17756 KATY FREEWAY STE G-1
HOUSTON, TX 77094
PHONE: 832-772-3330
FAX: 832-772-3332

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.

Today's Date: ___/___/___ Name: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Email Address: _____ Preferred Contact: ❒ Cell ❒ Home ❒ Work

Date of Birth: _____/_____/_____ Age: _____ Sex: ☐ M ☐ F Marital Status: _____

Social Security Number: _____- _____ - _____

Referring Physician's Name: _____ Phone:_____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Primary Insurance: _____	Secondary Insurance: _____
Insured's Name: _____	Insured's Name: _____
Social Security Number: _____	Social Security Number: _____
Policy #: _____	Policy #: _____
Group #: _____	Group #: _____
❒ Self ❒ Spouse ❒ Child ❒ Other	❒ Self ❒ Spouse ❒ Child ❒ Other
Insured's Employer:_____	Insured's Employer: _____
Insured's Date of Birth: _____/_____/_____	Insured's Date of Birth: _____/_____/_____

Patient's Employer: _____

Occupation: _____ Full-Time Student? ☐ Yes ☐ No

Emergency Contact: _____ Phone Number: _____

Relationship of Emergency Contact: _____

Name of Parent or Guardian (if patient is a minor): _____

How did you hear about us? ❒ Physician ❒ Family member ❒Friend ❒ ZocDoc
❒Employer/Insurance Company ❒Google/Internet Search ❒Magazine/Phonebook
❒ Other: _____

I understand that office visit charges are payable on the day service is rendered. I authorize Clear Dermatology to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Clear Dermatology and myself.

_____

Patient Name (print) Patient Signature Date

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MEDICAL HISTORY

Today's Date: ____/_____/_____ Name: _____

The reason for your visit: _____

Height: _____ Weight: _____ Age: _____

Pharmacy: _____ Pharmacy Phone: _____

Please list all medications you are currently taking: _____

_____

_____

Drug Allergies: _____

Are you interested in treating wrinkles, skin texture, skin tone, reversing sun damage, or facial rejuvenation? ❒ Yes ❒ No

Medical History: (Please check)

❒ Allergies/Sinus Problems
❒ Artificial Heart Valve
❒ Asthma
❒ Breathing Difficulty
❒ Bleeding/Clotting Problem
❒ Cancer
❒ Chest Pain
❒ Cold Sores
❒ Congestive Heart Failure
❒ Depression
❒ Diabetes
❒ Emphysema
❒ Excessive Sweating
❒ Glaucoma
❒ Hair Loss
❒ Hay Fever
❒ Headaches
❒ Heart Attack
❒ Heart Disease
❒ Hepatitis
❒ High Blood Pressure
❒ High Cholesterol
❒ HIV/AIDS
❒ Inflammatory Bowel Disease
❒ Joint Replacement
❒ Migraines
❒ Osteoporosis
❒ Pacemaker
❒ Polycystic Ovary Syndrome
❒ Stomach Problems
❒ Thyroid Problems
❒ Tuberculosis
❒ Ulcers

For Women: Are you currently pregnant, actively trying to get pregnant OR breastfeeding?
❒Yes ❒No

Social History:

Do you wear sunscreen regularly? ❒ Yes ❒ No Use tanning beds? ❒ Yes ❒ No
Do you smoke? ❒ Yes ❒ No Drink alcohol? ❒ Yes ❒ No

Family History:

Condition	Family Member (Relationship)
Skin Cancer	
Melanoma	
Asthma/Eczema/Seasonal Allergies	
Psoriasis	
Autoimmune Disorders	
Other: _____	

Please list any previous surgeries: _____

_____

_____

CLEAR
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APPOINTMENT CANCELATION POLICY

We understand that unplanned circumstances arise that might require you to cancel an appointment. If this happens, we respectfully ask that you provide us with **24 hours notice**. This allows us to offer the time to another patient who needs to see the doctor.

If **24 hours notice is not provided**, you will be billed a $50.00 fee for an office visit, or $150.00 for an office procedure. This fee is not covered by your insurance.

Thank you for your consideration.

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NOTICE OF PRIVACY AND HIPAA

Today's Date: _____/_____/_____ Name: _____

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.

Leave a message on your preferred contact number regarding **medical results**? Telephone:_____

Do we have permission to confirm your appointment via email? ❒ Yes ❒ No

Do we have permission to discuss your medical condition with a family member?

❒ Yes ❒ No

If yes, who? _____ Relationship: _____ Telephone:_____

Clear Dermatology 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 any questions, please address them with the physician during your visit.

I acknowledge that Clear Dermatology has made the Notice of Privacy Practices available to me. I authorized 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. I also authorize payment of medical benefits to the physicians.

_____

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FINANCIAL POLICY – Page 1 of 2

Clear Dermatology is committed to providing you with quality care. As a patient of Clear Dermatology, 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, Clear Dermatology 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. If you are unable to obtain a referral, you will be expected to pay for charges in full at the time of service.

CO-PAYMENTS/DEDUCTIBLES/COINSURANCE
All co-payments, applicable deductibles, coinsurance and will be collected at the time of service. In compliance with our contract with your insurance carrier, Clear Dermatology cannot discount/waive any co-payment, deductible and/or coinsurance amounts.

SELF-PAY/NON-CONTRACTED PLANS/NON-COVERED SERVICES/THIRD PARTY CLAIMS
Payment in full will be collected at the time of your office visit.

PATHOLOGY/LABORATORY
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.

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FINANCIAL POLICY – Page 2 of 2

COSMETIC FILLER APPOINTMENTS
Patients scheduling a cosmetic filler appointment will be asked to leave a $150 deposit. This will be applied towards service provided at that visit. If you need to cancel or reschedule your appointment, please provide us with 24hrs notice and your deposit will be fully refunded. In the event 24hrs notice is not given, the deposit is non-refundable.

MEDICARE PAYMENTS
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 will 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 will only 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.

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 and MasterCard.

- I have read the Financial Policy of Clear Dermatology.
- 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 Name (print) Patient Signature Date

CLEAR
DERMATOLOGY

PHYSICIAN DISCLOSURE OF FINANCIAL INTEREST

The physicians of Clear Dermatology P.L.L.C. are dedicated to providing the highest quality and complete dermatologic healthcare services. Ownership in ADG Houston Pathology P.L.L.C. reflects our commitment to providing the highest standard of patient care in the office, laboratory, and surgical settings.

Compliance & Disclosure under Texas Occupations Code – Section 102.006

In compliance with section 102.006 of Texas Occupations Code and in connection with my informed consent and personal choice of doctors or facilities, my attending doctor(s), and/or clinic (facility), have disclosed to me at the time of initial contact: (A) his/her affiliation, if any, with any doctor or facility for whom I may be referred to, and (B) whether he/she will receive, directly or indirectly, remuneration for a requested referral to the doctor or facility. Such disclosures have been made in compliance with all applicable federal and state laws, Medicare, the Employee Retirement Income Security Act (ERISA), the Patient Protection and Affordable Care Act (PPACA), as well as Section 102.006 of Texas Occupations Code.

Every effort will be made by ADG to process the charges associated with these services under your insurance plan, even if our office does not accept your insurance. In the event ADG cannot process these charges through your insurance plan, or if you do not have insurance, then you will be responsible for payment as with any dermatopathology lab.

Our relationship with ADG enhances our ability to direct the manner in which your care is delivered by the pathology laboratory. If you have any concerns regarding ADG or the manner in which we deliver pathology services, please do not hesitate to contact our office to request additional information.

Sincerely,
Katherine M. Cox, M.D. and Heather M. Richmond, M.D.

Patient Acknowledgement

I understand that this disclosure form is intended to help me make a fully informed decision about my personal choice of pathology providers and facilities. I understand that I have the right to choose and am not obligated to use a specific pathology provider or facility to which my physician has referred me.

I have read and fully understand the above disclosures. I hereby acknowledge receipt of the foregoing Physician's Disclosure of Financial Interest.

_____

Patient Name (print) Patient Signature Date