STX SOUTHTEXAS DERM DERMATOLOGY
4141 S. Staples, Ste. 300
Corpus Christi, Texas 78411
PHONE: 361-882-5560
FAX: 361-882-6011
info@southtxderm.com
southtxderm.com

PATIENT DEMOGRAPHIC INFORMATION

Name: _____ Date of Birth: _____
Home Phone: _____ Mobile Phone: _____
Email Address: _____ Birth Sex: ☐ Male ☐ Female
Address: _____ City:_____ State:____ ZIP: _____
Emergency Contact: _____ Phone: _____
Primary Care Physician: _____
Pharmacy of Choice: _____
Current Medications: _____
_____
_____
Allergies: _____
_____
_____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Decline
Race: ☐ Caucasian ☐ Indian ☐ Asian ☐ African American/Black ☐ Decline

Do we have your permission to:

Leave medical information on your answering machine or voicemail?

☐ Yes ☐ No

Discuss your medical condition with another member of your household?

☐ Yes ☐ No

If yes, who: _____ Relationship: _____
also: _____ Relationship: _____

POLICY HOLDER INFORMATION

(if different from patient)

Name: _____ Date of Birth: _____
Home Phone: _____ Mobile Phone: _____

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CONSENT FOR THE 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.

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. South Texas Dermatology may also send me SMS messages pursuant to the terms outlined in the SMS Terms and Conditions.

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 reminders and patient statements.

With my consent, South Texas Dermatology may e-mail any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that South Texas Dermatology restricts 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 bound by 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.

Name: _____

Date: _____

Signature: _____

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NO-SHOW POLICY

Thank you for choosing South Texas Dermatology. Our goal is to provide quality care in a timely manner for all patients.

When an appointment is missed without proper notice, it prevents us from offering that time to another patient in need. We understand that emergencies and unexpected conflicts can occur. Therefore, we offer one courtesy grace no-show for a patient's first missed office visit. Additional missed appointments will result in fees and could ultimately lead to dismissal from the practice.

What is considered a no-show?

- Failing to cancel or reschedule by 2:00 pm the business day prior to the appointment.
- Arriving more than 15 minutes late for your scheduled appointment.
- Cancellation requests received while the office is closed will be considered received on the next business day and may still be subject to the no-show policy.

No-show fees

- Office visit appointments: $25
- Cosmetic appointments: $50
- Surgical appointments: $100

Please note:

- The first missed surgery appointment will incur the $100 no-show fee.
- No-show fees are the patient's responsibility and are not covered by insurance.
- All outstanding fees must be paid at your next appointment.

If you have questions regarding this policy, please contact our office at (361) 882-5560.

Name: _____

Date: _____

Signature: _____

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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 is 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 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 prescriptions (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: _____

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FINANCIAL POLICY

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 practice and your obligations for payment for services.

Our practice maintains a credit card on file for payment. Maintaining a card on file simplifies your payment process by collecting your final portion for services only **after** we have received the explanation of benefits (EOB) from your insurance provider. We will still collect co-pays prior to your general dermatology appointment, and co-pays, co-insurance, and deductibles prior to your surgery appointment that are determined before your appointment as required by your insurance carrier. You will receive notification **5 days prior** to us processing your payment on the card you have on file. All systems used to maintain card information are both Health Insurance Portability and Accountability Act (HIPAA) and Payment Card Industry (PCI) compliant.

Private pay patients will continue to pay in full at the time services are rendered to ensure private pay discount.

Your signature below signifies your understanding and willingness to comply with this policy.

Name: _____

Date: _____

Signature: _____