KEY DERMATOLOGY

4949 Golden Triangle Blvd, Ste 611
Fort Worth, TX 76244
(tel):817-898-2188 (fax):817-439-6055

NEW PATIENT CHECK-IN PACKET

Thank you for scheduling with Key Dermatology. Please complete and bring this packet **prior to arrival** so that we can help expedite your visit and make your check-in process easier.

CHECKLIST REMINDER

Bring the following with you to your appointment:

☐ New Patient Check-In Packet (please complete prior to arrival)

☐ Form of picture identification (driver's license)

☐ Your insurance card (if applicable)

☐ Medication list (can be listed on the check-in form, or separately)

☐ Form of payment

☐ If your insurance requires a referral from your primary care physician (PCP), you will need to have your PCP send us the referral to allow us to see you.

☐ Please plan to arrive 15 minutes prior to your scheduled appointment time.

Please call us at (817) 898-2188 if you have any questions. Thank you and we look forward to seeing you soon.

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New Patient Checkin Forms

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Patient Demographics

First Name	Middle Name	Last Name	
Address	City	State	Zip
Do you go by a nickname?	Date of Birth	Social Sec #	☐ Male ☐ Female ☐ Transgender
Mobile Phone ☐ Primary Number	Home Phone ☐ Primary Number	Work Phone ☐ Primary Number	
Voicemail Messages on Mobile Phone? ☐ Yes ☐ No	Voicemail Messages on Home Phone? ☐ Yes ☐ No	Voicemail Messages on Work Phone? ☐ Yes ☐ No	
Text Messages on Mobile Phone? ☐ Yes ☐ No	Occupation	What is your preferred method of communication? ☐ Mobile Phone ☐ Home Phone ☐ Work Phone ☐ Email	
Employer	Email Address		

Complete this section if the patient is NOT the primary policyholder or if patient is a minor.

Responsible Person

First Name	Last Name	Relationship to Patient	
Address	City	State	Zip
Mobile Phone	Home Phone	Work Phone	

☐ Check here if emergency contact name and address is the same as responsible person above and skip "Emergency Contact" section below.

Emergency Contact

First Name	Last Name	Relationship to Patient	
Address	City	State	Zip
Mobile Phone	Home Phone	Work Phone	

How did you hear about us?	Who should we thank for the referral?

Insurance

PRIMARY Insurance Company	Insurance Plan Name	Group Number
Member Number		Effective Date
SECONDARY Insurance Company	Insurance Plan Name	Group Number
Member Number		Effective Date

☐ Check here if the patient (self) is the insurance subscriber policyholder and skip "Insured Person/Insurance Subscriber" section below.

Insured Person / Insurance Subscriber

How is the patient related to the insured person or insurance subscriber policyholder? ☐ Spouse ☐ Child ☐ Other:

First Name	Middle Name	Last Name	
Date of Birth	☐ Male ☐ Female ☐ Transgender	Phone Number	Other Phone Number
Address	City	State	Zip

Preferred Pharmacy Name	Address or Location (street or intersection and city)
Primary Care Physician Name	City

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PATIENT NAME		DATE OF BIRTH	
REASON FOR TODAY'S VISIT			
ALLERGIES (list medication allergies)			
MEDICATIONS (list ALL medications you are taking including vitamins, aspirin, supplements, herbals, over-the-counter)			
SKIN CONDITIONS HX	☐ NONE	☐ Acne	☐ Actinic keratosis / "AKs"
☐ Basal cell skin cancer	☐ Dysplastic nevus/moles	☐ Eczema/atopic dermatitis	☐ Keloids
☐ Malignant Melanoma	☐ Psoriasis	☐ Squamous cell skin cancer	
☐ Other skin conditions:			
MEDICAL CONDITIONS HX	☐ NONE	☐ Anxiety/Depression	☐ Arthritis
☐ Asthma	☐ Blood clotting disorder	☐ Crohn's disease	☐ Cancer: ____________________
☐ Diabetes	☐ HIV positive	☐ Heart attack	☐ Heart disease
☐ Heart failure	☐ Hepatitis B	☐ Hepatitis C	☐ High blood pressure
☐ Kidney disease	☐ Liver disease	☐ Lupus	☐ Mental disorder: ____________
☐ Migraine	☐ Seasonal allergy	☐ Seizure	☐ Stomach ulcer
☐ Stroke	☐ Thyroid disease	☐ Tuberculosis	☐ Ulcerative colitis
☐ Other:			
OBSTETRIC HISTORY	☐ NOT APPLICABLE	☐ Mother currently breastfeeding	☐ Pregnant
BODY MASS INDEX (BMI)	Height ________ft _________ in	Weight____________ lbs	
HISTORY OF EXPOSURE	Excessive sun exposure?	☐ Yes	☐ No
	Exposure to radiation?	☐ Yes	☐ No
	Sunscreen use?	☐ Yes	☐ No
	Skin tanning / tanning bed use?	☐ Yes, in the past	☐ Yes, currently ☐ No
PAST SURGERIES	☐ NONE	☐ Bone marrow transplant	☐ Heart valve replaced
	☐ Implant internal cardiac defibrillator	☐ Joint replaced	☐ Solid organ transplant
	☐ Implant cardiac pacemaker		
SMOKING STATUS	☐ Past tobacco smoker	☐ Never smoked tobacco	☐ Smoker currently
ALCOHOL USE	☐ Does not drink alcohol	☐ Heavy drinker 7-9 drinks/day	
	☐ Social drinker	☐ Moderate drinker 3-6 drinks/day	
		☐ Light drinker 1-2 drinks/day	
MARITAL STATUS	☐ Married ☐ Single	☐ Divorced	☐ Widowed
ADVANCE CARE PLAN / ADVANCE DIRECTIVE	If over age 65, do you have an advance care plan (advance directive)?		☐ Yes ☐ No
	If so, please name surrogate decision maker ______________________		
	☐ I do not wish to name a surrogate decision maker.		
FAMILY HISTORY	Do you have a first degree relative who had melanoma?		☐ Yes ☐ No
	If yes, which relative:		

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Fee Policy

Payment Guidelines: Each patient is responsible for knowing their own insurance coverage including the deductible, copayment and coinsurance and the coverage policies for procedures. Each patient is also responsible for obtaining their referral and knowing the number of visits allowed, the effective and expiration date of that referral. Our office attempts to verify each patient's insurance benefits with the insurance company prior to the visit. Each patient is charged according to the insurance benefit information we receive from their insurance company. ***All deductible charges, copayments and coinsurance charges are due at check-in and any additional procedure costs are due at the time service is rendered. If you are unable to comply with this policy, please reschedule your appointment.*** Once the insurance claim has been processed and an explanation of benefits (EOB) is received, a bill or a credit will be issued if necessary. Procedures are applied to the deductible and include freezing/cryosurgery, application of topical or intralesional medication, biopsy, surgical excision, drainage of abscess, wart removal, etc. These procedures are very seldom covered under the copay alone. Key Dermatology is a specialist office and as defined by the insurance companies, is not a primary care provider (PCP). The fee schedule for each procedure has been predetermined by each insurance company contracted with Key Dermatology. We will file all claims for all plans in which we participate. For all others, we will provide you with a computer-generated insurance form if requested. We accept credit cards, cash and checks (no checks above $100). A processing fee of $35.00 will be assessed in addition to the amount of the check if your check is returned.
Cancellation Policy: We require a 24-hour notice for all cancellations otherwise a $50.00 charge may be assessed.
Identification: A valid driver license or form of ID such as a passport for the patient is required at each visit in order to be seen. In the case of a minor, valid identification of the guardian or responsible person present is required.
Minors: Minors must be accompanied by their guardian at each visit in order to be seen.
Insurance Card: Please present your insurance card at EACH VISIT. Specifically bring to our attention any changes (new card, new subscriber or group number, etc.) since your last visit. This protects you from paying a bill due to providing incorrect information. There is a narrow window (30-45 days) to present an accurate claim to the correct insurance company. Failure to do so could mean the claim may be denied. If you have a secondary insurance, it will be filed as a courtesy. However, if we have not received payment from your secondary insurance in a timely manner, the balance will become your responsibility.

Patient Financial Acknowledgement

I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered to myself and/or my dependents. I understand that it is my responsibility to verify that Key Dermatology is a provider on my insurance plan before I present to the office for treatment. I agree to obtain a referral from my primary care physician if this is required by my insurance company. I understand that I am ultimately responsible for knowing the specifics of my insurance plan including copays, deductibles, and excluded treatments. Any charges from Key Dermatology not paid by my insurance company will be my sole responsibility. In the event this office files medical insurance on my behalf, I authorize the release of medical information necessary to process claims. I also authorize payment of medical benefits to the Doctor for services provided. A photocopy of this assignment is as valid as an original. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. ***I agree to pay deductible charges, copayments and coinsurance charges at check-in and any additional procedure costs at the time service is rendered.*** My account will be charged $35 for any returned checks.

Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Key Dermatology to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Key Dermatology's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Key Dermatology reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Key Dermatology, Privacy Officer at 3516 Golden Triangle Blvd, Suite 120, Fort Worth, TX 76244. With this consent, Key Dermatology may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. With this consent, Key Dermatology may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Key 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 Key Dermatology's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Key Dermatology may decline to provide treatment to me.

Patient/Guardian Signature	Patient/Guardian Name	Date

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General Consents

Consent for Medical Treatment: By signing below, I (or the patient's duly authorized representative) authorize the evaluation, examination, and treatment by Dr. Nguyen and her staff. I consent to treatment necessary for my dermatologic care. I voluntarily consent to and authorize medical care encompassing all diagnostic and therapeutic treatments considered necessary or advisable in the judgement of the physician, his/her assistants, or designees. All medical care and treatments will be discussed with me prior to any proposed treatments, testing, or medical procedures being scheduled. I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me as to the results of treatments or examinations performed.

Skin growths may be treated by freezing, injections, snip removal, extractions, application of a topical or intralesional medication and/or electrocautery with a heated needle. A skin biopsy (taking a small sample of skin under local anesthesia) may be used for diagnosis. I understand I can refuse any procedure. I understand that there are risks to any procedure, including, but not limited to: allergic reaction, skin discoloration (lighter or darker) or scarring, bleeding, nerve Injury (rare), pain, lesion recurrence, infection and wound dehiscence (opening). **I consent to having these procedures done as part of my evaluation and treatment.**

By my signature below, I also understand the following:

- Total body examinations for skin cancer screening are performed if specifically scheduled in advance or if time permits as this requires additional time.
- I understand that most clinic visits are scheduled for consultation of a specific skin condition. Procedures, even minor removals, may need to be scheduled at a separate time. Key Dermatology will try to accommodate procedures if time permits.
- I am aware that there are potential risks to any treatment or medication (oral or topical) prescribed. Dermatological conditions are often chronic in nature and may require ongoing care and the need for me to schedule follow up appointments.
- I understand that all tissue removed is sent to a pathology lab for analysis. Removals will not be performed without tissue analysis. **The pathology lab will charge a fee for tissue analysis separate and independent of the procedure charge.** If your insurance company does not cover this charge, it is the responsibility of the patient or guardian to cover this expense.
- **I understand that ANY PROCEDURE including but not limited to freezing/cryosurgery, application of topical or intralesional medication, biopsy, surgical excision, drainage of abscess, wart removal, etc. will be a procedural charge applied to my deductible. I may request cost prior to procedure.**

Consent for Photography: I also understand that in the course of that treatment, photographs may be taken for clinical purposes. If photographs will be used for commercial or educational purposes, I will be provided an additional authorization. No videotaping or photography is allowed by non-staff members.
Consent for Filing Insurance Claims: I understand that, in order to file claims and release medical information to any insurance company(s) I have listed in my financial record, Key Dermatology is required to keep my signature on file. I hereby authorize Key Dermatology to receive benefits directly from my insurance company when an assigned claim is filed. I also authorize Key Dermatology to appeal any denial to my insurance company on my behalf and authorize the release of any medical information to my insurance company(s) that is necessary for the processing of claims.
Consent for Electronic Communication of Appointment Reminders: I understand that Key will send appointment reminders and information on services via telephone, email and/or text message based on the contact information I have provided. I further understand that I will have the option to opt out of future text/email reminders.
Consent to Obtain External Prescription History: I understand Key Dermatology utilizes electronic prescribing technology via the electronic medical record system EZ Derm. I understand that my prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. Detailed prescription history provides your provider valuable information and improves accuracy in your medication list.
Notice of Privacy Practices: I acknowledge that I have been given the opportunity to receive the Notice of Privacy Practices. This notice identifies how medical information about you may be used and disclosed, and how you can gain access to this information.

I understand that the duration of this authorization and consents are indefinite unless otherwise revoked in writing. I hereby state that the above information is true and correct to the best of my knowledge.

Patient/Guardian Signature	Patient/Guardian Name	Date

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HIPAA Contact / Patient Authorization for Personal Representative

I authorize Key Dermatology to disclose or provide my protected health information to the following individual(s) who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information.

- You authorize the practice to disclose all your protected health information to your designated personal representative.
- This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.
- As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to: Key Dermatology PLLC, 3516 Golden Triangle Blvd, Suite 120, Fort Worth, TX 76244 / Attn: Privacy Manager.

☐ Check here if emergency contact is the patient's authorized personal representative to receive protected health information.

Name of Representative	Relationship	Phone Number
Name of Representative	Relationship	Phone Number
Name of Representative	Relationship	Phone Number

Re-disclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization, will no longer be protected by requirements of the Privacy Rule and will no longer be the responsibility of this practice. Copies of signed authorizations are available upon request.

Patient/Guardian Signature	Patient/Guardian Name	Date