COLLINS
Advanced Dermatology Institute

PATIENT'S PERSONAL INFORMATION

First Name _____ Last Name _____ Middle Initial _____

Mailing Address _____ Apt #_____

City _____ State _____ Zip _____

Date of Birth _____ / _____ / _____ Social Security # _____ - _____ - _____ Drivers License # _____

Phone # _____ _____ _____
CELL HOME WORK

Sex ❑ Male ❑ Female

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Partnered

Ethnicity ❑ Not Hispanic or Latino ❑ Hispanic or Latino
❑ I refuse to answer this question ❑ I don't know the answer to this question

Race ❑ White, Non-Hispanic or Latino ❑ Hispanic or Latino ❑ Black or African American
❑ American Indian Or Alaska Native ❑ Asian ❑ Native Hawaiian Or Other Pacific Islander
❑ I refuse to answer this question ❑ I don't know the answer to this question

Preferred Language ❑ English ❑ Spanish ❑ Other_____

EMAIL COMMUNICATION

Would you like access to our patient portal and newsletter via email? It is the policy of Collins Advanced Dermatology Institute to not share your contact or email info with any third parties.

❑ Yes, I consent to email communication

Email Address_____

❑ No, I decline email communication at this time.

Patient Signature _____ Date _____
(or parent/guardian)

EMPLOYMENT

Employer Name _____ Phone _____

Address _____ Occupation _____

EMERGENCY CONTACT

Name _____ Relationship _____ Phone _____

COLLINS
Advanced Dermatology Institute

PRIMARY CARE PHYSICIAN

Doctor Name_____ Did This Doctor Refer You To Us? ❑ Yes ❑ No

If you were not referred by your doctor, how did you hear about us?

❑ Billboard ❑ Community Impact ❑ Direct Mail ❑ Event ❑ Round Rock Express
❑ Facebook ❑ Followed ❑ Four Square ❑ Friend ❑ Word of Mouth
❑ Google ❑ Hospital ❑ Insurance Company ❑ Radio
❑ The View Magazine ❑ Twitter ❑ Website
❑ Yellow Pages ❑ ZocDoc ❑ Other_____

PERSON RESPONSIBLE FOR BILL *(complete only if different from patient)* ❑ Same as above

Name _____ Relationship _____

Mailing Address _____ Apt #_____

City _____ State _____ Zip _____

Date of Birth _____ / _____ / _____ Phone # _____ _____
HOME CELL

PRIMARY MEDICAL INSURANCE

Insurance Company_____ Employer_____

Policy Number _____ Group Number _____

Policy Holder's Name *(if different form patient)* _____ Date of Birth *(Required)* ____ /____ /____ SSN ____-____-____

Relationship to Patient ❑ Self ❑ Spouse ❑ Child ❑ Other _____

SECONDARY MEDICAL INSURANCE

Insurance Company_____ Employer_____

Policy Number _____ Group Number _____

Policy Holder's Name *(if different form patient)* _____ Date of Birth *(Required)* ____ /____ /____ SSN ____-____-____

Relationship to Patient ❑ Self ❑ Spouse ❑ Child ❑ Other _____

RELEASE OF INFORMATION

Other than yourself, with whom may we discuss your medical information? *(Please give the persons' name and relationship to you.)*

_____

_____

TREATMENT TO MINORS

Many times parents are unable to accompany their teen or child under age 18 to appointments. In such an event I hereby grant Collins Advanced Dermatology Institute permission to treat my child when they arrive at the office unaccompanied.

Guardian Signature _____ Date _____

Relationship To Patient _____

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MEDICAL HISTORY FORM

Name _____ Date _____

Referring Physician _____ Date of Birth _____ / _____ / _____ Sex ❑ M ❑ F

What is your occupation? _____ Age _____ Weight _____

Reason for Visit? _____

Best phone # to reach you to discuss results? _____ Is it ok to leave a message for you at this number? ❑ Yes ❑ No

Do you drink alcohol?	❑ Yes	❑ Never	If yes, how many drinks per day? _____
Do you smoke?	❑ Yes	❑ Never	If yes, how many packs per day? _____
Do you use an illegal street drugs?	❑ Yes	❑ No	If yes, list _____

PAST MEDICAL HISTORY

Have you ever had any of the following conditions?

Anxiety	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No
Artificial Joints	❑ Yes	❑ No
Asthma	❑ Yes	❑ No
Atrial Fibrillation	❑ Yes	❑ No
BPH (Enlarged Prostate)	❑ Yes	❑ No
Bone Marrow Transplant	❑ Yes	❑ No
Breast Cancer	❑ Yes	❑ No
Colon Cancer	❑ Yes	❑ No
COPD	❑ Yes	❑ No
Coronary Artery Disease	❑ Yes	❑ No
Depression	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
End Stage Renal Disease	❑ Yes	❑ No
GERD (Reflux)	❑ Yes	❑ No
Hearing Loss	❑ Yes	❑ No
Hepatitis	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No
HIV/AIDS	❑ Yes	❑ No
High Cholesterol	❑ Yes	❑ No
Hyperthyroidism	❑ Yes	❑ No
Hypothyroidism	❑ Yes	❑ No
Leukemia	❑ Yes	❑ No
Lung Cancer	❑ Yes	❑ No
Lymphoma/Leukemia	❑ Yes	❑ No
Pacemaker/Defibrillator	❑ Yes	❑ No
Prostate Cancer	❑ Yes	❑ No
Radiation Treatment	❑ Yes	❑ No
Seasonal Allergies	❑ Yes	❑ No
Seizures	❑ Yes	❑ No
Stroke	❑ Yes	❑ No
Valve Replacement	❑ Yes	❑ No
None	❑ Yes	❑ No

Other (List) _____

SKIN DISEASE HISTORY

Please check all that apply.

Actinic Keratoses	❑ Yes	❑ No
Basal Cell Skin Cancer	❑ Yes	❑ No
Melanoma - Malignant	❑ Yes	❑ No
Squamous Cell Skin Cancer	❑ Yes	❑ No
Precancerous Moles (Atypical/Dysplastic)	❑ Yes	❑ No
Acne	❑ Yes	❑ No
Asthma	❑ Yes	❑ No
Blistering Sunburns	❑ Yes	❑ No
Dry Skin	❑ Yes	❑ No
Eczema	❑ Yes	❑ No
Flaking or Itchy Scalp	❑ Yes	❑ No
Hay Fever/Allergies	❑ Yes	❑ No
Poison Ivy	❑ Yes	❑ No
Psoriasis	❑ Yes	❑ No
Cold Sores (HSV)	❑ Yes	❑ No

Other (List) _____

PAST SURGICAL HISTORY

Please circle any surgeries you have had and notate the year they took place in the space to the right.

Precancerous Mole Removal	_____
Skin Biopsy	_____
Basal Cell Carcinoma Surgery	_____
Squamous Cell Carcinoma Surgery	_____
Melanoma Surgery	_____
Appendix Removed	_____
Bladder removed	_____
Mastectomy (R, L, B)	_____
Lumpectomy (R, L, B)	_____
Breast Biopsy (R, L, B)	_____
MRSA (Resistant Staph)	_____
Breast Reduction	_____
Breast Implants	_____
Colectomy: Colon Cancer Resection	_____
Colectomy: Diverticulitis	_____
Colectomy: IBD	_____
Gallbladder removed	_____
Coronary Artery Bypass	_____
PTCA (Coronary Angioplasty)	_____
Mechanical Valve Replacement	_____
Biological Valve Replacement	_____
Heart Transplant	_____
Joint Replacement, knee (R, L, B)	_____
Joint Replacement, hip (R, L, B)	_____
Joint Replacement in Last 2 Years	_____
Kidney Biopsy	_____
Kidney Removed (R, L)	_____
Kidney Stone Removal	_____
Kidney Transplant	_____
Ovaries Removed: Endometriosis	_____
Ovaries Removed: Cyst	_____
Ovaries Removed: Ovarian Cancer	_____
Prostate Removed: Prostate Cancer	_____
Prostate Biopsy	_____
TURP (Prostate)	_____
Spleen Removed	_____
Testicles Removed (R, L, B)	_____
Hysterectomy: Fibroids	_____
Hysterectomy: Uterine Cancer	_____
None	

Other (List) _____

Do you have a history of bad, blistering sunburns?	❑ Yes	❑ No
Do you wear sunscreen?	❑ Yes	❑ No
If yes, what SPF?		
Do you use a tanning salon?	❑ Yes	❑ No
Do you have a family history of skin cancer? (BCC, SCC, Melanoma)	❑ Yes	❑ No
If yes, who?		

ALLERGIES

Please list all allergies & reaction. (Medication, food, etc.)

ALERTS

Are you currently experiencing any of the following?

Allergy to Latex or Tape	❑ Yes	❑ No
Allergy to Lidocaine	❑ Yes	❑ No
Allergy to Topical Antibiotic Ointment	❑ Yes	❑ No
Artificial Heart Valve	❑ Yes	❑ No
Artificial Joint in Past 2 Years	❑ Yes	❑ No
Accutane Use in Past 6 Months	❑ Yes	❑ No
Blood Thinner Use/Daily Aspirin	❑ Yes	❑ No
Defibrillator	❑ Yes	❑ No
Pacemaker	❑ Yes	❑ No
Premedication Prior to Procedures	❑ Yes	❑ No
Rapid Heart Rate with Epinephrine	❑ Yes	❑ No
Pregnant or Trying to Breast Feed	❑ Yes	❑ No
MRSA (Resistant Staph)	❑ Yes	❑ No

Other Symtoms _____

REVIEW OF SYMPTOMS

Are you currently experiencing any of the following?

Seasonal Allergies	❑ Yes	❑ No
Runny Nose/Itchy Eyes	❑ Yes	❑ No
Palpitations/Chest Pain	❑ Yes	❑ No
Leg Swelling	❑ Yes	❑ No
Fever/Chills	❑ Yes	❑ No
Unplanned Weight Loss	❑ Yes	❑ No
Cold/Heat Intolerance	❑ Yes	❑ No
Excessive Thirst/Hunger	❑ Yes	❑ No
Swallowing Problems	❑ Yes	❑ No
Mouth Sores or Cold Sores	❑ Yes	❑ No
Nausea/Vomiting	❑ Yes	❑ No
Diarrhea/Constipation	❑ Yes	❑ No
Burning with Urination	❑ Yes	❑ No
Blood in Urine	❑ Yes	❑ No
Enlarged Glands or Lymph Nodes	❑ Yes	❑ No
Joint Pains	❑ Yes	❑ No
Muscle Aches	❑ Yes	❑ No
Headaches	❑ Yes	❑ No
Memory Loss	❑ Yes	❑ No
Depression	❑ Yes	❑ No
Anxiety	❑ Yes	❑ No
Wheezing/Asthma	❑ Yes	❑ No
Shortness of Breath	❑ Yes	❑ No
Suppressed Immune System	❑ Yes	❑ No
Rash with Medication or Foods	❑ Yes	❑ No
Problems Healing	❑ Yes	❑ No
Scars (Keloids) after Surgery	❑ Yes	❑ No

Other (List) _____

MEDICATIONS (Use back if needed)

Please list all current medications. (OTC, Herbal, etc.)

PREFERRED PHARMACY

Please include location.

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Advanced Dermatology Institute

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ DOB: _____

Release records to:

Name: _____

Fax: _____

Release records from:

Name: _____

Fax: _____

And disclosed to/from the following individual/organization:

Collins Advanced Dermatology Institute
Leander
311 S. Hwy 183, Leander, Texas 78641
Phone: 512.379.6090 Fax: 512.379.6098

Round Rock
Forest Creek Medical Center
4112 Links Lane, Suite 205
Round Rock, Texas 78664
Phone: 512.379.6090 Fax: 512.989.8477

I request a copy or summary of the following medical records:

- ❑ Complete Medical Record
- ❑ Biopsy Report(s)
- ❑ Lab Report(s)
- ❑ Consultation Reports
- ❑ Medication Allergies
- ❑ Allergy Test/Treatment
- ❑ Surgical Procedures
- ❑ Other _____

Please check one:

- ❑ For dates of service from _____ /_____ /_____ to _____ /_____ /_____
- ❑ For all dates of service

Purpose:

❑ Continued Care ❑ Insurance ❑ Personal ❑ Other

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

- ❑ Yes, I consent to the release of this information.
- ❑ No, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the individual or organization releasing information. I understand the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires within one year of completion of this request.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the office of COLLINS ADVANCED DERMATOLOGY INSTITUTE.

I understand that there may be a reasonable medical records copying fee as permissible by state law.

Patient Signature _____ Date _____

COLLINS
Advanced Dermatology Institute

HIPAA PATIENT 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 health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care 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 and Accountability Act of 1996 (HIPAA).

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 that the patient has the opportunity to review this 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 the execution of this Consent

THIS CONSENT WAS SIGNED BY

Printed Name _____
PATIENT OR REPRESENTATIVE

Signature _____ Date_____

Relationship to Patient _____
IF OTHER THAN PATIENT

WITNESS

Printed Name _____
PRACTICE REPRESENTATIVE

Signature _____ Date_____

COLLINS
Advanced Dermatology Institute

OFFICE FINANCIAL POLICY

Patient Printed Name _____ Date of Birth _____

_____ INITIAL

Collins Advanced Dermatology Institute appreciates the confidence you have shown in choosing us to provide for your health care needs. The services you have elected to participate in imply a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. If you have insurance, please keep in mind that your insurance is a contract between you and your insurance company. As a courtesy we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill and our office cannot guarantee that your carrier will pay your claim.

_____ INITIAL

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. Payment is due at the time service is rendered, unless other arrangements have been made prior to the services being rendered. This includes Co-Pays. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period you will be responsible for your balance in full. Our office will not enter into a dispute with the insurance carrier over a claim. We will be happy to assist wherever possible. If an insurance payment is mistakenly sent to the patient, instead of the office for service rendered, the patient is expected to provide payment with 10 days of receipt along with the Explanation of Medical Benefit.

_____ INITIAL

LATE CANCELLATION AND NO SHOW POLICY:
A "late cancellation" is canceling an appointment without calling with a 24 hour notice for an office visit and a 48 hour notice for a procedure. A "no show" is missing a scheduled appointment.
A charge of $35.00 will be assessed for each late cancellation or no show for an office visit if less then 24 hours notice is given.
A charge of $50.00 will be assessed for each late cancellation or no show of a procedure appointment if less then 48 hours notice is given.

_____ INITIAL

I have read the above policies regarding my financial responsibilities to Collins Advanced Dermatology Institute for providing a medical service to me or above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Collins Advanced Dermatology Institute, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

_____ INITIAL

I agree to pay any costs incurred by Collins Advanced Dermatology Institute in collecting any amount due including, without limitations collection agency fees and attorney's fees.

Printed Name _____
PATIENT OR REPRESENTATIVE

Signature _____ Date _____

SELF-PAY POLICY

I do not have health insurance and will be responsible for services rendered here at Collins Advanced Dermatology Institute. I agree to pay the practice the full and entire amount of treatment given to me or to the above names patient at each visit.

Printed Name _____
PATIENT OR REPRESENTATIVE

Signature _____ Date _____