland Skin Cancer Center for your skin care needs. It is our goal to provide you with a positive experience. Over the past few years, the practice of medicine has become more complicated for physicians and patients alike.

Because of the growing complexity of the insurance business, we feel that we can no longer assume that patients fully understand the relationship between the insurance company, the physician, and themselves. To clarify this relationship, we have established a set of guidelines regarding financial responsibility and office policies.

We will file your insurance for you if we are in your network

- When making an appointment with one of our providers, it is your responsibility to confirm with your insurance company that the physician/provider is currently under contract with your plan. If your insurance is a plan for which we are not a contracted provider, we are more than willing to provide care but the total cost of your visit will be your responsibility at the time of service.
- It is your responsibility to understand your insurance plan coverage. If you do not understand your policy, you may wish to contact the number on the back of your insurance card to review and verify your benefits. Not all services are a covered benefit in all contracts. Some insurance companies select certain services or diagnosis codes that they will not cover. Our office never guarantees that your insurance will pay for all services. We will make every attempt to file your claim as straightforward and simple as possible. However, if for any reason your claim is denied, you are responsible for the amount due on your account.

Referrals

- With some insurance plans, you may be required to see a Primary Care Physician (PCP) in order to see a dermatologist or other specialist. If your plan requires authorization by a PCP, you must obtain a referral prior to scheduling your visit. If your plan requires a referral and you or your PCP does not provide one by your scheduled appointment time, please be prepared to pay for your visit in full or reschedule.

Copayments, Deductibles and Coinsurance

- A copayment is a set dollar amount you owe for each office visit. All claims are subject to a deductible if a procedure is performed (i.e., biopsy, cryosurgery, Mohs, excisions, etc.). A deductible is the amount you are obligated to pay before your insurance company starts paying for your healthcare costs. Some insurance plans may also have a coinsurance, in which you may be responsible for a percentage of healthcare costs in addition to your copayment or deductible. It is your responsibility to understand your plan and any associated deductible or coinsurance. Payment will be due at time of service if your deductible has not been met or if your plan requires a coinsurance payment. You may be billed for these amounts should your insurance company notify us that additional payment is due from you.

A valid <u>Picture ID</u> and your <u>Insurance Card</u> are required at the time of your office visit

- Without a valid insurance card, we are unable to file a claim to your insurance company and you will be responsible for the day's charges at the time of service.
- It is your responsibility to notify the staff of any changes in your address, phone number and/or insurance plan, and provide a current up-to-date insurance card at each visit. Failure to do so may cause your insurance claim to be rejected, thus making it your responsibility to pay for the total cost of the visit.

Patients Undergoing Skin Cancer Treatment:

- I understand that if I have a skin cancer and that it is my responsibility to seek follow-up care by Midland Dermatology and Midland Skin Cancer Center personnel or other dermatology professionals. ***Failure to seek follow-up care is my responsibility and I do not hold Midland Dermatology and Midland Skin Cancer Center personnel professionally or personally responsible for skin cancer follow-up.***

Not Medically Necessary or Cosmetic Procedures

- Your insurance company may deem certain procedures as not medically necessary, or cosmetic. If you and your doctor/provider decide to continue with a procedure that falls into this category, we require payment in full at the time of service. The following are some examples:
  - Removal of benign lesions (i.e., skin tags, angiomas, sun spots or liver spots, cysts, milia, sebaceous hyperplasia, or seborrheic keratoses, etc.)
  - Botox, fillers such as Restylane and Perlane, scar revisions, cosmetic consults, or cosmetic procedures such as chemical peels, microdermabrasions, and laser hair removal, etc.
  - The cost of any procedure will be a separate fee from an office visit or consultation fee.

Prescription Refill Policy

- Midland Dermatology and Midland Skin Cancer Center requires that you be seen at least once a year in to maintain any prescription given by our providers. These prescriptions have been written to allow the maximum number of refills the provider is comfortable giving without having to assess your condition or review or test for side effects. Please keep your follow-up appointments and plan ahead to avoid being without your medication. We do not give prescription extensions if you fail to keep recommended visits.

Laboratory and Pathology Fees

- At times, it may be necessary to obtain a tissue sample (biopsy) or perform lab tests to confirm a diagnosis or determine a course of treatment. If a biopsy or other lab work is done, you will receive a separate bill from the pathologist or laboratory for these tests. If your insurance plan has a preferred provider for blood work or pathology, please notify our office staff prior to any procedure for special handling. Although the lab will file with your insurance, you are responsible for any bill you may receive from the laboratory or pathologist. Please discuss any billing errors or discrepancies with those institutions.

Medical Record Copies

- There is a $25 fee for medical record copies for the first 20 pages. There is an additional $0.50 per page fee for each additional page. There may be additional fees if notary service or affidavits are required. This fee covers the cost of our staff and supplies required to make copies.

Check-In

- Your time is important to us. The first step in keeping your appointment on time is being prepared. This includes filling out all required paperwork prior to your first appointment. It is extremely important that you provide each piece of information that is requested on both the Patient Information and Medical History Questionnaire. This will avoid delays in creating your chart and account at your visit. Please arrive at least 15 minutes prior to your scheduled time so that all paperwork may be completed BEFORE you are scheduled to see the provider.

Missed Appointments, Late Cancellations, Late Arrivals and Non-Compliance

- Please keep in mind that appointments are time-slots reserved specifically for you. We require a 24-hour advance notice if you are unable to keep your scheduled appointment. For your convenience, we offer appointment reminder calls 48 hours prior to your appointment that will allow you to cancel at that time. However, it is ultimately your responsibility to keep track of your appointments whether you receive a reminder call or not.
- If you miss an appointment without a 24-hour notice or cancel the same day as your appointment a $25.00 cancellation fee may be assessed to your account. Surgery/cosmetic patients who fail to contact us for cancellation or whom no-show may have a $50.00 fee assessed to your account. This fee is not billable to your insurance.
- We do our best to keep to the schedule. When a patient arrives late, it is impossible to stay on schedule. If you arrive more than 15 minutes past your scheduled appointment time, you may be rescheduled so that other patients are not inconvenienced.
- At times, a surgery may take longer than anticipated or a patient has been worked in for an emergency that may cause our providers to run late. You won't be rushed when you see the doctor and your patience is appreciated if we are running behind.
- Patients with multiple cancellations or missed appointments may be discharged from our practice.
- Please note that noncompliance with treatment plans (including medications and/or lab work) and abusive/inappropriate behavior towards staff and/or patients will result in immediate dismissal of your care from our practice.

Forms of Payment

- We accept payment in the form of cash, check, MasterCard, Visa, Discover and American Express.
- Instacheck processes any checks returned to us due to insufficient funds. In addition to charges assessed by Instacheck, we will assess a $30 fee for all returned checks.

Collection Fees

- We will send you three statements regarding your balance. The second statement is considered past due. If you should receive a third statement noted "Final", the account balance will be turned over to a collection agency. If your account is turned over to a collection agency, you will be discharged from the practice.

Minors

- The parent(s) or guardian(s) of minor patients MUST accompany the child for the initial evaluation and sign an informed consent to treat the child. Future visits will be covered under this consent. It is the responsibility of the parent or guardian to provide current insurance information and payment in full for services provided, should the child be unaccompanied at future visits. In cases of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those charges. If the divorce decree requires the other parent to pay all or part of the costs, it is the authorizing parent's responsibility to collect from the other parent.

Electronic Devices Policy

- In observance of the confidentiality rights of other patients and out of respect for the privacy of our employees and physicians, ***please either turn off your cell phone or place it on silent. Video or audio recordings in this office are strictly prohibited.*** You are welcome to take notes during your visit, and please remember that all medically necessary information is documented in detail in your medical record.

I have read, understand and agree to the above office and financial policies of Midland Dermatology and Midland Skin Cancer Center. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of information necessary for insurance filing by signing this statement. My signature below states my agreement and understanding of the Midland Dermatology and Midland Skin Cancer Center office and financial policies and serves as a request and consent for treatment. I authorize and assign all benefit payments to be made directly to Midland Dermatology and Midland Skin Cancer Center.

Signature of Patient/Legal Representative: _____ Date: ___/___/___

Name of Patient/Legal Representative: _____

Name: _____ Date of Birth: _____/_____/_____

HISTORY AND INTAKE FORM

Past Medical History: (please mark all that apply):

Anxiety
Arthritis
Asthma
Atrial fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid Reflux)
Hearing Loss
HIV/AIDS
Hypertension
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker/Defibrillator
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Artificial Joints **If so, year** _____
Hepatitis C

Other _____

_____

_____

Past Surgical History: (please list all prior surgeries)

_____

_____

_____

Skin Disease History: (please mark all that apply):

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Basal Cell Carcinoma
- ☐ Eczema
- ☐ None
- ☐ Melanoma
- ☐ Precancerous (Dysplastic) Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma

Other _____

_____

_____

Do you have a family history of Melanoma? ☐ Yes ☐ No
If yes, which relative(s)? _____
Any other family history: _____
If you checked yes, it is recommended and you will be asked to have a total body skin examination that is a fully disrobed exam.

THIS FORM IS CONTINUED ON BACK

Current Medications: (prescribed, supplements/herbs, non-prescribed)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: (medications, latex, food)

_____

_____

Hospice:
Are you currently in Hospice? ☐ Yes ☐ No
If yes, what is your Hospice diagnosis? _____

Social History: (please mark all that apply)

Cigarette Smoking:
- ☐ Never Smoked
- ☐ Quit: Former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily – cigarettes
- ☐ Uses tobacco daily

Alcohol Use:
- ☐ None
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3-4 drinks per day
- ☐ 5 or more drinks per day

Language:
- ☐ English
- ☐ Spanish
- ☐ Other: _____

Race:
- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ American Indian or Native Alaskan
- ☐ Native Hawaiian/Pacific Islander

__ How many times in past year have you had 5 (for men) or 4 (for women or adults older than 65 years) drinks per day

Ethnicity:
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Latino

Pharmacy:
Name: _____
Street Location: _____

Occupation: _____

Patient Name: _____ Date of Birth ____/____/____

ADDITIONAL HISTORY AND INTAKE QUESTIONS AS REQUIRED BY MEDICARE AND NEW HEALTHCARE REGULATIONS

Who is your primary care provider _____?

Who is your referring provider if not your primary care provider _____?

Influenza Vaccine: (for patients 6 months AND older)
Please check the one that best fits:

- ☐ Received a flu vaccine this flu season.
- ☐ Did not receive a flu vaccine this flu season because of medical reasons.
- ☐ Did not receive a flu vaccine this flu season because I did not want one.
- ☐ Did not receive a flu vaccine this flu season.

Other Vaccines: (For patients who are EXACTLY 13 years old). If you are NOT currently 13 years old, please skip these questions. Please check all that apply.

- ☐ Received 1 dose of meningococcal vaccine on or between my 11th-13th birthdays.
- ☐ Received 1 tetanus, diphtheria and pertussis vaccine (TDAP) on or between my 10th and 13th birthdays.
- ☐ Received at least 3 HPV vaccines on or between my 9th and 13th birthdays.

Pneumococcal Vaccine: (for patients 65 AND older) Please check the one that best fits:

- ☐ Received a pneumococcal vaccine. (Pneumonia)
- ☐ Did not receive a pneumococcal vaccine.

Advanced Directives: (for patients 65 AND older)
Advanced Directives are designed to respect your wishes and determine what future life-sustaining medical treatment you would like, if you are unable to indicate those wishes on your own. Key interventions and treatment decisions are: Resuscitation procedures such as cardiopulmonary resuscitation (CPR), and mechanical respiration (breathing tube).

Which statements **best reflect** your wishes on advanced care recommendations?

- ☐ I want full cardiopulmonary resuscitation efforts to be made. (Full Codes).
- ☐ 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 necessary to save my life. (Do Not Resuscitate)
- ☐ I have a living will. (A living will is a document that you have in place that specifies the type of care that you would like to receive in the event that you are incapacitated or names another person to make those decisions for you.)
- ☐ I have a health care proxy who name is _____ and whose contact information is _____.

_____ ____/____/____
Patient/Patient Representative Signature