The Skin Surgery Center of Houston
Libbyette E. Wright, M.D.
Tarek Fakhouri, 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? _____

Skin Surgery Center of Houston

Informed Consent for Surgery

Patient Name: _____ Date: _____Time: _____

Diagnosis requiring procedure: _____

Please *read* and *initial* the items below.

- _____ I hereby request and authorize Skin Surgery Center of Houston, aided by assistants, to perform surgery on me on or about the _____ day of _____, 20_____ for the purpose of removing skin cancer and reconstructing the resultant defect.

- _____ I also authorize the operating surgeon to perform any other procedures that she may deem necessary or desirable in the attempt to improve the condition(s) stated above or any other unhealthy or unforeseen condition that she may encounter during the operation. Occasionally, dermabrasion or chemical peel (normally considered cosmetic) may be recommended along with the scheduled surgery. I consent to the administration of anesthetics to be applied by or under the direction of my physician to the use of such anesthetics and medications as deemed advisable in my case.

- _____ I have been advised that this surgery involves external skin incisions which may leave permanent scars, as is the case in all human beings. I understand that scars may take one year or more to fully mature, usually starting out pink to red and usually fading gradually to white in the first 12 months depending on skin tone. I have been advised that in the first few months after surgery, sunlight tends to darken scars and make them more noticeable. Though most scar lines heal normally, some scars can heal abnormally thick (keloids and hypertrophic scars) or abnormally thin (atrophic scars). How scar lines heal depends on many factors, including but not limited to body location, individual variations in the healing process between patients, and quality of wound care postoperatively. I understand that additional procedures are sometimes necessary in order to obtain the best possible functional and cosmetic result and that these costs may or may not be covered by insurance. I also understand that after removal of the cancer I may have the area repaired by a plastic surgeon of my choice. If I have surgery on my leg(s) I understand the importance of limiting walking as much as possible. This includes no exercise until permission is given by my physician. I understand that leg elevation above the level of the hip is important to decrease swelling. Swelling may slow healing, cause an infection of the wound and/or result in the opening of a sutured wound. Healing may take weeks to months on the lower extremity. Therefore, I understand to assist in healing, I will limit activity, elevate the extremity and follow wound care instructions.

- _____ I agree to follow the instructions given to me by my physician or medical assistant to the best of my ability before, during, and after the operation, and I will, as soon as possible, notify the office of any questionable conditions that may arise.

- _____ I have read and understand the handouts pertinent to my surgery. The nature and usual effects of the proposed operation, the foreseeable risks involved, and alternative methods of treatment have all been explained to me in terms that I understand. **In particular, the risks may include: bleeding, infection, excessive scarring, nerve damage, altered sensation, adverse reaction to medications, and incomplete tumor removal. Practical alternative methods of treatment include: radiation, traditional excision, cryosurgery, electrodessication and curettage.**

- _____ I understand that any price quoted by The Skin Surgery Center of Houston will include physician services only and does not include outside laboratory or facility fees unless otherwise specified.

- _____ I am aware that the practice of medicine and surgery is not an exact science and, therefore, reputable physicians cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding this operation that I have herein requested and authorized. I have been advised that the goal of the operation I have requested is improvement of the condition and that there is a possibility that imperfection may arise and that results might not live up to my preconceived expectations.

- _____ I hereby give permission to our physicians or any assistant to take photographs for diagnostic purposes and to enhance the medical record. I agree that these photographs will remain the property of Skin Surgery Center of Houston.

- _____ I hereby state that the information furnished as part of my comprehensive preoperative evaluation is correct. I have been given an opportunity (your physician will consult with you before surgery) to ask questions regarding this operation and the matters covered in the preceding paragraphs, and all questions have been answered to my satisfaction.

_____ _____

Patient or Legal Guardian's Signature Date

_____ _____

Witness Signature Date

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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: _____