South Texas Dermatology

(Please Print)

Please present insurance card(s) at time of visit or a private pay waiver will be required

Name____ SS#______________________
Last First M.I.

DOB ______/_______/______ **(Circle response) Preferred contact method:** Home phone Cell Phone Email

Birth Sex: Male Female **Marital Status:** Single Married Divorced Widowed

Ethnicity: Hispanic Not Hispanic Decline **Race:** Caucasian Indian Asian African American/Black Decline

Address____
City State Zip

Home Phone___________________________________ Cell Phone _____________________________

Work Phone___________________________ Email address:__________________________________

Do we have your permission to:

Leave medical information on your answering machine at home or cell phone: Yes No

Discuss your medical condition with any member of your household: Yes No

If yes, whom____ Relationship:______________________________

In case of Emergency, who should be notified?______________________________Phone____________________

Primary Care Physician ______________________________Referred By:______________________________

Current Medications (List)____

Allergies:____

Pharmacy of choice ____Phone____________________

POLICY HOLDER INFORMATION (if different from patient)

Name ____
Last First M.I.

Home Phone __________________Work Phone _______________________Cell Phone____________________

SS#_________________________DOB _____/______/_____ Sex ______

To establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are on a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected. We accept payment in the form of cash, check or credit card. Your signature below signifies your understanding and willingness to comply with this policy.

Patient/Guardian Signature ____Date: _____/_____/______

SOUTH TEXAS DERMATOLOGY

Physician Assistant/Nurse Practitioner Consent

This facility does have on staff **Physician Assistants** and **Nurse Practitioners** to assist in the delivery of medical dermatology care.

A **Physician Assistant/Nurse Practitioner** is not a doctor. A **Physician Assistant/ Nurse Practitioner** is a graduate of a certified training program and are licensed by the state board. Under a physician's supervision, a Physician Assistant/Nurse Practitioner can diagnose, treat, and monitor common acute and chronic diseases and provide health maintenance care. "Supervision" does not require the constant physical presence of the supervision physician, but rather overseeing the activities of and accepting responsibility for the medical service provided.

A Physician Assistant/Nurse Practitioner may provide medical services within his/her education, training, and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and /or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting/performing surgery
- Supplying sample medications and writing prescription (where allowed by law)
- Making appropriate referrals

I have read the above and hereby consent to the services of **Physician Assistant/Nurse Practitioner** for my health care needs.

I understand that I can refuse to see the **Physician Assistant/ Nurse Practitioner** and request a physician.

_______________________________________   ____________________

Name   Date

_______________________________________   ____________________

Signature   Witness (Optional)

SOUTH TEXAS DERMATOLOGY

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, South Texas Dermatology may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to South Texas Dermatology's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices before signing this consent. South Texas Dermatology reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to

4141 S. Staples Suite #300
Corpus Christi, Texas 78411.

With my consent, South Texas Dermatology may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

With my consent, South Texas Dermatology may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, South Texas Dermatology may e-mail to my home or designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that South Texas Dermatology restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is beyond this agreement.

By signing this form, I am consenting to South Texas Dermatology's use and disclosure of my PHI to carry out TPO, release medical information to my primary care or referring physician, for consults if needed and as necessary to process insurance claims, applications, and prescriptions. I also authorize payment of medical benefits to the physician.

I may revoke my consent in writing except if the practice has already made disclosures in reliance on my prior consent. If I do not sign this consent, South Texas Dermatology may decline to provide treatment to me based on my decision not to comply with their PHI Policy.

____
Print Name of Patient or Legal Guardian

______________________________________ ______________________

Signature of Patient Date

NO SHOW POLICY

Thank you for choosing our practice for all your dermatology needs. We have made a few changes to our office policies effective January 1st, 2024. If you have any questions, please call our office (361)-882-5560.

Our goal here at South Texas Dermatology is to best serve our patients with quality care, as well as in a timely manner. To do so, we have established a "**NO SHOW**" policy. When a patient fails to show up to their scheduled appointment or cancel outside of 24 hrs., our valuable time and resources are missed. Most importantly, our ability to care for a patient in need is missed. We appreciate your courtesy when notified that you are unable to make your appointment, because it allows our office staff to schedule another patient who needs care. We do understand that on some occasions emergencies happen, or a conflict may arise that prevents you from making your appointment. We offer ONE grace no show for your first missed office visit appointment. However, if a future appointment is missed again, a no-show fee will be added to your account. Do understand, all fees accumulated are not your insurance's responsibility and will be billed directly to you. These fees will also be due upon your next scheduled appointment. Also, please be advised that multiple "NO SHOWS" may result in termination of care.

What is considered a no show: If you are scheduled and fail to cancel your appointment 24 hrs prior to your scheduled appointment time and/or arrive 15 minutes AFTER your appointment time, you will be considered a No Show.

What is the fee of a no show: All office visit appointments you will be charged a fee of $25 if you fail to cancel/reschedule within 24 hrs.; any cosmetic appointments, you will be charged a fee of $50.

For any scheduled surgeries that are not canceled/rescheduled within 24 hrs. of the appointment a $100 fee will be charged. The first missed surgery appointment will incur an immediate no show fee.

Patient name (PRINTED)______________________________________

Signature____

Date:____