Texas Tone Dermatology

Dear Patient,
We would like to share the following policy with you so that you understand your responsibility regarding the charges for services rendered to you by this office.

We are a Medicare participating provider. We will bill Medicare for your services. You are responsible at the time of service for payment of:

- **The annual deductible**
- **Co-Payments (20% of the approved Medicare amount)**
- **Charges for non-covered or cosmetic services**

If you have a supplement, it may not cover the deductible with Medicare.
Some supplements do not pay all of the 20% due, such as Plan D,G,N and J.
You will be asked to sign an Advanced Beneficiary Notice Form in the events that a service is provided which we know is not covered by Medicare.

Please present all supplemental cards to the receptionist copying.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office. All unpaid accounts sent to collection agency are subject to service charges.

If you have a Medicare replacement plan we will be pleased to check your benefits prior to your appointment and inform you if our services are covered on your plan.

Patient Signature: _____

Date: _____

Self-Pay Patient Policy

Dear Patient,
To better serve our patients, we have updated our self-pay policy. Effective immediately, all self-pay patients are required to pay a office visit fee prior to being seen by the provider. New Patient office visit fee is $175. Established Patient office visit fee is $150. This payment is due at check-in and covers the evaluation and consultation portion of your visit,

Please note that any procedures, treatments, biopsies or additional services performed during your appoinment are not included in the office visit fee. Charges for these services will be discussed with you and collected at the conclusion of your visit.

We appreciate your understanding and cooperation with this policy. If you have any questions regarding fees or payment options, please do not hesitate to speak with our office manager.

Thank you for allowing us to participate in your dermatologic care.

Patient Signature: _____

Date: _____

Kelly Jackson, FNP - C
9423 S Hwy US-69
Huntington Tx, 75949
Phone: (936) 955-5540
Fax: (936) 955-5541

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payors.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read, and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Texas Tone Dermatology has the right to change its Notice of Privacy Practices from time to time and that I may contact Texas Tone Dermatology at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private health information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Signature: _____

Date: _____

I hereby authorize my private health infomation to be released to the following individuals:

_____ Relationship: _____

_____ Relationship: _____

----------OFFICIAL USE ONLY----------

I attempted to obtain the patient's signature on acknowledgement on this Notice of Privacy Practices agreement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

Commercial and Commercial Managed Insurance Plans

Dear Patient,
If you are enrolled commercial insurance or a commercial managed insurance plan, please read and sign the following statement.

Commercial care programs and managed care programs are different from traditional health insurance plans. In an effort to clear up some confusion and questions regarding your insurance plan, we have summarized some important details for you.

The office is required to collect a co-pay at the time of your visit for the office consultation. An office consultation usually includes taking of a history, physical examination, medical evaluation, and management of skin problems. Some laboratory work is also included in the co-payment amount with some policies.
The performance of surgical procedures in the office are not covered by the co-payment amount with most insurance policies. Instead surgical procedures are applied to your annual/plan year deductible amount and coinsurance.

Examples of some of the surgical procedures performed in our office are mole removals, skin tag removals, skin biopsy, liquid nitrogen treatment on warts and actinic keratosis, etc. You may request an estimate before services are preformed and we will be happy to check your specific plan benefits. We do collect deductibles and coinsurance amounts, in addition to your co-pay at the time services are rendered. A claim will be filed to your insurance plan for all services provided.
If you have any questions, please inquire at the front desk.
Thank You.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office. All unpaid accounts sent to the collection agency are subject to service charges.

_____ _____

Signature (of the patient or responsible party). **Date:**

First: _____ Last: _____ Mi: _____

Address: _____ City: _____ ST: _____ Zip: _____

DOB: _____/_____/_____ SS: _____ DL# : _____

Home # (_____)_____ Cell # (_____)_____ Work # (_____)_____

Email: _____ Pharmacy: _____

Primary Care Physician: _____ Preferred contact method: _____

Patient Employer: _____ Occupation: _____

Please Circle One - Marital status: Married Single Widowed Divorced Separated

Ethnicity: _____ Race: _____ Preferred Language: _____

Spouse's Name: _____ DOB: _____/_____/_____

Emergency Contact: _____ Phone # (_____)_____ Relationship: _____

Insured Policy Holder : (IF NOT PATIENT)

Name: _____ DOB: _____/_____/_____ Phone # (____)_____

Address: _____ City: _____ ST: _____ Zip: _____

Relationship to patient: _____ Employer: _____

<u>Release of Medical Information and Release of Information and Assignment of benefits</u>

HIPPA requires written authorization from the patient in order to release any confidential information regarding care. I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize Texas Tone Dermatology to apply benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payments be made from my insurance company directly to Kelly Jackson, APRN, FNP-C. (Or any party who accepts assignments.)

Signature: _____ Date: _____

I understand that I am financially responsible for the charges regardless of insurance coverage and/or payment. All unpaid accounts sent to collections are subject to a $35.00 collection fee. NSF (returned check) fees: $35.00.

Signature: _____ Date: _____

Intake and History Form

Name: _____ **Date:** _____

Preferred Pharmacy: _____ **City or Zip Code:** _____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hypertension
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other
- ☐ _____
- ☐ _____
- ☐ _____

Past Surgical History

Have you had any surgeries in the past? _____

_____

Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itching Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ None
- ☐ Other : _____

Intake and History Form

Do you wear sunscreen?

☐ Yes ☐ No

If yes, What SPF? _____

Do you tan in a tanning salon?

☐ Yes ☐ No

Do you have a family history of Melanoma?

☐ Yes ☐ No

If yes, which relative?

☐ Mother
☐ Father
☐ Sister
☐ Brother
☐ Daughter
☐ Son
☐ Uncle
☐ Aunt
☐ Nephew
☐ Niece
☐ Grandmother
☐ Grandfather
☐ Grandson
☐ Granddaughter
☐ Other
☐ _____
☐ _____
☐ _____

Social History

Smoking Status (Please choose one)

☐ Current everyday smoker
☐ Current someday smoker
☐ Former smoker
☐ Never smoker

Alcohol Intake (Please choose one)

☐ None
☐ 1 or less per day
☐ 1-2 per day
☐ 3 or more perday

For 18 years and younger -ONLY-.

Height _____

Weight_____

Medications

List all current medications:

_____

_____

_____

Allergies / Reactions

_____

_____

_____