The Skin Surgery Center of Houston
Libbyette E. Wright, M.D.

PATIENT REGISTRATION

Welcome and thank you for visiting our office today! My staff and I are committed to providing you with quality care. Please make yourself comfortable and let us know if we can assist you with anything.

Date _____ *E-mail Address* _____

Name: _____
First *Middle Initial* *Last*

Address: _____
Street *City* *State* *Zip* *Country*

Phone: _____
Home *Cell* *Work/Alternate*

Date of Birth: _____ *SSN:* _____ *Married* ____ *Single* ____ *Widowed*_____ *Other* _____

Patient's Employer _____ *Occupation* _____

Emergency Contact _____ *Phone* _____ *Relationship* _____

*Are you the **primary** insurance policyholder? Yes* _____ *No* _____ *If No, please tell us who is below.*

Primary Policyholder _____
First *Middle* *Last*

Relation to Patient _____ *Date of Birth* _____ *SSN* _____

AUTHORIZATION OF TREATMENT & ASSIGNMENT OF INSURANCE BENEFITS

I authorize Skin Surgery Center of Houston to perform medical and/or surgical procedures as deemed necessary. The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents. I will be bound by this signature as though the undersigned had personally signed the particular claim. I also agree, and understand that if my insurance company does not reimburse, Skin Surgery Center of Houston within 60 days, I give my full and written consent to file a normal written complaint with the Insurance Commissioner. I acknowledge and understand that I am responsible for all of the charges for the services rendered to me or any member of my family. The information above is complete and accurate to the best of my knowledge.

Signature of Patient or Guardian _____ ***Date*** _____

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PATIENT MEDICAL HISTORY

This information is considered confidential as part of a patient/physician relationship. THE INFORMATION PROVIDED BELOW WILL NOT BE RELEASED WITHOUT YOUR WRITTEN AUTHORIZATION. Please answer completely and accurately to the best of your knowledge.

Name: _____
First Middle Initial Last

Reason for Consultation? _____

Height _____ Weight _____ Age _____

Pharmacy _____ Address or Cross Streets _____ Phone _____

Please list all medical problems/conditions past or present: _____

Please list any previous surgeries or accidents: _____

Family History:

Family Members	Deceased, Alive or Unknown	Age of diagnosis	Diabetes I or Diabetes II	Hypertension (high blood pressure)	Heart Disease	Stroke	Cancer (type)
Father							
Mother							
Siblings							
Paternal Grandfather							
Paternal Grandmother							
Maternal Grandfather							
Maternal Grandmother							

Do you have or have you had any of the following? Please circle yes or no.

Asthma	Yes	No	Seizures	Yes	No	Heartburn	Yes	No
Bronchitis	Yes	No	Stroke	Yes	No	Ulcers	Yes	No
Emphysema	Yes	No	Kidney Disease	Yes	No	Stomach Problems	Yes	No
Breathing Difficulty	Yes	No	Dizziness	Yes	No	Intestinal Problems	Yes	No
Pneumonia	Yes	No	Tuberculosis	Yes	No	Hay Fever	Yes	No
High Blood Pressure	Yes	No	Liver Disease	Yes	No	Depression	Yes	No
Heart Disease	Yes	No	Cirrhosis	Yes	No	Cancer	Yes	No
Heart Attack	Yes	No	HIV/AIDS	Yes	No	Sinus Problems	Yes	No
Chest Pain	Yes	No	Hepatitis	Yes	No	Headaches	Yes	No
Diabetes	Yes	No	Thyroid Problems	Yes	No	Migraines	Yes	No
Pacemaker/Defibrillator	Yes	No	Fever Blisters	Yes	No	Arthritis	Yes	No

Have you had a flu shot? □ Yes □ No If YES, when? _____ / _____ / _____ Comments: _____
mm dd yyyy

Please list all medications you are currently taking: _____

Do you take Aspirin, Coumadin, Plavix, or any other blood thinners? _____

Any known allergies? (please list) _____

Are you a smoker? _____ If so, how much? _____ Do you drink alcohol? _____ If so, how much? _____

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PATIENT QUESTIONNAIRE AND HIPAA ACKNOWLEDGEMENT

Patient Name (print): _____ Date: _____

You may be contacted by the practice to remind you of appointments, healthcare treatment options or other health services that may be of interest to you.

Do we have permission to:

Leave a message on your answering machine at home? ____ Yes ____ No

Leave a message on your cell phone? ____ Yes ____ No

Leave a message at your place of employment? ____ Yes ____ No

Discuss your medical condition with a family member? ____ Yes ____ No

If yes, who? _____ Relationship _____ Telephone _____

Comment: _____

Skin Surgery Center of Houston has provided me with a copy of my rights (find a copy on our web site or ask for a copy in the office) as a patient under the HIPAA act. I have been provided the opportunity to read and understand my rights and ask questions regarding my rights and receive answers to my satisfaction. If you have questions, please address them with your physician during your visit.

_____ _____

Patient's/Guardian Signature Date

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Financial Policy

Skin Surgery Center of Houston is committed to providing you with quality care. As a patient of Skin Surgery Center of Houston, you are financially responsible for all medical services. Your clear understanding of our financial policy is important to our professional relationship. Our office will be pleased to discuss our professional fees with you at any time.

Patient/Insurance/Verification Information

As a patient you are responsible for providing accurate and complete insurance information. Your health insurance is a contract between you and your insurance company. It is your responsibility to contact your carrier to verify if provider is in network, coverage and payment obligations. At the time of scheduling your appointment, you will be asked to provide your insurance information. Our office reserves the right to contact your health insurance carrier to verify your coverage and payment responsibilities: this is not a guarantee of payment. If we are providers with your insurance carrier, as a courtesy to you, we will file a claim with your insurance carrier.

Again, your health insurance is a contract between you and your insurance company. We are not a party to your contract. Therefore, Skin Surgery Center of Houston cannot become involved in disputes between you and your insurance company regarding deductibles, non-covered charges, co-insurance, secondary insurance, coordination of benefits, pre-existing conditions, or "reasonable and customary" charges other than to supply factual information as necessary. You are responsible for timely payment of your account.

At check–in you will be asked to provide your insurance identification card, social security number, and state-issued identification. This is for your protection as well as to ensure that no changes in coverage have occurred.

Referrals

If you have a health plan that requires a referral from your primary care physician it is your responsibility to obtain this information prior to your appointment. It is also your responsibility to verify that you do not exceed the number of visits authorized by your primary care physician/health care plan. If you exceed your authorized visits you will be billed for all services rendered. <u>If you are unable to obtain a referral, your appointment will be rescheduled or you will be expected to pay for charges in full at the time of service.</u>

Co-payments/Deductibles/Coinsurance

All co-payments, applicable deductibles and coinsurance amounts will be collected upon patient check-in. In compliance with our contract with your insurance carrier, Skin Surgery Center of Houston cannot discount/waive any co-payment, deductible and/or coinsurance amounts.

Scheduled Procedures

If you have been scheduled to have a procedure, a representative from our office will contact you with instructions and prepayment of any unmet deductible. This amount will be collected prior to your procedure date. Our office works very diligently to schedule all procedures in a timely manner and coordinate authorizations with your insurance carrier; therefore, if you request to reschedule a procedure, our office requests at least 48 hours notice prior to your procedure date.

Self-Pay/Non-Contracted Plans/Non-Covered Services/Third Party Claims

Payment in full will be collected at the time of your office visit.

Medicare Patients

If you have regular Medicare part B and a secondary carrier (Medi-Gap plan) we will not collect any payment at the time of your visit. Our office will bill you for any portion of your bill not paid by Medicare and your secondary carrier.

If you have regular Medicare Part B only and have not met your deductible, we reserve the right to collect the deductible amount along with your 20% coinsurance at the time of your visit.

If you have regular Medicare Part B only and have met your deductible, we reserve the right to bill your 20% coinsurance at the time of your visit.

Out of Network Patients

Any applicable deductible, co-payment, coinsurance, and non-covered services will be collected at the time of your office visit. Please contact your insurance carrier for guidelines pertaining to your coverage.

Laboratory Authorization

Skin samples are sometimes sent to a laboratory for microscopic evaluation to determine or confirm proper diagnosis. I authorize and understand that I am responsible for the cost of any testing or lab services performed for me and that billing of such services may be billed independently by another physician or laboratory if my insurance doesn't pay or I am a self-pay patient.

Medical/Billing Records Requests/Patient Document Requests

All records requests must be submitted in writing and must include a signed release from the patient. All records requests will be processed within 15 days from the receipt of payment.

Patient Balances

Any patient balance due after your insurance company has processed your medical charges will be billed: this balance is due upon receipt. If the balance is not paid or payment agreement established, your account will be forwarded to an outside collection agency within 90 days of the first billing statement.

Upon arrival for an appointment, any outstanding balance due will be collected at check-in.

Methods of Payment

Our office accepts cash, check (with proper identification), Debit, VISA, Discover, American Express and MasterCard.

- I have received a copy of Skin Surgery Center of Houston's Financial Policy, which I have read and understand.
- I understand that I am personally responsible for payment on my account.
- In the event my insurance company deems a service to be "non-covered", I understand that I am personally responsible for payment.

Patient's/Guardian Signature: _____ Date: _____

Printed Name: _____