Date_____

Name_____ Date of Birth_____

Age_____ Sex_____ Marital Status_____ Last 4 digits of SS#_____

Address_____

City_____ State_____ Zip_____

Race: □ American Indian □ African American □ Pacific Islander □ Asian □ White □ Decline to Specify

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Decline to Specify Preferred Language_____

Home Phone_____ Work Phone_____

Cell Phone_____ Email_____

Employer_____

Employer's Address_____

Primary Physician/Referring Physician_____

Physician's Phone Number_____

Insurance Name_____

Policy Number_____ Group Number_____

Insurance Subscriber's Name (if different than self)_____

Subscriber's Date of Birth_____ Relationship to Patient_____ Last 4 digits of SS#_____

Address_____

Home Phone_____ Work Phone_____

Emergency Contact_____

Phone Number_____ Relationship to Patient_____

Preferred Pharmacy_____

Location_____ Pharmacy Phone Number_____

Do you currently use a daily sunscreen (yes/no)?_____

Would you like to be contacted about future Cosmetic Specials (yes/no)?_____

How did you hear about us?_____

Heights Dermatology & Aesthetics Center
Texas Dermatology Associates

Patient Name: _____ **Date:** _____

Past medical History:
(Circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplantation
Benign Prostate Hyperplasia (BPH)
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Other _____

Past Surgeries: (List all with dates)

_____
_____
_____
_____

Family history:

Do you have a family history of melanoma?
If yes, which relative?
_____

Skin Disease history:
(Circle all that apply)

Acne
Actinic Keratosis
Asthma
Basal cell skin cancer
Blistering sunburns
Dry skin
Eczema
Flaky or itchy scalp
Hay fever/Allergies
Lupus
Melanoma
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
Other:

Medications:

_____
_____
_____
_____
_____
_____

Drug Allergies:

_____
_____
_____

Flu Vaccine: Yes No Date:_____

Pneumococcal Vaccine: Yes No Date:_____

Social history:

(Circle all that apply)

Current smoker _____packs per day
Former smoker
Never smoker
Other drug use: _____

Alcohol use:

None

Less than 1 drink per day

3 or more drinks per day

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ROS (circle all that you are CURRENTLY experiencing)
Check if none apply ◯

Problems with bleeding
Problems with healing
Problems with scarring
Rash
Immunosuppression
Hay fever
Chest pain
Fever or chills
Night sweats
Unintentional weight loss
Thyroid problems
Sore throat
Blurry vision
Abdominal pain
Bloody stool
Bloody Urine
Joint aches
Muscle weakness
Neck stiffness
Headaches
Seizures
Cough
Shortness of breath
Wheezing
Anxiety
Depression

ALERTS (circle all that apply)
Check if none apply ◯
Allergy to adhesive
Allergy to lidocaine
Allergy to topical antibiotics ointments
Artificial heart valve
Artificial joints within past two years
Blood thinners
Defibrillator
History of MRSA
Pacemaker
Premedication prior to surgical or dental procedures
Rapid heartbeat with epinephrine
Pregnancy or Planning pregnancy

Patient Name: _____

Patient Signature:_____

Date: _____

HEIGHTS DERMATOLOGY
& AESTHETICS CENTER
&
Texas Dermatology Associates

INFORMED PATIENT CONSENT

Please initial all of the following statements.

_____ I give my permission for the doctors and staff of Heights Dermatology & Aesthetic Center/Texas Dermatology Associates to treat me, including any biopsy or procedure(s), as deemed necessary in the exercise of their professional judgement.

_____ I understand that medical care requires my cooperation, and I will follow my doctor's orders and prescriptions. If indicated, I will make and keep appointments for follow-up care and call the office to note any changes or concerns in my condition.

_____ I authorize Heights Dermatology/Texas Dermatology Associates to take photographs, video tape, or by other similar means to record my surgery/procedure(s). I understand that reproduction or publication of said photographs and recordings will be used for the purpose of medical/scientific study and research, education, before and after surgical portfolios, and/or documentation for my medical record.

_____ I understand that as part of a medical education institution, I may be seeing a Dermatology Resident, Dermatology Research Fellow, or a Mohs Surgical Fellow.

_____ I understand that the photographs and recorded material may include appropriate portions of the body to demonstrate surgery/procedure(s) and that every effort will be made to protect my identity in those materials.

_____ I further acknowledge that all recorded media obtained is the sole property of Heights Dermatology and Aesthetic Center & Texas Dermatology Associates.

_____ I have read and understand the medical consent forms that have been provided to me by the doctors and the staff of Heights Dermatology & Aesthetic Center.

_____ I authorize my doctor to release any information, including the diagnosis and the records of any treatment or examinations rendered to me or my child during the period of such medical care to third party payers, including Medicare.

_____ I authorize and request my insurance company, in lieu of reimbursing me directly, pay to the doctor or medical group any benefits for services rendered.

_____ I understand that my medical insurance carrier may pay less than the actual bill for services. I agree that I may be responsible for payments of all services rendered on my behalf or my dependents.

_____ I understand I may be billed by an outside laboratory for work that is performed in this office, if my insurance company does not have a contracted lab or facility, or if services are not covered by my insurance company.

Please check and print name in one of the choices below:

❑ I, _____ have received a copy of the Notice of Privacy Practices
PATIENT NAME

❑ I, _____ have been offered a copy of the Notice of Privacy Practices, but declined to accept a copy.
PATIENT NAME

_____ _____
Signature of Patient Date

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective January 1, 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing an insurance or health maintenance organization function, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year_____

ADDRESS _____

_____

CITY _____ **STATE**_____ **ZIP**_____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____Fax (_____)_____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to other covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.506(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective January 1, 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing an insurance or health maintenance organization function, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests.

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization.

Authorizations for Marketing Purposes - If this authorization is being provided or obtained for marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must also clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code § 181.152; 45 C.F.R § 164.508(a)(3)).

Limitations of this form - This authorization form should not be used for: (1) the disclosure of any health information as it relates to health benefits plan enrollment and/or related enrollment determinations (45 CFR §§164.508(b)(4)(ii), .508(c)(2)(ii)); or (2) the use or disclosure of psychotherapy notes (45 C.F.R. § 164.508(b)(3)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

Heights Dermatology & Aesthetic Center

&

Texas Dermatology Associates

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

Medical Record Number: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

Private Insurance Authorization for Assignment of Benefits and Information Release:
I, undersigned, authorize payment of medical benefits to Heights Dermatology & Aesthetic Center & Texas Dermatology Associates for any services furnished to me. I understand I am financially responsible for any amount not covered by my insurance.

Date: _____ Signed: _____
Insured or Responsible Party

Medicare Patients Only:
I request the payment of authorized Medicare benefits be made on my behalf to Heights Dermatology & Aesthetic Center & Texas Dermatology Associates for any services furnished me by the physician. I authorize any holder of medical information about me to release to The Health Care Financing Administration and its agents, by mail or fax; any information needed to determine these benefits or benefits payable for related services.

Date: _____ Signed: _____
Insured or Responsible Party