



New Patient Information Record

Patient Information

<u>Name</u> Last _____ First _____ MI _____		
<u>Address</u> Street _____ City _____ State _____ Zip Code _____		
<u>Contact</u> Home Phone: _____ Work: _____ Cell Phone: _____ Email: _____		
<u>Personal Info</u> Date of Birth (MM/DD/YYYY): _____ Sex: Male ___ Female ___ SSN _____ Race: American Indian ___ Asian ___ Black ___ Pacific Islander ___ Other ___ Decline to Answer ___ Ethnicity: Hispanic ___ Non-Hispanic ___ Decline to Answer ___ Language: English ___ Spanish ___ Other _____		

Emergency Contact

Name: _____ Home Phone: _____ Cell: _____		
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Employment Information

Employer: _____ Status: Not Employed ___ Full-Time ___ Part-Time ___ Retired ___ Unknown ___ Work Phone: _____ Extension _____		
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Insurance Information

	<i>Primary</i>	<i>Secondary</i>	<i>Additional</i>
Insurance Name			
Policy Holder			
Policy Holder Date of Birth			
Relationship to Insured			
Policy Number			
Group Number			

Name _____ Date of Birth _____ SuperBill# _____

Referred By _____ CHECK-IN _____

Reason for visit : _____

Where (location)? _____ How Long? _____

Symptoms (CHECK) None ___ Itching ___ Stinging ___ Burning ___ Painful ___ Worsen ___ Improve ___ Unchange ___

Severity: Not noticeable ___ Intense ___ Moderate ___ Mild ___

Duration of the symptoms: Present all the time ___ Come and Go ___ Rarely occurs ___

How has it been treated? _____

Other skin condition(s): _____

Topical (skin) medications already used: _____

System Review Do you have or have you RECENTLY had any of the following? PLEASE CHECK

Const: ___ weight loss	___ weight gain	___ fever	___ chills
Eyes: ___ sudden vision changes		___ loss of vision	
ENT: ___ sores in the mouth or lip		___ blisters the mouth or on the lips	___ hearing loss
CV: ___ palpitation		___ chest pain	
Resp: ___ severe cough		___ shortness of breath	
GI: ___ nausea or vomiting		___ change in bowel (diarrhea/constipation)	
GU: ___ painful urination		___ blood in urine	
M/S: ___ muscles stiffness		___ joint pain	
Skin: ___ masses or lumps on the skin		___ hair or nail changes	
Neuro: ___ memory change	___ vision change	___ vision loss	___ loss of balance

Past Medical History/Inactive Problems:

High Blood Pressure	Yes	No	Anemia	Yes	No	Stomach/Bowel Problem	Yes	No
Heart Disease	Yes	No	HIV infection	Yes	No	Recent Weight Loss	Yes	No
Cardiac Pacemaker	Yes	No	Seizures or epilepsy	Yes	No	Asthma or Lung Problems	Yes	No
Heart Murmur	Yes	No	Radiation Therapy	Yes	No	History of skin cancer	Yes	No
Diabetes	Yes	No	Ultraviolet light treatment	Yes	No	Kidney/Bladder Problem	Yes	No
Liver disease or hepatitis	Yes	No	Cancer	Yes	No	Other:		

Surgical History:

Pacemaker or Defibrillator? Yes No If YES, When? _____ and Which? _____

Artificial Heart Valve/Heart Stent? Yes No If YES, When? _____ and Which? _____

Artificial Joints Replacement? Yes No If YES, When? _____

Anticoagulants? Yes No If YES, Please circle: _____

Mitral Valve Prolapse or Endocarditis? Yes No If YES, When? _____ and Which? _____

Allergy to Injected Anesthetics? Yes No If YES, Which one(s)? _____

Do you need antibiotics before all surgical or dental procedures? Yes No

Medication: Please List all your current medications:

Allergy: List any medication allergies:

Family History: List any family member with History of Skin Cancers or other skin related diseases:

Alcohol consumption : No Occasionally Daily

Social History: Please list your occupation

Smoking Status: NEVER ___ SOME DAYS ___ EVERYDAY ___ FORMER(QUIT) ___ UNKNOWN ___

Currently Pregnant: ___ or Breastfeeding: ___

PREFERRED PHARMACY: _____

By my signature below, I confirm the above information regarding the medical history and review of systems are correct and up-to-date. **PICTURES TAKEN**

X _____ PATIENT SIGNATURE	_____ Date	Witnessed by: _____
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___ Kevin Burningham MD ___ Eric Sandrock DO ___ Valeria Gonzalez MD ___ Gabriela Ramirez PA-C
 ___ Kelly Maedo MD ___ Sonia Neave MD ___ Hervey Galvan PA-C ___ Daisy Elizondo PA-C
 ___ Kara Asbury MD ___ Jamie Hedrick MD ___ Saba Suleman MD ___ Alexis Wood PA-C
 ___ Sri Naidnur PA-C ___ Mia De La Garza PA-C ___ Rick Lin DO

REVIEWED BY - HEALTHCARE PROVIDER INITIALS



Photography Permit

I hereby authorize the appropriate personnel of the office of Dr. Rick Lin, Dermatologist and/or Oasis Dermatology Group, PLLC. to take photographic and digital pictures of my skin condition.

I hereby state that it has been fully explained to me that said pictures are taken for the purpose of medical record documentation and for the showing to the duly licensed physicians, and authorized paramedical personnel, for teaching, research, and publication purposes.

I further state that at the time of the execution of the consent, that I am fully aware of the pictures to be taken and the uses, as described above. I also have had the opportunity to ask all questions with respect to the taking of the pictures and the use thereof which have been fully explained to me and to my complete satisfaction by personnel of Oasis Dermatology Group, PLLC.

Signature

Date



Patient Consent For Use and Disclosure of Protected Health Information

The following Individuals are authorized to receive my healthcare information regarding medical records, appointments and/or any other information Oasis Dermatology has in its medical records regarding treatment, diagnosis, labs or pathology reports.

	NAME	RELATIONSHIP
1.	_____	_____
2.	_____	_____
3.	_____	_____

In order to revoke my consent for the above individuals to receive my healthcare information; I must submit in writing my revocation of consent directly to Oasis Dermatology HIPAA Compliance Officer: Jessica Guerra.

Phone: (956) 971 - 0404
Email: jguerra@oasisderm.com

Signature

Date



Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Oasis Dermatology Group, PLLC., hereinafter referred to as "The Practice", or their office staff, may use and disclose PHI (Protected Health Information) about me to carry out TPO (Treatment, Payment and healthcare Operations). Please refer to Oasis Dermatology Group, PLLC., Notice of Privacy Practices for a more complete description of such uses and disclosures which has been provided to you along with this form. I understand it is my right to review the Notices of Privacy Practices prior to signing this consent. Oasis Dermatology Group, PLLC., or their office staff, reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by visiting the practice and requesting a copy or by forwarding a written request to the Privacy Officer at 3100 Buddy Owens Blvd, McAllen, Texas 78504.

With my consent, The Practice may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out clinical care, including laboratory results among others.

With my consent, The Practice may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and/or billing.

With my consent, The Practice may email to my home or other designated 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 The Practice, restrict 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 The Practice to use and disclose my PHI to carry out TPO. I also have been informed that I have the right to inspect and/or request copies of my child(ren) medical information and to receive an accounting of disclosures that have been made regarding Release of Medical Records/Information.

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, The Practice may decline to provide treatment to me.

You may complain to us through our HIPAA Compliance Officer or to the Secretary of Health & Human Services through the U.S. Department of Health & Human Services Office for Civil Rights if you believe your privacy rights have been violated.

I consent to my medical information being disclosed and used for purposes as stated above.

I also acknowledge that I have been provided with a "**Notice of Privacy Act**" as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and had an opportunity to ask questions and acknowledge that I understand my rights as they pertain to HIPAA and the Texas Privacy Act.

Patient Name (please print)

Date

Signature of Patient or Legal Guardian



Office Financial Policy

Welcome to Oasis Dermatology Group, PLLC. In order for our medical staff to be able to deliver the quality of care that you are accustomed to, we have established our financial policies. The following is the list of guidelines that are necessary in order to continue to provide high quality care and make your visit as pleasant as possible.

PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.

1. We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance.
2. If you have a change of address, telephone numbers, or employer, please notify the receptionist.
3. We will collect your deductible, co-payment, or charge for non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. We accept cash, checks, Visa, MasterCard, Amex, and Discover.
4. If we do not participate with your insurance company, you will be expected to make payment in full at the time service is rendered.
5. If your insurance denies our charges or does not pay us in a timely manner, or if your account becomes delinquent, we reserve the right to refer your account to a collection agency and to be reported to one or more credit bureau(s).
6. **MEDICARE PATIENTS:** We are participating providers with Medicare and will bill Medicare for all of your covered charges. If you have Supplemental Insurance, we will also bill that for you. If payment is not received from your supplemental insurance within 45 days of being submitted, we will bill you for the balance due. If you do not have supplemental insurance, your portion (20% of the amount allowed by Medicare) will be collected at the time of service. Each year you will be expected to pay the allowed amount of your charges until your Medicare deductible is met.
7. **HMO-PPO PATIENTS:** If we participate with your plan, we will bill your insurance for you. Your co-payment will be collected at the time of service-**NO EXCEPTIONS**. If your plan requires you to choose a primary care physician (PCP), it is your responsibility to make sure your insurance company has the physician and/or physician assistant you are seeing as your PCP. If your plan requires you to have an authorization to see a specialist, you will need to obtain that from your PCP. Note that this office does not do retroactive billing or accept retroactive referrals. If we do not participate with your plan, we will verify your out-of-network benefits, and will expect payment of your portion of the charges at the time of service.
8. **SELF-PAY PATIENTS:** Patients with no Insurance will be expected to pay at the time of service. If you will not be able to pay in full; you must contact our billing department prior to seeing your physician and/or physician assistant to make payment arrangements.
9. Your insurance is a contract between you, your employer, and the Insurance company. **We are not a party to that contract.** It is very important that you understand the provisions of your policy. We cannot guarantee payment of all claims. If your insurance company pays only a portion of the bill or rejects your claim, any contract or explanation should be made to you, their policy holder. Reduction or rejection of your claim by your insurance does not relieve you of your financial obligation.

Remember, whether you do not have Insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please feel free to contact us.

I have read and have full understanding of the financial policy of Oasis Dermatology Group, PLLC.

Signature

Date