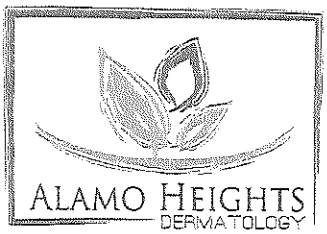

131 W. Sunset Rd, Suite 101
San Antonio, Texas 78209
Office: (210) 255-8447
Fax: (210) 255-8446

NEW PATIENT ENROLLMENT FORM

PATIENT INFORMATION (PLEASE PRINT)

Last Name	First Name	M.I.		
Mailing Address (Please include Apartment/Unit #)	City □ Check here for San Antonio	State □ TX	Zip Code	
Home Phone # □ *Check here if this is the best contact number*	Work Phone #	Date of Birth	Sex □ Male □ Female	
Cell Phone # □ *Check here if this is the best contact number*	Email address:			
If Patient under age of 18 Mother's Name:	If Patient under age of 18 Father's Name:	Patient's Driver's License # and State (if patient is under 18, please list parent DL# and State):		
Name of Emergency Contact	Relation	Emergency Contact Phone #		
Primary Insurance □ *Check here if new insurance (eff: _____)*	Policy/Member #	Group #		
Primary Insurance Policyholder's Name □ *Check here if Self*	Primary Insurance Policyholder's D.O.B.	Primary Insurance Policyholder Relation to Patient		
Secondary Insurance □ *Check here if new insurance (eff: _____)*	Policy/Member #	Group #		
Secondary Insurance Policyholder's Name □ *Check here if Self*	Secondary Insurance Policyholder's D.O.B.	Secondary Insurance Policyholder Relation to Patient		
Tertiary Insurance □ *Check here if new insurance (eff: _____)*	Policy/Member #	Group #		
Tertiary Insurance Policyholder's Name □ *Check here if Self*	Tertiary Insurance Policyholder's D.O.B.	Tertiary Insurance Policyholder Relation to Patient		

□ Primary Care Physician
Last Name: First Name: Office #:
Address: City/State: Zip Code: Fax #:

□ Referring Physician
Last Name: First Name: Office #:
Address: City/State: Zip Code: Fax #:

How did you hear about us? □ Google Search □ Yahooo Search □ Bing Search □ Other Internet search engine □ Yellow Pages □ Friends □ Family
□ Referral from physician □ Magazine/Newspaper Ad □ Search on my Insurance company website □ Other:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I acknowledge that I have received a copy of Alamo Heights Dermatology's Notice of Privacy Practices. This notice describes how Alamo Heights Dermatology may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

RELEASE OF ALAMO HEIGHTS DERMATOLOGY MEDICAL RECOREDS TO HEALTH CARE PROVIDERS
I hereby consent and authorize Alamo Heights Dermatology to release any and all information in my medical records to my physician(s) and other health care providers involved with my care and treatment.

RELEASE OF MEDICAL RECORDS TO ALAMO HEIGHTS DERMATOLOGY
I hereby request and authorize my health care provider(s) to release to Alamo Heights Dermatology medical records, radiology reports, pathology reports or any other medical information as needed in assisting Alamo Heights Dermatology in providing my medical consultation, care and/or treatment.

I accept and agree to all of the provisions listed above.

_____ _____
Signature of Patient/Legally Authorized Person/Financially Responsible Party **Date**

ALAMO HEIGHTS DERMATOLOGY

131 W. Sunset Rd, Suite 101
San Antonio, Texas 78209
Office: (210) 255-8447
Fax: (210) 255-8446

FINANCIAL POLICY FORM

Patient Name: _____ **D.O.B.:** _____ / _____ / _____

Thank you for choosing Alamo Heights Dermatology, PA as your healthcare provider. We appreciate your trust in us and the opportunity to provide you the best dermatological care. Please read, initial and sign the following financial policy. Please let us know if you have any questions.

Patient Payments

_____ The following payments are due at time of service (Copayments, coinsurance, deductibles, and any outstanding balance). We are contractually obligated to collect these payments due to the contract with your insurance company. Please send a form of payment with your child/children 18 and under if they are coming alone. We accept, cash, check, and all major credit cards. We can also keep a credit card on file for ease of payment.

Statements

_____ Statements will be sent on the 15th of each month to the address we have on file. If your address has changed, you are responsible for notifying us. Payment is due upon receipt of the statement. If you have any questions concerning your balance, please contact the billing department in our office as soon as possible. We have several payment options available included automated recurring credit card payments (available for amounts over $150.00) on-line payments and CareCredit. If your account remains unpaid, subsequent statements will be sent. We will send a total of three statements. If the account remains unpaid it will be forwarded to an outside collection agency for non-payment.

Insurance Coverage

_____ Although we make every effort to verify your coverage, we cannot guarantee that the information given to us by your insurance carrier is correct. It is your responsibility to know what services may or may not be covered by your insurance. At the time of your appointment, we will charge you based on the most up-to-date information from your insurance plan. After insurance pays, there may be an additional amount due to us or a refund due to you. If your insurance carrier changes at any time, it is your responsible to update the office with your new insurance policy, along with a copy of the insurance card at your next appointment.

Pathology and Laboratory Services

_____ If a biopsy is performed, the pathology will be sent to an outside lab. The lab will send an invoice for their services. Since this is a third party, you will be responsible for payment to them directly.

Third party payers

_____ Our office does not bill third party payers, such as motor vehicle accident claims or worker's compensation claims. Should you wish to see one of our providers for one of these services, you will be considered self-pay and payment in full will be required at time of service. You will be supplied with a receipt and you may seek reimburse from them.

Adult Advocacy

_____ As an advocate for our patients, we will not intervene in any divorce dispute or financial responsibility dispute between married, legally separated, or other responsible parties. We will send statements to the address provided; however, we cannot look to more than one party for financial responsibility.

Cancelled or No-Show Appointments

_____ We require 24-hour notice for cancellation of scheduled appointments if you are more than 15 minutes late for your scheduled appointment, the physician will determine whether the appointment will need to be rescheduled. This courtesy will allow other patients to be seen in a timely manner. Missed appointments and appointment rescheduled less than 24 hours will be charged a $40.00 fee.

Fees

The following is a listing of fees charged

- Medical Records - $25.00 and up (based on pages of the chart)
- No Show or Less than 24 hr cancellation $40.00
- FMLA – Disability Paperwork $25.00
- Returned Check Fee $30.00

I have reviewed the Financial Policy information and provide my consent regarding any and all the issues as stated in the policy above.

I understand a copy of this policy will become a part of my medical records and I may receive a copy upon request.

_____

Signature of Patient/Legally Authorized Person/Financially Responsible Party (Must be 18 or over to sign)

_____

Date

HIPAA RELEASE FORM

ALAMO HEIGHTS DERMATOLOGY
131 W. Sunset Rd, Suite 101
San Antonio, TX 78209
Office: 210-255-8447
Fax: (210) 255-8446

HIPAA Authorization Release of Information

Patient Name: _____ **Date of Birth:** _____ / _____ / _____

Release of Information

( ) I authorize the release of information including the diagnosis, examination records, claims information, and billing information. This information may be released to:

( ) Spouse _____

( ) Children _____

( ) Parent(s) _____

( ) Other _____

( ) Information is not to be released to anyone.

This Release **of Information** will remain in effect until terminated by me in writing.

Phone Messages

Please call ( ) my home _____

( ) my work _____

( ) my cell _____

If unable to reach me:

( ) you may leave a detailed message

( ) please leave a message asking me to return your call

Signed: _____ **Date:** _____ / _____ / _____

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Destruction/Cryo Consent Form

BILLING NOTICE AND BILLING AGREEMENT

DESTRUCTION/REMOVAL/SCARS
Of Benign Lesions – includes liquid nitrogen

INTRODUCTION
The treatment and removal of the conditions above are frequently performed by Dermatologists. Certain conditions will not disappear spontaneously. There are many different techniques for removing the conditions above. Your doctor will discuss the various treatment options with you.

RECURRENCE
The conditions listed above can recur after treatment. Additional treatment may be necessary.

CRYOSURGERY MEDICAL CONDITIONS

- Actinic Keratosis
- Prurigo Nodules
- Seborrheic Keratosis, Irritated
- Seborrheic Keratosis, Non-irritated
- Wart Treatment and Removal
- Other: _____

ALTERNATIVE TREATMENTS
Alternative forms of medical and surgical management of the conditions listed above may exist. Your doctor will discuss these options with you. Alternative treatments may include not treating the condition or managing its removal on your own with over the counter remedies. An example would be the removal of a wart. Removal of war s may be accomplished by other treatment options including the use of over the counter solutions (which may be less costly but might be less effective), liquid nitrogen (freezing), lasers, topical medications and electric cautery.

SCARS/Hypertrophic/Keloid
Many times scars can enlarge or grow and become symptomatic. When this happens, scars can be call hypertrophic or keloidal. Symptoms can include itching, pain, and tenderness. Patients often request treatment for scars of this nature; however, treatment including therapeutic injections, is not covered by most insurance plans. In these instances, the scars can be treated but you will need to pay out of pocket at time of service

FINANCIAL RESPONSIBILITIES
The cost of treating the conditions listed above include several different charges for the medical services provided. The total amount due includes fees charged by your doctor and the cost of surgical supplies. Depending on whether the cost of the treatment of the condition listed above is covered by your insurance plan, you will be responsible for necessary co-payments, any deductibles and any other charges not covered by your insurance. If you have not met your deductible, you agree to be responsible for the entire cost of the treatment. Additional costs may occur should complications develop from treatment. Secondary removal treatments will be charged and would also be your responsibility.

I hereby authorize the physicians of Alamo Heights Dermatology, PLLC and such assistants as may be selected to perform treatment of the condition listed above.
I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.
I acknowledge that the doctor and their staff are treating me and that if I want a less expensive treatment or alternative treatment, I understand there may be over the counter products I can purchase. I understand I am responsible for paying any copay or insurance deductible. Furthermore, I understand if there is an insurance deductible that has not been met, I agree to be responsible for the entire cost of the treatment of the condition listed above.

Patient's Name (Please Print): _____

Patient's Signature: _____

Date: _____

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Medication List

Patient Name: _____ **Date of Birth:** _____ / _____ / _____

Please list all medications you are currently taking. This includes over-the-counter, and herbal supplements.

Medication	Dosage	Frequency	Route (Topical Oral)	Reason taking

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NOTICE OF PRIVACY PRACTICES

Effective September 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ THIS NOTICE CAREFULLY.

At Alamo Heights Dermatology, PA, we believe that your health information is personal. We keep records of the care and services that you receive at our facilities. We are committed to keeping your health information private, and we are also required by law to respect your confidentiality. This Notice describes the privacy practices of Alamo Heights Dermatology, PA. This Notice applies to all of the health records that identify you and the care you receive at Alamo Heights Dermatology, PA. If you are under 18 years of age, your parents or guardian must sign for you and handle your privacy rights for you. We are legally required to give you this Notice and to follow the terms of the Notice that is currently in effect.

Our doctor's office follows the terms of this Notice. The doctors and other caregivers at Alamo Heights Dermatology, PA may exchange information about you as a patient. They may share your health information with each other for reasons of treatment, payment, and health care operations as discussed below.

HOW ALAMO HEIGHTS DERMATOLOGY, PA MAY USE AND DISCLOSE YOUR HEALTH INFORMATION
When you become a patient of Alamo Heights Dermatology, PA, we will use your health information within Alamo Heights Dermatology, PA and disclose your health information outside Alamo Heights Dermatology, PA for the reasons described in this Notice. The following categories describe some of the ways that we will use and disclose your health information.

Treatment. We use your health information to provide you with health care services. We may disclose your health information to doctors, nurses, technicians, or other persons at Alamo Heights Dermatology, PA who need that information to take care of you. For example, a doctor treating you for a broken leg may need to ask another doctor if you have diabetes because diabetes may slow the leg's healing process. This may involve talking to doctors and others not employed by us. We also may disclose your health information to people outside Alamo Heights Dermatology, PA who may be involved in your health care, such as treating doctors, home care providers, pharmacies, drug or medical device experts, and family members.

Payment. We may use and disclose your health information so that the health care you receive may be billed and paid for by you, your insurance company, or another third party. For example, we may give information about surgery you had here to your health plan so it will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive so we can get prior payment approval or learn if your plan will pay for the treatment.

Health Care Operations. We may use your health information and disclose it outside Alamo Heights Dermatology, PA for our health care operations. These uses and disclosures help us operate Alamo Heights Dermatology, PA to maintain and improve patient care. For example, we may use your health information to review the care you received and to evaluate the performance of our staff in caring for you. We may combine health information about many patients to identify new services to offer, what services are not needed, and whether certain therapies are effective. We may disclose information to doctors, nurses, technicians and other persons at Alamo Heights Dermatology, PA for learning and quality improvement purposes. Lastly, you have the right to request a restriction on certain disclosures to your health plan if the disclosure is purely for carrying out payment or health care operations and the requested restriction is for services paid out-of-pocket.

Contacting You. We may use and disclose health information to reach you about appointments and other matters. We may contact you by mail, telephone or email. We may leave voice messages at the telephone number you provide us with, and we may respond to your email address.

Health-Related Services. We may use and disclose health information about you to send you mailings about health-related products and services available at Alamo Heights Dermatology, PA.

Legal Matters. We will disclose health information about you outside Alamo Heights Dermatology, PA when required to do so by federal, state, or local law, or by the court process. We may disclose health information about you for public health reasons, like reporting births, deaths, child abuse or neglect, reactions to medications or problems with medical products. We may release health information to help control the spread of disease or to notify a person whose health or safety may be threatened. We may disclose health information to a health oversight agency for activities authorized by law, such as for audits, investigations, inspections, and licensure.

Breach Notification. We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your health information. We are required by law to notify individuals following a breach of unsecured health information.

AUTHORIZATIONS FOR OTHER USES AND DISCLOSURES

As described above, we will use your health information and disclose it outside Alamo Heights Dermatology, PA for treatment, payment, health care operations, and when permitted or required by law. We will not use or disclose your health information for other reasons without your written authorization. For example, you may want us to release medical information to your employer or to your child's school. These kinds of uses and disclosures of your health information will be made only with your written authorization. You may revoke the authorization, in writing, at any time, but we cannot take back any uses or disclosures of your health information already made with your authorization.

YOUR RIGHTS REGARDING HEALTH INFORMATION

Right to Accounting. You may request an accounting, which is a listing of the entities or persons (other than yourself) to whom Alamo Heights Dermatology, PA has disclosed your health information without your written authorization. The accounting would not include disclosures for treatment, payment, health care operations, and certain other disclosures exempted by law. Your request for an accounting of disclosures must be in writing, signed, and dated. It must identify the time period of the disclosures and Alamo Heights Dermatology, PA facility that maintains the records about which you want the accounting. Your request should indicate the form in which you want the list (for example, on paper or electronically). You must submit your written request to Alamo Heights Dermatology, PA. We will respond to you within 60 days. We will give you the first listing within any 12-month period free, but we will charge you for all other accountings requested within the same 12 months.

Right to Amend. If you feel that health information we have about you is incorrect or incomplete, you have the right to ask us to amend your medical records. Your request for an amendment must be in writing, signed, and dated. It must specify the records you wish to amend, identify Alamo Heights Dermatology, PA facility that maintains those records, and give the reason for your request. You must address your request to the Privacy Official of Alamo Heights Dermatology, PA. Alamo Heights Dermatology, PA will respond to you within 60 days. We may deny your request; if we do, we will tell you why and explain your options.

Right to Inspect and Obtain Copy. You have the right to inspect and obtain a copy of your completed health records unless your doctor believes that disclosure of that information to you could harm you. You may not see or get a copy of information gathered for a legal proceeding or certain research records while the research is ongoing. Your request to inspect or obtain a copy of the records must be submitted in writing, signed and dated, to the medical records department of Alamo Heights Dermatology, PA. We may charge a fee for processing your request. If Alamo Heights Dermatology, PA denies your request to inspect or obtain a copy of the records, you may appeal the denial within Alamo Heights Dermatology, PA.

Right to Request Restrictions. You have the right to ask us to restrict the uses or disclosures we make of your health information for treatment, payment, or health care operations, but we do not have to agree. You also may ask us to limit the health information that we use or disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. Again, we do not have to agree. A request for a restriction must be signed and dated, and you must identify Alamo Heights Dermatology, PA. The request should also describe the information you want restricted, say whether you want to limit the *use* or the *disclosure* of the information *or both*, and tell us who should not receive the restricted information. You must submit your request in writing to the medical records department of Alamo Heights Dermatology, PA. We will tell you if we agree with your request or not. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications. You have the right to request that we communicate with you about your health in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Your request for confidential communications must be in writing, signed, and dated. It must identify Alamo Heights Dermatology, PA and specify how or where you wish to be contacted. You need not tell us the reason for your request, and we will not ask. You must send your written request to Alamo Heights Dermatology, PA. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a paper copy of this Notice at Alamo Heights Dermatology, PA.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Alamo Heights Dermatology, PA or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with Alamo Heights Dermatology, PA, you must submit your complaint in writing to Alamo Heights Dermatology, PA.

CHANGES TO THIS NOTICE

Alamo Heights Dermatology, PA may change this Notice at any time. Any change in the Notice could apply to medical information we already have about you, as well as any information we receive in the future. We will post a copy of the current Notice at each of our facilities and on our website, www.alamoheightsderm.com. The effective date of the Notice is on the first page in the top right corner.

If you have questions about this Notice, you may dial 210-255-8447 and ask for the privacy official.