

Coppell Dermatology

215 S. Denton Tap Rd, Suite 225

Coppell, Texas 75019

469-941-0440

Patient Name _____ Date _____
First MI Last

Home Address _____
Street/Apt City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Date of Birth _____ Age _____ Social Security Number _____

Drivers Lic # _____ State _____ Gender _____ Marital Status _____

Emergency Contact _____ Relationship _____

Home Phone _____ Work Phone _____ Cell _____

Referred By _____

PERSON RESPONSIBLE FOR PAYMENT (if different from above information)

Name _____ Relationship _____

Address _____
Street/Apt# City State Zip

Home Phone _____ Work Phone _____ Cell _____

Social Security Number _____ Date of Birth _____

INSURANCE INFORMATION **Present Your License, Medicare and/or Insurance Cards**

Primary Insurance _____

Policy Holder _____ Relationship _____ DOB _____

Insurance Effective Date _____

Secondary Insurance _____

Policy Holder _____ Relationship _____ DOB _____

Insurance Effective Date _____

I authorize the release of medical information necessary to process insurance claims. I authorize and assign all medical and/or surgical benefits to which I am entitled to Coppell Dermatology.

Signature of Patient or Legal Guardian Relationship to Patient Date

MEDICAL HISTORY

Patient Name: _____

Please list any drug allergies _____

Other allergies _____

Please list all medications you are currently taking (include all over the counter medications): _____

Are you under the care of a Physician? Yes No

Name of Personal Physician _____ Physician's Phone # _____

Please list any significant current or past medical illness with dates: _____

Please list any major surgeries with dates: _____

Do you smoke? Yes No

DO YOU TAKE ASPIRIN? YES NO

Do you drink alcohol? None Occasionally Moderately

Have you ever had a bad surgical result? Yes No Explain _____

HAVE YOU EVER USED A TANNING BED? YES NO YES CURRENTLY

If female, are you pregnant or planning a pregnancy? Yes No

Have you ever had or been treated for: Please circle YES where applicable.

AIDS	Yes	Frequent infections (skin)	Yes	Neurological Disorder	Yes	FAMILY HISTORY	
Allergy to local anesthetic	Yes	Gallbladder Disease	Yes	Radiation	Yes		
Arthritis	Yes	Glaucoma	Yes	Rheumatic Fever	Yes	Asthma	Yes
Artificial Joint	Yes	Have you ever taken Accutane	Yes	Seizures	Yes	Eczema	Yes
Auto-Immune Disease	Yes	Hayfever	Yes	Skin Cancer	Yes	Melanoma	Yes
Blood Disease	Yes	Heart Surgery	Yes	Stroke	Yes	Psoriasis	Yes
Bone Disease	Yes	Heart Disease	Yes	Thrombophlebitis	Yes	Skin Cancer	Yes
Cancer	Yes	Heart Attack	Yes	Thyroid	Yes		
Cardiac Pacemaker	Yes	Hepatitis	Yes	Urinary/Bladder problems	Yes		
Cataract Surgery	Yes	Herpes	Yes	Venereal Disease	Yes		
Chemotherapy	Yes	High Blood Pressure	Yes	Yeast Infections	Yes		
Colitis	Yes	HIV	Yes	Raynaud's (cold intolerance)	Yes		
Diabetes	Yes	Intestinal Disease	Yes				
Difficulty with healing	Yes	Keloids or scarring	Yes				
Duodenal or Peptic Ulcer	Yes	Kidney Disease	Yes				
Eczema	Yes	Liver Disease	Yes				
Emotional/Psychiatric problems	Yes	Lung Disease (Tuberculosis)	Yes				
Excessive bleeding when cut	Yes	Lymph Gland Disorder	Yes				
Eye Disease	Yes	Mitral Valve Prolapse	Yes				

I have completed this form fully and completely, and certify that I am the patient or duly authorized to furnish the information requested. I understand that even though I have some insurance coverage, I am responsible for payment of services, at the time services are rendered.

Signature

Date

Max F. Adler, M.D., Lauren M. Davis, PA-C
215 S. Denton Tap Rd, Suite 225, Coppell, Texas 75019

Coppell Dermatology
215 S. Denton Tap Rd, Suite 225
Coppell, TX 75019

HIPPA
RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGMENT FORM

I, _____, have received a copy of Coppell
Dermatology's Notice of Privacy Practices.

Signature of Patient

Date

If a Personal Representative's signature appears above, please describe Personal Representative's relationship to patient.

Thank you.

COPPELL DERMATOLOGY
PATIENT AUTHORIZATION USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Coppel Dermatology to use and/or disclose certain protected health information (PHI) about me to:

1. _____ Patient Name
 2. _____ Spouse Name
 3. _____ Parent or Guardian Name
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This authorization permits Coppel Dermatology to use and/or disclose the following individually identifiable health information about me) specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):
ALL MY MEDICAL INFORMATION BY PHONE OR FAX.

The information will be used or disclosed for the following purpose: **“At the request of the individual.”** If requested by the patient, purpose may be listed as “at the request of the individual.” The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on **NO EXPIRATION DATE.**

COPPELL DERMATOLOGY
215 S. Denton Tap Rd, Suite 225
Coppel, Texas 75019

Signed by: _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

Print Name of Patient or Legal Guardian

FINANCIAL POLICY

Coppell Dermatology

Thank you for selecting our practice for your dermatological needs. Our goal is to provide you with the highest quality of treatment and service. Your complete understanding of your financial responsibilities is an essential element of your care. If you have any questions about the following policy, please do not hesitate to ask our staff.

Billing & Insurance

Patients are responsible for payment at the time of service. We accept cash, check and most major credit cards.

We are contracted providers with many insurance plans and will accept assignment of benefits. As a courtesy, we will file all claims, including secondary insurance, to the plans with which we participate. Please inform us of any special requirements in your plan.

In addition, if you have coverage with an insurance plan that we do not contract with, we will prepare a detailed statement for you with all the necessary information needed for you to file the claim. All charges for your care and treatment are due at the time of service for these health plans.

You are responsible to pay for any co-payments, deductibles, and co-insurance designated by your insurance company at the time of each visit. Please be aware that many dermatology procedures go toward your deductible. Should your insurance pay in full, we will refund your payment upon receipt of payment from your insurance. If your insurance company denies your bill, you will be billed directly for those services and held financially responsible.

In the event your health plan determines a service to be "not covered", or you do not have an authorization, you will be responsible for the complete charge. We encourage our patients to understand their policy and to contact their plan for clarification of benefits prior to services being rendered.

In cases of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those charges. If the divorce decree requires the other parent to pay all or part of the costs, it is the authorizing parent's responsibility to collect from the other parent.

You may receive a separate bill for laboratory or pathology services from an off-site lab for any test your physician may order. Please discuss any billing errors or discrepancies with that laboratory.

We are pleased to offer a complete range of cosmetic services, including laser hair removal, photo rejuvenation, chemical peels, BOTOX, Juvederm and Sclerotherapy. These services are not covered by insurance and payment for these procedures is expected in full at time of service.

Skin tag removal and seborrheic keratosis removal are also considered cosmetic procedures. Most insurance carriers do not pay for cosmetic services, thus payment for these procedures is expected in full at time of service. If you wish to seek reimbursement from your insurance, we will provide you with a billing statement that you may submit.

In an effort to serve our patients in a timely manner, we ask that you are on time for your scheduled appointment. In the event that you are running late, please call our office. If you arrive more than 15 minutes late to your appointment, you may be asked to reschedule.

Other Miscellaneous Fees	
Cancellation, Missed Appointments and Late Arrivals	If you need to cancel an appointment, we kindly request that you allow at least 24-hours notice so that your appointment may be given to another patient who may be in need of urgent care. If we do not receive 24-hours notice there may be a \$35 missed appointment fee billed. Patients with multiple cancellations or missed appointments also may be discharged from our practice.
Returned Check Fee	There will be a \$25 charge for all returned checks.
Collection Fee	If your account is turned over to our collection agency, you will be responsible for the collection fees charged by the agency in addition to your outstanding balance.

I have read and understand the financial policy, and I agree to be bound by its terms. I understand and agree that such terms may be amended in the future by the practice.

Signature of Patient or Legal Guardian

Date

Printed Name of Patient

Date of Birth