UNITED DERMATOLOGY ASSOCIATES

2800 E. Broad Street, Suite 124
Mansfield, TX 76063
Phone: 817-539-0959
Fax: 817-539-0480

723 N. Fielder Road, Suite C
Arlington, TX 76012
Phone: 817-539-0959
Fax: 817-261-1123

780-B NE Alsbury Blvd
Burleson, TX 76028
Phone: 817-529-1753
Fax: 817-529-1757

2560 Central Park Avenue, Suite 395
Flower Mound, TX 75028
Phone: 469-635-5990
Fax: 469-635-5995

Patient Registration Form

Patient Name:		**Appointment Date:**	
How did you hear about us?		**May we contact you by email for product discounts?** Y N **Email address**:	
Date of Birth:	**Marital Status:**	**Social Security Number:**	**Race:** **Ethnicity:**
Mailing Address:			
Home Phone:	**Cell Phone:**	**Work Phone:**	
****Would you prefer appointment confirmation by text or voice call?**			

Referring Physician:	**Referring Physician Phone:**
Primary Physician Name:	**Primary Physician Phone:**

Primary Insurance:	**Policyholder Name:**
Subscriber ID:	**Policyholder Date of Birth:**
Group Name and Number:	**Policyholder Address:**
Relationship to Patient:	**Policyholder Phone Number:**

Secondary Insurance:	**Policyholder Name:**
Subscriber ID:	**Policyholder Date of Birth:**
Group Name and Number:	**Policyholder Address:**
Relationship to Patient:	**Policyholder Phone Number:**

Responsible Party Name and Relation:	**Employer Name and Phone Number:**
Responsible Party Address:	**Responsible Party Date of Birth:**

Emergency Contact Name:	**Phone Number:**	**Relation:**
Pharmacy Name:	**Pharmacy Number:**	

Medical Benefits/Self Pay Assignment

The benefits you receive from our staff are an estimate and are not guaranteed until processed through your insurance.

I hereby authorize the assignment of benefits (payments) directly to United Dermatology Associates for all my insurance claims including Medicare, private insurance, and any other health/medical plan related to services received. I agree to pay any and all charges that are not covered by my insurance. I understand that co-pays, deductibles, and payment for non-covered services are due at the time of service.

If I do not carry insurance, I understand payment for services rendered is due in full at the time of service.

Signature of Responsible Party: _____ Date:_____

Records Release for Medical Claims to Insurance

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party: _____ Date:_____

UNITED DERMATOLOGY ASSOCIATES

MEDICAL HISTORY

Patient: _____ Date of Birth: ____/____/____ Today's Date: ____/____/____
Reason for today's visit: _____
Did a doctor refer you? YES NO Which MD? _____ Phone: _____

Influenza Vaccine for this year? YES NO If yes, when? _____ **Pneumococcal Vaccine**? YES NO If yes, when?_____
Surrogate Medical Decision Maker? Do you have this in place YES / NO If yes, who?_____

List **all** medications you are currently taking (including vitamins, herbals, prescriptions, and over-the-counter medications):
_____
_____

Are you allergic to any medications? YES NO If yes, please list: _____
Have you ever had dental anesthesia (Novacaine): YES NO Any bad reaction? YES NO

Do you have now or have you ever had diseases, conditions, or procedures pertaining to: (Please check YES or NO)

Asthma	YES NO	Diabetes	YES NO	Allergic Rhinitis	YES NO
Thyroid	YES NO	Shortness of breath	YES NO	Kidney	YES NO
High blood pressure	YES NO	Bladder	YES NO	Chest pain	YES NO
Liver/Gall bladder	YES NO	Heart attack	YES NO	Lung disease	YES NO
Pacemaker	YES NO	Heart murmur	YES NO	Phlebitis	YES NO
Arthritis/Joint problems	YES NO	Blood clots	YES NO	Seizure	YES NO
Irregular heartbeat	YES NO	Fainting	YES NO	Tuberculosis	YES NO
Mitral valve prolapse	YES NO	Sexually transmitted disease	YES NO	Lupus or other autoimmune disease	YES NO
Bleeding abnormalities	YES NO	Hepatitis	YES NO	Artificial joint	YES NO
Cancer	YES NO	Cataracts/Glaucoma	YES NO	Depression	YES NO
GI/Stomach problems	YES NO	Polycystic ovaries	YES NO		

Are you currently pregnant? YES NO Are you trying to become pregnant? YES NO

SKIN

Have you ever had skin cancer?	YES NO	If yes, what type? _____
Has anyone in your family had skin cancer?	YES NO	If yes, what type? _____
Do you have a history of any specific skin disease?	YES NO	If yes, what type? _____
Do you have problems with healing?	YES NO	
Do you develop keloids (scars) after surgery?	YES NO	
Do you bleed easily?	YES NO	
Do you develop skin rashes in reaction to anything? (e.g. Medication? Food? Environment? Bandages? Topical Neosporin?)	YES NO	If yes, what type? _____
Do you have any moles that are changing?	YES NO	If yes, what type? _____
Are you prone to herpes (fever blisters/cold sore) outbreaks?	YES NO	
Have you had any blistering sunburns?	YES NO	

List any other disease or conditions: _____
List surgical procedures you have had in the last 6 months: _____

SOCIAL HISTORY

Do you drink alcohol?	YES NO	If yes, how much? _____
Do you use IV drugs?	YES NO	
Do you smoke?	YES NO	If yes, how much? _____
Do you chew tobacco?	YES NO	If yes, how much? _____
Have you been exposed to HIV/AIDS?	YES NO	

What is your occupation? _____ Hobbies? _____

Are you interested in cosmetic treatments/products for sun damaged or aging skin? YES NO
If yes, what type? _____

Completed by: _____ Relationship to patient: _____

UNITED DERMATOLOGY ASSOCIATES

OFFICE POLICIES AND PROCEDURES

Financial Responsibility
I understand that United Dermatology Associates will collect my portion at the time services are rendered, and will attempt to verify my insurance coverage. If my insurance fails to reimburse despite all efforts, I will be responsible for the balance in full. Co-pays, deductibles, and procedures not covered by my insurance are my responsibility. Partial payments will not be accepted unless prior arrangements have been made. Your insurance company may need you to supply certain information directly to them; it is your responsibility to comply with their request in a timely manner. Any charges that incur from failure to comply will be solely patient responsibility. I will inform United Dermatology Associates of any changes in my insurance plan immediately. **If a biopsy performed, depending on your health coverage for the facility, you may receive a separate bill from the servicing laboratory**. _____initials

Office Policy
United Dermatology Associates reserves the right to charge patients who fail to cancel, reschedule their appointments **48 hours prior** (weekdays) or "no show" to their appointments. **A $50.00 charge for office surgery/cosmetic procedures and $25 charge for office visit will be assessed**. You will be contacted to confirm your appointment 1-2 days prior via our automated system, please listen to the entire message to make the appropriate selection. We will make every effort to accommodate your appointment request, and ask you in return to be courteous and punctual. If you are more than 15 minutes late, we may ask you to reschedule your appointment.
_____initials

HIPAA
This practice complies with the Health Insurance Portability and Accountability Act (HIPAA). By signing this form, you consent to our use and disclosure of Protected Health Information about you for treatment, payment, and health care operations. This also means we may not disclose information, including medical diagnoses, test results, or treatment plans to anyone other than you (i.e. spouse, child over the age of 18, or any other relation) without your written consent. I understand that I have the right to privacy of my Protected Health Information as maintained by United Dermatology Associates. By my signature below, I certify that I have read and understand my rights to the privacy of my Protected Health Information as well as the terms and conditions of this notice. _____initials

Release of Information to Family Member
I authorize that my medical records and results be released to: _____
Relation and phone number: _____

Normal Test Results
I give my permission for United Dermatology Associates to leave a message regarding **normal** test results on my home or cellular voice mail. _____initials

Authorization for Photography
For my medical records, United Dermatology Associates uses an electronic medical records system and requires my photograph to be taken. This photograph will not be used or released for any other purposes. _____initials

Referrals
If insurance requires a referral from your primary care physician it is patient responsibility to obtain a referral for your visit **PRIOR** to your appointment. We recommend that you obtain your referral at least 2 weeks in advance of your appointment so we may have the authorization on file. This will help to avoid needing to reschedule your appointment due to lack of a referral on file. _____initials

Female Patients of Child Bearing Potential ☐ **N/A**
I understand that if I am trying to get pregnant or I become pregnant I will stop all oral and topical medications you have prescribed and contact this office. _____initials

Authorization for Medical Treatment of a Minor ☐ **N/A**
Name of Minor: _____ Date of Birth: _____/_____/_____
I, being the parent or guardian of the above named minor, do hereby authorize providers of United Dermatology Associates to administer dermatologic medical treatment to my child. It is my intention that this authorization be effective during my absence. _____initials

Refunds
I understand United Dermatology Associates collects my portion at the time services are rendered, and in spite of all efforts to collect toward the Insurance fee schedule, there are some instances where refunds are created. It is patient/guardian responsibility to follow up on refunds to confirm any changes on the account. If you wish to leave a refund on the account, please submit written authorization by fax at 817-539-0480 or by mail. _____initials

Hours	**Arlington** 8-5pm CST	**Burleson** 8-5pm CST	**Flower Mound** 8-5pm CST	**Mansfield** 8-5pm CST	**Mansfield** 8-3:45pm CST
	Monday-Friday	Monday-Friday	Monday-Friday	Monday-Thursday	Friday

After Hours
You may call 817-539-0959 after hours to reach our answering service who can contact the provider on-call if you are in need of urgent medical advice. In case of an emergency, call 911 or go to the nearest emergency room.

_____	_____/_____/_____	_____	_____/_____/_____
Patient Name (Print)	Patient Date of Birth	Guardian, if applicable (Print)	Today's Date

UNITED DERMATOLOGY ASSOCIATES

PATIENT PORTAL CONSENT

Patient Acknowledgement and Agreement

Despite the risks associated with the e-mail, I agree that Jeannine K. Hoang, MD and her workforce may use e-mail to facilitate communications to or about me. I understand that disclosures regarding my treatment and diagnosis may be made to not me only, but also internally within United Dermatology Associates.

Also, due to the recent software upgrade, you will have the ability to eventually access a Patient Portal in which patients can view labs and other important information regarding your healthcare. Please provide your e-mail so we may begin the process.

PATIENT NAME (printed): _____ **DOB:** _____

E-MAIL: _____

In order to obtain compliance with Meaningful Use protocol for electronic health records, we are asked to acquire particular demographic information on all of our patients, not just those of Medicare age. We do not mean to offend anyone by asking these questions, we are merely following the government's mandate.

RACE: Caucasian / Hispanic / African-American / Asian / Other: _____

ETHNICITY: Hispanic / Non-Hispanic

PRIMARY LANGUAGE: English / Spanish / Other: _____

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communications of e-mail as set forth in this consent form.

PATIENT SIGNATURE: _____ **DATE:** _____

EMPLOYEE SIGNATURE: _____

UNITED DERMATOLOGY ASSOCIATES

NOTICE OF PRIVACY POLICIES & PRACTICES FOR UNITED DERMATOLOGY ASSOCIATES

At United Dermatology Associates, we are committed to treating and using Protected Health Information (PHI) about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your PHI. This Notice is effective April 14, 2003 and applies to all PHI as defined by federal regulations.

UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION

Each time you visit United Dermatology Associates, a record of your visit is made. Typically, this record contains information about your visit including your examination, diagnosis, test results, treatment as well as other pertinent healthcare data. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication with other health professionals involved in your care,
- Legal document outlining and describing the care you received,
- A tool that you, or another payer (your insurance company) will use to verify that services billed were actually provided,
- An education tool for medical health providers,
- A source for medical research,
- Basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards,
- A source of data for planning and/or marketing, and
- A tool that we can reference to ensure the highest quality of care and patient satisfaction.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your PHI,
- The right to receive confidential communications concerning your medical condition and treatment,
- The right to inspect and copy your PHI,
- The right to amend or submit corrections to your PHI,
- The right to receive and accounting of how and to whom your PHI has been disclosed, and
- The right to receive a printed copy of this notice.

OUR RESPONSIBILITES

United Dermatology Associates is required to:

- Maintain the privacy of your health information,
- Provide you with the Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have regarding communication of health information via alternative means and/locations.

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all PHI that we maintain. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according procedures included in the authorization.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

We will use your health information for treatment.

Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example: results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

We will use your information for payment.

Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the service rendered to you.

We will use your information for regular health operations.

Your health information may be used as necessary to support the day-to-day activities and management of United Dermatology Associates. For example: information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Business Associates.

In some instances, we have contracted separate entities to provide services for us. These “associates” require your health information in order to accomplish the tasks that we ask them to provide. Some examples of these “business associates” might be a billing services, collection agency, answering service, and computer software/hardware provider.

Communication with family.

Due to the nature of our field, we will use our best judgment when disclosing health information to a family member, other relatives, or any other person that is involved in your care or that you have authorized to receive this information. Please inform the practice when you do NOT wish a family member or other individual to have authorization to received your information.

REVISED 01/2015

UNITED DERMATOLOGY ASSOCIATES

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of United Dermatology Associates. I hereby acknowledge receipt of their Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ (patient name).
I hereby acknowledge receipt of United Dermatology Associates' Notice of Privacy Practices with respect to the patient.

Name (please print): _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____