ACKNOWLEDGEMENT OF OFFICE POLICIES

Name:___________________________
Date of Birth:_____________________

Please review and sign after reading each policy listed below

General Patient Authorization: I hereby authorize providers of Magnolia Dermatology to render care to me during my office visits and to fulfill the orders of my physicians, including consultants, associates, and assistants of the physicians' choice.

Receipt of Notice of Privacy Practices: Magnolia Dermatology's Notice of Privacy Practices provides information about how Magnolia Dermatology may use and disclose protected health information about me. The Notice of Privacy Practices contains a Patients Rights section describing my rights under the law. I acknowledge that I have had the opportunity to review the Notice of Privacy Practices of Magnolia Dermatology. Magnolia Dermatology reserves the right to change the Notice of Privacy Practices.

Cancellation Policy: If a patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel within 24 hours of the scheduled appointment. Magnolia Dermatology reserves the right to charge a $50 fee if the patient does not cancel his/her appointment within 24 hours or loss of a deposit if a patient does not cancel a surgical appointment within 24 hours. Administrative fees incurred for failure to provide cancellation notice are not billable to insurance or any other third party payor. These policies include appointments with all providers and estheticians.

Release of Medical information:

I do do not (select one) authorize Magnolia Dermatology and its designated representatives to release my medical information to my primary care physician. If authorized, please provide name of physician:____.

If at any time you should need a copy of your medical records, we require a written release to be signed and dated. The form is available at our front desk and can be requested by email. Please allow up to 15 business days to complete your request. If your request is urgent, please mark the request as urgent and someonefrom our staff will contact you to expedite your request. Absent providing a secure fax number, records must be MAILED to your address of record. Copies of blood work and pathology reports are provided at no charge, copies of your complete medical record or our office notes will require a $25 fee.

Magnolia Dermatology requires a written records release form to transmit records to any physician or medical organization that is not listed as your referring physician. If you have a consulting physician you would like to have listed as an authorized recipient of your medical information, please request and complete a release for each physician you wish to receive your records.

Contact Permission: In the event that Magnolia Dermatology needs to contact you (the patient), regarding an appointment, lab result, medication, or any other reason, it is permissible to :

Yes **No** (select one) Leave a message on an answering machine/voicemail system.
Yes **No** (select one) Speak with other authorized individuals listed below.
Name:____**Relationship**_____________________
Name:____**Relationship**_____________________
Name:____**Relationship**_____________________
Yes **No** (select one) Send a Text to the following number____________________

ACKNOWLEDGEMENT OF OFFICE POLICIES

Expiration of and Right to Revoke Authorization To Disclose Protected Health Information: I understand that I can withdraw my permission set forth above at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under “Release of Medical Information” and “Contact Permission”. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.
The duration of this authorization is valid until the earlier to occur of the death of the individual; the individual reaching the age of majority; permission is withdrawn; or the following specific date (optional): Month_____ Day:______Year:_________.

Physician Assistant, Nurse Practitioner, & Esthetician Information: Magnolia Dermatology may staff physician assistants, nurse practitioners and estheticians to assist in the delivery of dermatology care. A physician assistant (“PA”) is not a doctor but is a graduate of a certified training program and is licensed by the Texas Physician Assistant Board. Under the supervision of a physician, a PA can diagnose, treat, and monitor common and acute diseases. Estheticians provide services as directed by a PA, nurse practitioner or physician. I understand that at any time I can request to see a physician. I have read the above and hereby consent to the services of a PA, nurse practitioner, or esthetician for my health care needs.

By signing this Acknowledgement of Office Policies you acknowledge that you have read, understand, and accept the above policies.

Signature of Patient/Guardian____Date_______________
Relationship____

NEW PATIENT DEMOGRAPHICS

Patient Name:(Last,First)______________________________**Nickname:**________________
SSN:______________ **Date of Birth:**____________ **Age:**_____ **Sex: Male Female**
Address:__________________________________**City, State, ZIP**______________________
Home Phone:______________________**Mobile Phone:**_______________________
Email address:____
Emergency Contact Name:_________________________**Phone:**______________________
Marital Status:___________________**Race:**_________**Ethnicity:**______________________
Preferred Language:______________________________**Employer:**___________________

How did you hear about us: *Select one*

Patient Referral Provider Referral:___________________ Insurance Referral
Internet Social Media Event Direct Mail/Magazine Radio/TV
Billboard Other:______________________

Responsible Party Information (if different than above or if patient is a minor)

Guarantor Name (Last, First):___________________________**Relationship**_______________
SSN:_______________**Date of Birth:**________________**Sex: Male Female**
Address:__________________________________**City, State, ZIP**_____________________
Home Phone:______________________**Mobile Phone:**_____________________
Email address:____

Insurance Information

Primary Insurance:______________________ **Secondary Insurance**__________________
Policy Holder Name:_____________________ **Policy Holder Name**___________________
Relationship to patient____________________ **Relationship to patient**_________________
Policy Holder date of birth_________________ **Policy Holder date of birth**_____________
Policy #/Member ID______________________ **Policy #/Member ID**___________________
Group #______________________________ **Group #**____________________________

Patient/Guarantor Signature___________________________________**Date**_____________

MAGNOLIA
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HEALTH HISTORY
PATIENT INFORMATION

Name:____Date of Birth:____________Date of visit________

Primary Care Provider:____________________________City__________________Phone:________________

Preferred Pharmacy:______________________________City/Zip_______________Phone:________________

Emergency Contact Name:_______________________________________Phone:________________________

Please describe briefly the reason for today's visit:____
Area(s) involved:______________________________How long have you had the problem_____________

Please select any of the following medical conditions as each applies to your current or past history:

Anxiety	Depression	Hyperthyroidism	Transplant
Arthritis	Diabetes	Hypothyroidism	Cancer/Type
Asthma	Dementia	Hepatitis, Type______	_____________
Artificial Heart Valve	GERD	HIV/AIDS	_____________
Artificial Joint (Past 2 Years)	Hearing Loss	High Cholesterol	_____________
Atrial Fibrillation	Hypertension	Radiation Treatment	OTHER
Autoimmune condition	COPD	Pacemaker/Defibulator	
Vasovagal reaction (fainting)	Seizures	Stroke	

Surgical Procedures (within last 2 years)____
Do you require premedication prior to procedures? NO YES: antibiotic/dose________________

Have you had a previous history of skin cancer? NO YES: What Kind?_________________________
Do you wear sunscreen? NO YES: What SPF?___________
Have you used tanning beds in the past? NO YES
Do you have a family history of Malignant Melanoma? NO YES: Which family member?____
What skin conditions have you had?____
Please list medication allergies:

____
____
____

Patient Name:________________________D.O.B______________

CURRENT MEDICATIONS: Please list all current medications, dose and frequency(including chemotherapy, over-the-counter medications, vitamins and herbal supplements):

____

____

____

SOCIAL HISTORY (Please choose one in each section)

SMOKING STATUS:

____NEVER
____Current occasional smoker
____Current every day smoker
Total years smoking______
____Former smoker

ALCOHOL USE:

____NONE
____< 1 drink a day
____1-2 drinks a day
____3 or more a day

(65 and over only): Do you have the following:

____Living will
____Do not Resuscitate

___Advanced Directive Y N
Name:_______________________________Phone:________________________

*** **Government required question:**
MEN: How many times in the past year have you had more than **5** drinks in a day?______
WOMEN: How many times in the past year have you had more than **4** drinks in a day?_____

VACCINES (Have you received the following vaccines? Y or N)

____Flu (October thru March only)
____COVID/Booster
____Pneumonia (65+ Years old only)
____Shingles (50+ Years old only)

I attest that I have read and answered all the above questions on both pages.

Signature:____Date:____________________

PATIENT CONSENTS CONSENT FOR TREATMENT

I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

CONSENT FOR PHOTOS
I understand that during the course of treatment, photographs may be taken for clinical and educational purposes. No audio taping, videotaping, or photography is allowed by non-staff members.

CONSENT FOR FILING INSURANCE CLAIMS
I understand that to file claims and release medical information to my insurance company, Medicare and/or supplemental policy, *Magnolia Dermatology* is required to keep my signature on file. I hereby authorize *Magnolia Dermatology* to receive benefits directly from my insurance company, Medicare and/or supplemental policy when an assigned claim is filed. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I also authorize *Magnolia Dermatology* to appeal any denials to my insurance company, Medicare and/or supplemental policy, on my behalf and authorize the release of any medical information to my insurance company, Medicare and/or supplemental policy that is necessary for the processing of claims. I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to *Magnolia Dermatology*. I further understand that should my account become delinquent, I shall pay the reasonable collection and attorney's fees of *Magnolia Dermatology*, if any.

CONSENT FOR ELECTRONIC PRESCRIPTION HISTORY
I understand that to offer the best patient care, *Magnolia Dermatology* will retrieve my prescription history that has been ordered and filled through an EHR system. I authorize *Magnolia Dermatology* to import the prescription history obtained through an EHR system into my electronic chart.

CONSENT FOR APPOINTMENT REMINDERS / THIRD PARTY COMMUNICATIONS I authorize *Magnolia Dermatology* to send me appointment reminders via automated SMS text messages, phone calls, emails, and additional information regarding dermatology, including health-related products or services and quality of care surveys provided by *Magnolia Dermatology.* I understand that message/data rates may apply to messages sent by *Magnolia Dermatology* under my cell phone plan. I authorize *Magnolia Dermatology* and third-party collection agents to utilize all contact information I have provided in efforts to communicate regarding my account. I agree that affiliates may contact me through text messages, ring-less calls, and emails to provide me with my bill and to remind me to pay for services provided by *Magnolia Dermatology*, in compliance with federal and state laws. I understand that I am under no obligation to receive automated notifications and may opt-out of these communications at any time by following the prompts in the reminder. Further, I may revoke my consent to receive any and all communications.

Patient/Guardian Signature:_______________________________________Date:___________________

NOTICE OF PRIVACY PRACTICES

ACT OF 1AS REQUIRED BY THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY996 (HIPAA)

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your protected health information (PHI). By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights regarding your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will always post a copy of our current Notice in our offices in a visible location, and you may request a copy of our most current Notice at any time.

B. **IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:**

Magnolia Dermatology of Frisco, PLLC
13192 Dallas Parkway Ste 620
Frisco, Texas 75034
info@magnoliadermfrisco.com

C. **WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:**

1. **Treatment.** Our practice may use your PHI to treat you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment.
2. **Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us.
3. **Health Care Operations.** Our practice, and its affiliated entities and management company, may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.
4. **Appointment Reminders.** Our practice may use and disclose your PHI to contact you and remind you of an appointment. We will notify you about your appointment utilizing an automated phone system, a personal call, text or by mail. This notification may involve leaving a message on an answering machine or other automated or electronic equipment for such purposes, which could (potentially) be received or intercepted by others.
5. **Sign in Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. **Treatment Options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
7. **Health-Related Benefits and Services.** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
8. **Release of Information to Family/Friends**. Our practice will routinely disclose to your responsible party(ies) the PHI directly relevant to his/her involvement with your health care, PHI related to payment of your health care, and PHI used for notification purposes. Our practice may release your PHI to another responsible party(ies) you identify, that is involved in your care.
9. **Marketing.** We may contact you to give you information about products or services related to your treatment, or care. We will not otherwise use or disclose your medical information for marketing purposes, without your prior written authorization.
10. **Sale of Health Information.** We will not sell your health information without your prior written authorization.
11. **Disclosures Required by Law.** Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.
12. **Breach Notification.** In the case of a breach of unsecured protected health information, we will notify you as required by law.
13. **Responding to Lawsuits**. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

D. **USE AND DISCLOSURE OF PHI IN SPECIAL CIRCUMSTANCES** The following categories describe unique scenarios in which we may use or disclose your protected health information:

1. **Public Health Risk Reporting.** Our practice may disclose your PHI to public health authorities that are authorized by law. For example, we are required to report certain communicable diseases to the state's public health department.
2. **Law Enforcement.** Your health information may be disclosed to law enforcement agencies, military, and national security without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.
3. **Workers' Compensation.** Our practice may release your PHI for workers' compensation and similar programs that provide benefits for work-related injuries or illnesses.

E. **YOUR RIGHTS REGARDING YOUR PHI** You have the following rights regarding the PHI that we maintain about you. These include:

- The right to request restrictions on the use and disclosure of your protected health information, including to request that a health plan not be informed of treatment for which patient paid entirely out of pocket.
- The right to prohibit the sale of your protected health information, its use for marketing purposes, or participation in research.
- The right to request to receive confidential communications concerning your medical condition and treatment in a specific manner.
- The right to inspect and obtain copies of your protected health information.
- The right to request an amendment or corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed outside of our practice if not for treatment, payment, or health care operations.
- The right to file a complaint if you believe your privacy rights have been violated. Please file your complaint in writing. You will not be penalized for filing a complaint.
- The right to receive a printed copy of this notice.

All requests must be in writing and directed to Magnolia Dermatology of Frisco, PLLC, 13192 Dallas Parkway, Ste 620, Frisco, Texas 75034. Our practice may charge a fee for the costs associated with any request.

F. **RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time **in writing.** After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

If you believe your privacy rights have been violated, you may complain to the secretary of the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or to the Compliance/Privacy Officer listed below. There will not be retaliation against you for filing a complaint. Again, if you have any questions regarding this notice or our health information privacy policies, please contact:

Magnolia Dermatology of Frisco, PLLC
13192 Dallas Parkway, Ste 620
Frisco, Texas 75034
info@magnoliadermfrisco.com

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FINANCIAL POLICY NOTICE

Thank you for choosing Magnolia Dermatology. Please understand that the services you elect to participate in imply a financial responsibility on your part and you are ultimately responsible for payment of our bill. If you have any financial questions about your visit please contact our billing department as soon as possible. We strongly encourage each patient to contact their insurer directly prior to receiving services to ensure that they fully understand their benefits and coverage. We accept cash, checks, Mastercard, Visa, Discover, American Express and CareCredit.

Please review and sign after reading each policy listed below

Private Pay (Self-pay): I understand that if I do not have health insurance, full payment is due at the time of service.

Policy Benefits/Non-Covered Charges: I understand it is my responsibility to know my insurance policy coverage and benefits and to notify Magnolia Dermatology of any insurance changes in a timely manner. Many insurance companies have additional stipulations that may affect my coverage. I understand that I am responsible for any amounts not covered by my insurer. Routine in-office procedures, including but not limited to biopsies, injections, destruction of precancerous and non-cancerous growths and surgical removal and repair of cancerous and non-cancerous growths and Mohs surgery are billed separately from my office visit and may be subject to my deductible or coinsurance. I agree to fulfill all policy provisions which my insurance companies may require for payment.

Copayments: I understand that all copays are due at the time of my appointment and before I see the provider. Given that Magnolia Dermatology physicians are specialists, a high copay may be required.

Deductibles: I understand that if it is determined that my insurance policy has an unmet deductible, payment for services at the contracted rate between Magnolia Dermatology and my insurer will be due at the time of service.

Managed Care (HMO) Plans or Health Select: I understand that it is my responsibility to obtain any and all necessary referrals including referrals for follow up visits if my plan requires one. Magnolia Dermatology will strive to keep me informed of visits remaining on a referral and/or the expiration date but it is ultimately my responsibility to know this information and to make the necessary arrangements through my primary care physician. I understand that failure to obtain a referral, if required by my insurance for coverage, will result in me bearing complete financial responsibility for any and all services received.

Benefit Representation: I understand that the staff of Magnolia Dermatology will make every effort to accurately verify my insurance benefits but will not solely rely on this preliminary verification as a basis for making financial decisions regarding treatment. I understand that I have a right to refuse any and all services before they are rendered if I think they are non-covered services or non-payable by my insurance. I understand that the final determination regarding my benefits and any amounts owed will be made by my insurer at the time of claim processing according to the provisions of the policy contract that I have with them

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Assignment of Benefits: I understand I must provide a copy of my current insurance card in order to file an insurance claim. I assign directly to the providers at Magnolia Dermatology all insurance benefits, if any, otherwise payable to me for services rendered. If a Medicare patient, I request that payment of authorized benefits be made on my behalf. I understand that I am financially responsible for all charges whether or not paid by insurance or Medicare. I further agree to pay for any items or services not covered by insurance or Medicare, as applicable. I hereby authorize Magnolia Dermatology to release all information necessary to secure all payments or approvals of benefits.

Payment for Ancillary Services (Laboratory/Pathology): I understand Magnolia Dermatology utilizes the services of outside laboratories for pathology (biopsies), microbiology (cultures) and blood chemistry. These laboratories will bill for services separately from Magnolia Dermatology. I acknowledge that payments made to Magnolia Dermatology are for services rendered by Magnolia Dermatology and authorize the use of outside laboratories as deemed necessary and warranted by my doctor(s). I understand that this may result in a financial responsibility to the laboratory providing these diagnostic services.

Worker's Compensation: I understand that Magnolia Dermatology does not accept Worker's Compensation cases.

Returned Checks: I understand that checks presented to Magnolia Dermatology as payment for services rendered and subsequently returned by my bank for any reason as unpaid will be charged a returned check fee of $25. Balances must be handled by cash, credit card or money order. Magnolia Dermatology reserves the right to represent returned checks electronically for their face value plus the returned check fee.

Past Due Accounts: I understand that all outstanding accounts will be turned over to a collection agency after three statements and one pre-collection letter. I acknowledge that I must contact Magnolia Dermatology before this time if I wish to make other payment arrangements.

By signing this Financial Policy Notice you, the guarantor, acknowledge that you have read, understand and accept all of the above policies.

Patient Name:____ ***Patient DOB:***_____________________________

____ _______________________________________

Signature of Patient or Guardian/Guarantor **Date**

Relationship:____