DERMATOLOGY CONSULTANTS OF FRISCO
AND
PRECISION DERMATOLOGY
Three Convenient Locations, One Great Team

PATIENT INFORMATION:

Name: ________________________________ Home #: (____) ______ - _________

Address: _______________________________ Cell #: (_____) ______ - ___________

City: ___________ State: ______ Zip: ______ E-mail: ______________@_________

DOB: ____/____/______ Age: ___________ Sex: M / F

Married? Y / N Spouse Name: ____________________________

SSN: _____/_____/_______ Driver's License #: ________________

Occupation: ____________________________ Work #: (_____) ______-_________

Employer: ____________________________ City: _________________________

NEXT OF KIN/FRIEND NOT LIVING WITH YOU:

Name: ______________________ Relationship: ____________ Phone #: (____) ______-_______

IF PATIENT IS A MINOR, PLEASE COMPLETE:

Name of Parent/Guardian: ______________________________ Phone #: (____) ______-_______

Employer: ____ Work #: (____) ______-_______

DID A PHYSICIAN REFER YOU?

☐ Physican Name: __________________________________ Tel #: (_____) ______-________

Address: ______________________________ City: ____________ State: __________

IF NOT, HOW DID YOU HEAR ABOUT US?

☐ Friend/Family ☐ Saw our sign ☐ Insurance Book ☐ Google ☐ Frisco Style
☐ AT&T Collin County Yellow Pages ☐ Verizon Collin County Yellow Pages
☐ Verizon Denton County Yellow Pages ☐ 380 Guide ☐ 380 News ☐ Our Website
☐ Other: ____

INSURANCE/PAYMENT INFORMATION (if not self):

Insured Person's Name: _________________________________ Relationship: ________________

DOB: _____/_____/________

At Dermatology Consultant of Frisco and Precision Dermatology, we strive to offer exceptional and thorough care, while also being respectful of the time of every patient. With this in mind, we can successfully address up to 3 medical problems per visit. However, problems beyond this may need to be addressed at a future scheduled visit. We appreciate your understanding and thank you for choosing us!

Electronic prescribing systems can help reduce error rates and allow your dermatologist to check medications prescribed by other offices. I agree to allow my dermatologist to perform this check if found to be medically necessary or useful.

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Current Skin Condition of Concern: ____

____

____

Please list any specific cosmetic concerns: ____

____

____

MEDICAL HISTORY:

☐Cataracts ☐Cancer ☐Osteoarthritis ☐Osteoporosis ☐Glaucoma
☐Diabetes ☐Hay Fever ☐Asthma ☐HIV/AIDS ☐Kidney Dz ☐Thyroid Dz
☐Heart Dz ☐Liver Dz ☐↑Blood Pressure ☐Nail Disorder ☐Epilepsy ☐Acid Reflux
☐↑cholesterol ☐Pacemaker/defibrillator

☐Currently Pregnant/Due Date: _____/______/_______ ☐Currently Breastfeeding

☐Operations:____

☐Transplants (list organ):______________________

☐Current Medication: ____
____

Circle one: Smoke: Yes / No Drink Alcohol: Yes / No If yes, how many?___________

Used a tanning bed in the past year: Yes / No

☐Previous Skin Cancer (circle)? BCC Location:__________________ When?______
SCC Location:__________________ When?______
Melanoma Location:__________________ When?______

BCC= basal cell carcinoma; SCC= squamous cell carcinoma

☐Family History of Skin Cancer? BCC SCC Melanoma Unknown Type

☐Family History of Skin Problems? ____

Race: African American / Asian / Caucasian / Hispanic / Other: ______________________

Medication Allergies

Medication: Reaction:
Medication: Reaction:
Medication: Reaction:
Medication: Reaction:

4685 ELDORADO PKWY, STE 100
FRISCO, TEXAS 75033
P. 972.335.2727
F. 972.668.8444

1601 W. HEBRON PKWY, STE 220
CARROLLTON, TEXAS 75010
P. 469.208.7181
F. 972.668.8444

2435 W. OAK STREET, STE 102
DENTON, TEXAS 76201
P. 940.312.6767
F. 972.668.8444

Summary of Office Policies

NOTICE REGARDING PAYMENTS/INSURANCE CLAIMS:

If we are filing insurance for your visit, we must have complete information and any required referral at the time of visit. If you cannot provide the information, we will be unable to file your insurance and payment in full will be required on the day the service is provided.

The exact payment amount cannot be determined with complete accuracy until the claim is submitted to your insurance company. Your payment will be based on your individual health plan, deductible and/or coinsurance. Procedures and evaluations, which are excluded from coverage including cosmetic procedures (benign mole removal, skin tag removal, cosmetic procedures, etc) and cosmetic evaluations, based on your plan's determination of medical necessity, will also be your responsibility. Your office co-pay is due at the time of the visit and, in most cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance usually apply. If we can determine with reasonable certainty that your insurance company is likely to leave a balance for you to pay (ie. apply it to a deductible), payment will be required on the day of service. For all other patients, payment in full is required at the time of service.

Any quotes or estimates given are simply estimates only and nothing more and are based on the information your insurance company provides at that time, which may or may not be accurate. Regardless of the accuracy of said quotes/estimates, the patient is always responsible for the full amount required by your insurance company when the claim is submitted for confirmation.

Standard office policy requires that you must present your drivers' license (or ID), insurance card (if applicable) and a credit/debit card for verification and for our records.

No Shows

"No-shows" are defined as any patient who fails to attend his or her appointment or any patient who cancels less than 2 business days in advance. Last minute cancellations (<2 business days) hamper our ability to fill the slot and make other patients wait longer to see a provider. If a patient "no-shows," we reserve the right to require a deposit to hold any future appointments. This deposit will be forfeited if the ensuing appointment is not attended or if rescheduling/cancellation occurs less than 2 business days in advance. No exceptions. Otherwise, the deposit can be applied to co-pays and other services.

Minors

Minors (<18) are required to be accompanied by their legal guardian. We reserve the right to cancel or reschedule the visit if this criterion is not met in the exclusive opinion of the practice. On occasion and by advance request only, a legal guardian may sign our "Minor Consent Release Form." If this form is signed, a minor who is an established patient may return for care without a guardian, if allowed by state law; however, the legal guardian takes full responsibility for any decisions the minor makes without the guardian present.

Compliance & Disclosure under Texas Occupations Code - Section 102.006

In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation and patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor(s) and/or clinic (facility) has disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and / or facility: (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he / she will receive, directly or indirectly, remuneration for referring upon my such request and exercising my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA and the Section 102.006 of Texas Occupations Code.

Facility with affiliation and remuneration: ADG Pathology

Payments and Past-Due Amounts

Payment is due on the date of service. If your estimated deductible and estimated fees can be determined or estimated, payment for services applied to the deductible may be required on the date of service. The Practice reserves the right to amend the estimated fees if a contracted insurance company advises us to do so. Any additional payment not collected during your visit is required on receipt of your 1st bill from the Practice. Balances that are outstanding for >30 days will automatically incur an administration fee, currently set at **$10**, but subject to change. The Practice reserves the right to turn over to collections any balance outstanding for over 60 days. If an account is turned over to a collections agency, an additional administration fee will be added, currently **$30**, but subject to change. If you fail to pay your complete balance before leaving the premises, the Practice reserves the right to use any credit or debit card on file to pay the balance in full. Any remaining balance may go to collections without further warning.
The Practice is not responsible for any lab, pathology, or other 3rd party fees incurred due to your visit here. This document may supercede any previously signed office policy.

Release of Information

I would like the following person(s) (besides myself) to have full and unfettered access to all of my records here including my health records. By writing their name(s) and birth date(s) below, I agree not to hold the practice responsible for any release of information to this person and I understand that I would only be able to revoke this access in writing:

Name: ____ Phone #: (____) _____-_______ DOB: ____/____/_______

Name: ____ Phone #: (____)_____-________ DOB:____/____/_______

I have read the above information and agree to abide by the policies set forth above and I understand that I am responsible for payment of services I receive. I understand that I cannot be seen at this Practice if I do not sign this document. I agree to pay any remaining balance within 30 days of receiving my 1st statement.

Patient/Guardian Signature: ____ Date: ________________