Today's Date: _____

PATIENT INFORMATION

Patient's Last Name: _____ First: _____ M.I. _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Cell: (_____)_____ Age: _____Sex: _____

Date of Birth: _____ /_____ /_____ SSN: _____Marital Status: _____

Email Address of Patient or Responsible Party: _____

Referring Physician/PCP: _____ Phone: (_____)_____

RESPONSIBLE PARTY (If Different from Patient)

Last Name: _____ First: _____ M.I. _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Cell: (_____)_____ Sex: _____

Date of Birth: _____ /_____ /_____

POLICY HOLDER INFORMATION (If Different from Patient)

Policy Holder Name: _____ Date of Birth: _____ /_____ /_____

SSN: _____ Employer: _____Phone: (_____)_____

Relationship to the Patient: _____

How Did You Hear About Us? (Please Check One)

Family _____ Friend _____ Doctor _____ Insurance _____ Facebook _____ Website _____

Other:_____

Do We Have Permission to: (Please Circle One)

Leave messages on your home/cell answering machine? **Y** or **N**

Leave messages regarding biopsy or lab results? **Y** or **N**

Discuss your medical condition with any member(s) of your household? **Y** or **N**

If Yes, Whom? _____ Relationship: _____

In case of emergency, who should be notified? _____

Relationship: _____ Phone: (_____)_____

I hereby consent to treatment by Bare Dermatology for the care of the patient indicated on this form. I authorize the release of medical information to my primary care, referring physician or other specialist and as necessary to process insurance claims or assist in the patient's treatment. I also authorize payment of medical benefits to the provider.

Signature of Patient OR Responsible Party _____

HISTORY AND INTAKE FORM

Patient Name: _____ **Patient DOB:** _____

Today's Date: _____

Reason for Today's Visit: _____

Past Medical History: (Please circle all that apply)

Anxiety	Depression	High Blood Pressure	Lymphoma
Arthritis/Osteoarthritis	Diabetes	HIV/AIDS	Multiple Sclerosis
Asthma	End Stage Renal Disease	High Cholesterol	Rheumatoid Arthritis
Atrial Fibrillation	Fibromyalgia	Hyperthyroid Seizures	None
Bone Marrow Transplant	GERD	Hypothyroid Stroke	
COPD	Hearing Loss	Leukemia	
Coronary Artery Disease	Hepatitis	Lupus	

Cancer: _____

Other: _____

Past Surgical History: (Please circle all that apply)

Appendix Removed	Coronary Artery Bypass	Ovaries Removed
Bladder Removed	Mechanical Valve Replacement	Prostate Removed
Breast Biopsy (Right/Left)	Biological Valve Replacement	Spleen Removed
Lumpectomy (Right/Left)	Hip Replacement (Right/Left)	Testicles Removed
Mastectomy (Right/Left)	Knee Replacement (Right/Left)	Thyroid Removed
Breast Implants	Kidney Biopsy	Partial Hysterectomy
Colectomy	Kidney Stone Removal	Full Hysterectomy
Gallbladder Removed	Kidney Removed (Right/Left)	NONE

Organ Transplant: _____

Other: _____

Skin Disease History: (Please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratosis	Eczema	Psoriasis
Asthma	Flaking or Itchy Scalp	Rosacea
Atypical Moles	Hay Fever	Shingles
Basal Cell Skin Cancer	Seasonal Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	NONE

Other: _____

Do you wear sunscreen? **YES** **NO** If yes, what SPF? _____

Do you or have you ever tanned in a tanning salon? **YES** **NO** When? _____

Do you have family history of Melanoma? **YES** **NO**

If yes, which relative(s)? _____

Do you have family history of Non-Melanoma Skin Cancer? **YES** **NO**

If yes, which 1st degree relative(s)?

_____

Medications & Dosages: (Please list all current medications and dosages)

_____

_____

_____

Drug Allergies: (Please list all medication allergies)

_____

_____

_____

Alerts: (Please circle all that apply)

Allergy to Adhesive	Artificial Heart Valve	Pacemaker
Allergy to Lidocaine	Blood Thinners	Defibrillator
Allergy to Topical Antibiotics	MRSA	Other Electronic Implanted Device

Have you had a joint replacement within last 2 years? **YES** **NO**

Does epinephrine give you rapid heartbeat? **YES** **NO**

Do you require antibiotics prior to a surgical procedure? **YES** **NO**

Do you have a history of fainting? **YES** **NO**

Are you pregnant or currently trying to get pregnant? **YES** **NO**

Vaccine History: (Please circle all that apply)
Have you had the flu vaccine? **YES** **NO** When?
Have you had the pneumonia vaccine? (65 or older) **YES** **NO**

Preferred Pharmacy Name: _____

Pharmacy Phone #: (_____)_____ City or Zip Code:_____

Social History: (Please circle all that apply)

Cigarette Smoking:	**Alcohol Use:**
Currently Smoke Cigarettes	3 or more drinks per day
Smoke Electronic Cigarettes	1-2 drinks per day
Have Smoked in the past	Less than 1 drink per day
Never Smoked	NONE

Preferred Language: English / Spanish / Other

Details/Comments:_____

_____

_____

_____

CONSENT FOR MEDICAL TREAMENT, ADMINISTRATION OF LOCAL ANESTHESIA AND THE PERFORMANCE OF MINOR SURGERY AND/OR PROCEDURES

1. I do hereby authorize the use and administration of such drugs, anesthetics and other treatments, including but not limited to performance of skin biopsies, the use of cryosurgery with liquid nitrogen and the injection of intralesional cortisone, therapeutic or investigational purposes by any appropriately trained and/or license health care professional on the medical staff of Bare Dermatology, for myself or my dependent.
2. I further consent to the examination for diagnostic or investigational purposes and disposal by authorities of the above named facility or its designates herein, of any tissue or parts which may have been removed.
3. I understand that the skin biopsy involves removal of a piece of tissue and that such removal results in a permanent scar and/or discoloration of the skin at the site of the biopsy. I further understand that more than one biopsy may occur during the visit.
4. I understand that all specimens removed are sent for analysis by a dermatopathologist and that the charges for dermatopathology will be billed to my insurance for a portion or all of these charges.
5. I understand that the destruction of a precancerous lesions, also known as actinic keratosis or solar keratosis, by liquid nitrogen may be deemed necessary by a member of the medical staff of Bare Dermatology to prevent the risk of these lesions evolving into a Squamous Cell Carcinoma.
6. I understand that the destruction of warts or molluscum by liquid nitrogen may be advised by a member of the staff at Bare Dermatology, but these types of lesions are not cancerous and do not necessarily need to be treated. I am aware that these types of lesions may require more than one single treatment.
7. I understand that the injection of intralesional cortisone for the treatment of scars, cysts, acne, and inflammatory conditions like Psoriasis, Atopic Dermatitis, and Alopecia may be deemed necessary, advisable, or desirable by a member of the medical staff of Bare Dermatology.
8. I understand that any of the above procedures may have some unwanted side effects, which include, but are not limited to permanent scarring, permanent discoloration of the skin at the site of treatment, atrophy (thinning or depression of the skin), infection, bleeding, nerve damage resulting in temporary or permanent numbness or temporary or permanent loss of function of certain muscles (paralysis).
9. I recognize the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures.

I acknowledge that I have read and fully understand the above information. Furthermore, I certify that all my questions and concerns regarding the procedure, its attendant risk, benefits, and alternatives have been explained to my satisfaction. I hereby authorize my provider(s) to perform the above discussed procedures as deemed necessary in my treatment plan.

Sign*:* _____ **Date** _____

BARE DERMATOLOGY

Financial Policy

Insurance

Insurance is a contract between you and your insurance company. In most cases, we are not a party to this contract. It is your responsibility to know your health plan benefits, including co-payment amounts, deductibles, coinsurance, and lab contracts. We will bill your primary insurance company on your behalf as a courtesy to you. To properly bill your insurance company, we require that you disclose all insurance information, including primary and secondary insurance, as well as any change of insurance information. We also require your ID and insurance card to be presented at your first visit. We will obtain a photocopy of these documents to assist in filing your claim. *You are responsible for any charges not covered by your insurance plan. Any amount not covered by the insured/patient's insurance is due within 30 days of the time of service.*

It is your responsibility to know if your insurance plan requires a referral authorization from your primary care physician or a pre-authorization from your insurance. You will need to contact your primary care physician or insurance company to be sure it has been obtained. If we have yet to receive authorization prior to your appointment time, we may reschedule. Failure to obtain the referral or preauthorization may result in a lower or no payment from the insurance company, and the balance will become the patient's responsibility. The patient will be responsible for services denied by insurance due to "No Eligibility", "Non-Covered Service", "Preauthorization/Certification Not Obtained". Statements are released after your insurance pays, denies, or non-payment by your insurance. Bare Dermatology does not bill workers' compensation or third parties.

It is our office policy that all accounts with pending balances be sent two statements, each one month apart. If payment is not made on the account, a single phone call will be made to try and make payment arrangements. Accounts with unpaid balances for 90 calendar days or more may be sent to an external collection agency or attorney for collection. Unpaid bills can also lead to possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for the collections costs, including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office if you are 18 years old or older and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

Time of service payments

Recent shifts in the healthcare industry have resulted in insurance companies increasingly transferring costs to patients. Although we estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility, benefits, and what portion of charges must be paid by you. Payments collected at the time of service are a calculated estimate based off the information provided by you and your insurance company, and they are not to be considered payment in full.

For insurance companies that we are contracted with, we will calculate an estimate of your co-payments (co-pays), co-insurance, and deductibles at the time of the visit. Co-payments, coinsurance, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are DUE AT THE TIME OF SERVICE.

If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. You may also elect to be seen as a Self-Pay patient and submit your own bill for reimbursement to your insurance company.

Self-pay or uninsured patients are responsible for payment at the time of service. The fee schedule is based on prevailing market rates. Cosmetic services cannot be submitted to insurance and payment in full is due at the time of service by credit card or cash only, no checks will be accepted.

Co-payments and co-insurance amounts, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are DUE AT THE TIME OF SERVICE. Failure to produce payment may result in your appointment being rescheduled. If this policy might prevent you from receiving necessary care, please contact us.

Credit card

Bare Dermatology retains credit/debit/HSA cards on file after the services are provided. This is done as a convenience for patients, as well as a measure to adjust to the constantly changing health insurance industry. Please keep in mind, we will not charge your card if you do not owe anything.

**Once your credit card information is entered, it is encrypted and cannot be viewed or accessed by our organization.

By signing the agreement, you understand that once the health plan has paid their portion for your care that you will receive an Explanation of Benefits (EOB). The health plan EOB will state any balance remaining to be paid by the patient. Bare Dermatology may charge your credit card the balance due when they receive a copy of the EOB. Charges will be made ONLY after the claim has been adjudicated by your insurance and you will have received an EOB from your insurance detailing the amount billed. If the charge exceeds $100, you will receive a courtesy call or email prior to authorizing the card on file. Circumstances when your card would be charged include but

are not limited to missed co-payments, deductibles and co-insurance, and non-covered services and/or denial of services.

If the credit card we have on file for you changes, please notify us immediately by calling our office. It's not uncommon for people to change or cancel their credit cards, including when it expires. If we run your credit card and it's denied for any reason, we reserve the right to charge an additional $25 declined card fee if we are not able to run a new credit card within 7 days. We will contact you or leave you a phone message if this occurs.

Pathology and Laboratory Services

Bare Dermatology uses third parties for our laboratory work and pathology services. You/your insurance will receive an additional bill from the lab service provider (e.g., DermPath Labs). These charges are independent of Bare Dermatology and are not part of the financial estimate provided at time of service. We are unable to adjust these charges as they are provided by a separate entity. We have no financial relationship with these third-party entities and receive no reimbursement these Services

No-Show/Late Cancellation Policy

We understand that you may need to cancel an appointment occasionally. In such circumstances, please contact us no later than 24 hours before your scheduled appointment time. You may do so by calling 972-483-9228.

If you do not show up for your appointment, or cancel or reschedule within 24 hours of your appointment time, we will consider that a no-show. No-show appointments may be subject to a $25 fee for office visits, and $50 for surgery or procedures. No-show fees are the patient's sole responsibility and must be paid in full before your next appointment. If the no-show fee might prevent you from receiving necessary care, please contact us.

We know that unexpected situations sometimes arise. In the case of emergencies or extenuating circumstances, we may waive the no-show fee. Waivers are determined on a case-by-case basis at the practice management's sole discretion.

If our office must cancel your appointment with less than 24 hours notice, you may choose to meet with a different provider (if available) on the same day, to reschedule, or to cancel. In these circumstances, we will not charge you a cancellation fee.

Minor Policy

A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account, according to the policy outlined on the previous pages.

Prescription Refills

Please contact your pharmacy to submit a refill request. If you need our assistance, please call for refills during regular office hours and leave the patient's name, DOB, phone number, medication, and the pharmacy requested. Please allow 48 business hours to complete the request. Some prescriptions may be delayed due to completing a PRIOR AUTHORIZATION form set forth by the insurance companies. For oral medications, biologics, and some topical medications, the patient needs to be evaluated every 6 months. We cannot refill a prescription if the patient has not been evaluated within 12 months.

I have read, understand, and agree to the above Financial Policy. I understand my financial responsibility to make payments for services provided to me and the courtesy extended by [Practice name] to simplify insurance reimbursement for the services provided to me. I acknowledge that these policies do not obligate [Practice name] to extend credit to me for services provided.

Patient or authorized representative signature:_____

Date:_____

Patient or authorized representative name:_____

BARE DERMATOLOGY

AUBREY
27045 E UNIVERSITY DR. STE 1A,
AUBREY TX 76227
#972-430-3888

MELISSA
3041 WASHINGTON DR. STE 400
MELISSA, TX 75454
#469-581-0599

DALLAS
2110 RESEARCH ROW, STE 310
DALLAS, TX 75235
#972-483-9200

GAINESVILLE
834 HWY 82, STE 102
GAINESVILLE, TX 76240
#972-483-9200

ROCKWALL
1005 W RALPH HALL PKWY, STE 207
ROCKWALL, TX 75032
#972-483-9228

FRISCO
12850 DALLAS PKWY, STE 300
FRISCO, TX 75033
#469-214-5202

ALLEN
977 RAINTREE CIRCLE, STE STE 120
ALLEN, TX 75013
#972-666-0636

HIPAA
NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you acknowledge and consent Bare Dermatology to use and disclose protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Bare Dermatology provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

BARE
DERMATOLOGY

ACKNOWLEDGEMENT FOR CONSENT TO USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

(PHI)

By signing below, I acknowledge that Bare Dermatology has made the Notice of Privacy Practices available to me. I authorize release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications and prescriptions.

The patient consents that the Protected Health Information will be used by Bare Dermatology or disclosed to other physicians, hospitals, pathology labs, insurance companies, billing agencies, financial institutions, or pharmacies for the purpose of treatment, obtaining payment, or supporting day-to-day health care operations of this office as well as the representatives named below. Under certain circumstances, we may use and disclose medical information for research purposes. However, all information will be de-identified (names, phone numbers, and addresses will be removed) and will not allow for the researchers or anyone else to determine that the information is related to you. The patient should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information (PHI) may be used or disclosed. The patient may request a copy of the Notice at the Front Desk.

By signing below, I acknowledge that I have received, read, and understand the Notice of Privacy Practices. I consent and or approve Bare Dermatology to release the medical information below to the following person(s):

Name: _____ Relationship: _____

Phone Number: (_____) _____-_____

Name: _____ Relationship: _____

Phone Number: (_____) _____-_____

- ☐ All medical information, including but not limited to: appointments, billing, test results,diagnosis, and procedures.
- ☐ Only the following types of information: _____

Patient (Guardian) Name: _____ **DOB:** _____
Printed Name

_____ **Date:** _____
Signature