



ACKNOWLEDGEMENT OF OFFICE POLICIES

Please review and sign after reading each policy listed below

Office Hours: The office opens at 8am and closes at 5pm Monday-Thursday with a closure during lunch from 12pm-1pm. On Friday the office opens at 8am and closes at 12pm.

Cancellation/No Show 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. A loss of deposit for surgical or aesthetic services may occur if the patient does not cancel 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.

Late Arrivals: Rescheduling may be necessary if you arrive more than 15 late for your scheduled appointment. In the event you are running late, please contact our front desk and we will do our best to accommodate you. If time allows and your provider has the ability to work you back into the schedule, please be aware there may be a wait for you to be seen.

Appointment Reminders: You will receive a text message and email confirmation after booking any appointment. Another reminder text message will be sent out two days prior to your scheduled appointment to allow for changes to be made, if necessary. You may choose to opt-out of these types of communications at any time.

Release of Medical information: If at any time you should need a copy of your medical records, a written release is required to be signed and dated. The form is available at our front desk and can be found on our website. Please allow up to 15 business days to complete your request. If your request is urgent, please mark the request as urgent and someone from our staff will contact you to expedite your request. If a secure fax number cannot be provided, records must be mailed to your address on file. Copies of blood work and pathology reports are provided at no charge, but copies of your complete medical record or our office notes may require a fee. 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.

Expiration of and Right to Revoke Authorization To Disclose Protected Health Information: I understand that I can withdraw my permission given at any time by giving written notice stating my intent to revoke authorization to a person or organization named under "Consent for Communication". I understand that prior actions taken on this authorization by entities that had permission to access my health information will not be affected. The duration of this authorization is indefinite unless revoked with written notice.

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 I will be treated by the provider I am scheduled with and will be notified prior to my appointment if any changes to the servicing provider must be made.. 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:** _____

Relation to Patient: _____



MAGNOLIA

DERMATOLOGY

NEW PATIENT DEMOGRAPHICS

Patient Name: _____ Preferred Name: _____
LAST FIRST M.I.

Date of Birth: _____ SSN: _____ - _____ - _____ Sex: *Male Female*

Address: _____
STREET CITY, STATE ZIPCODE

Home: (____) _____ Cell: (____) _____ Work: (____) _____

Email address: _____ Preferred Language: _____

Emergency Contact: _____ Phone: (____) _____

Relation to Patient: _____

Marital Status: *Minor Single Married Divorced Widowed*

Race: _____ Ethnicity: _____

Occupation: _____ Employer: _____

How did you hear about us? (Select one)

Patient Referral Provider Referral: _____ Insurance Directory
Internet Social Media Event Mailer/Magazine/Publication
Other: _____

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

Guarantor Name: _____ Relation: _____

SSN: _____ - _____ - _____ Date of Birth: _____ Sex: *Male Female*

Address: _____ City, State, ZIP _____

Primary Phone: _____ Email: _____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Policy Holder: _____ Policy Holder Name: _____

Relation: _____ DOB: _____ Relation: _____ DOB: _____

Member ID: _____ Member ID: _____

Group #: _____ Group #: _____

Patient/Guarantor Signature _____ Date _____



MAGNOLIA

DERMATOLOGY

MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____

Reason for Visit, location of problem, duration of problem: _____

Preferred Pharmacy: _____ Telephone: _____ City, Zip: _____

Name of Primary Care Physician: _____ Telephone: _____

Medical History (Check all that apply. If none, check NONE)

- | | | |
|--|---|--|
| <input type="radio"/> Allergies | <input type="radio"/> Heart Valve Replacement | <input type="radio"/> Lumpectomy |
| <input type="radio"/> Asthma | <input type="radio"/> High Blood Pressure | <input type="radio"/> Lupus/Rheumatoid Arthritis |
| <input type="radio"/> Bleeding Disorder | <input type="radio"/> High Cholesterol | <input type="radio"/> Mastectomy |
| <input type="radio"/> Cancer: _____ | <input type="radio"/> HIV/AIDS | <input type="radio"/> Organ Transplant |
| <input type="radio"/> Coronary Artery Bypass | <input type="radio"/> Joint Replacement | <input type="radio"/> Thyroid Disease |
| <input type="radio"/> Diabetes | <input type="radio"/> Liver Disease | <input type="radio"/> NONE |
| <input type="radio"/> Fever Blister | | |

History of skin cancer & skin conditions (Check all that apply. If none, check NONE)

- | | | |
|--|---|--------------------------------|
| <input type="radio"/> Basal Cell Carcinoma | <input type="radio"/> Squamous Cell Carcinoma | <input type="radio"/> Melanoma |
| <input type="radio"/> Actinic Keratosis | <input type="radio"/> Psoriasis | <input type="radio"/> Acne |
| <input type="radio"/> NONE | <input type="radio"/> Other: _____ | |

Family history of skin cancer including Melanoma: Yes ___ No ___

If yes, Whom: _____

Medications (List all current medications including non prescriptions and birth control. If none mark N/A)

Allergies (List all allergies including medication allergies. If none mark N/A)

Social History

Do you smoke? Yes No If yes, how much? _____

Do you drink alcohol? Yes No If yes, how much? _____

65 and over ONLY: Do you have the following:

- | | |
|--|--|
| <input type="radio"/> Living will | <input type="radio"/> Advanced Directive: Yes ___ No ___ |
| <input type="radio"/> Do Not Resuscitate | Name: _____ Phone: _____ |

Vaccines (check all that apply)

- | | |
|--|---|
| <input type="radio"/> Flu (October thru March only) | <input type="radio"/> COVID/Booster |
| <input type="radio"/> Pneumonia (65+ years old only) | <input type="radio"/> Shingles (50+ years old only) |

Review of Systems (Check all that apply)

- | | | |
|--|--|--|
| <input type="radio"/> Problems with bleeding | <input type="radio"/> Problems with healing | <input type="radio"/> Problems with scarring/keloids |
| <input type="radio"/> Fever/Chills | <input type="radio"/> Night Sweats | <input type="radio"/> Unintentional weight loss |
| <input type="radio"/> Joint Pain | <input type="radio"/> Surgical procedures in the past 2 years: _____ | |

Alerts (Check all that apply. If none check none)

- | | | |
|--|--|----------------------------|
| <input type="radio"/> Allergy to adhesive | <input type="radio"/> MRSA | <input type="radio"/> NONE |
| <input type="radio"/> Allergy to lidocaine | <input type="radio"/> Pacemaker | |
| <input type="radio"/> Allergy to topical antibiotics | <input type="radio"/> Defibrillator | |
| <input type="radio"/> Allergy to latex | <input type="radio"/> Require antibiotics prior to a surgical procedure | |
| <input type="radio"/> Artificial heart valve | <input type="radio"/> Rapid heart beat with Epinephrine | |
| <input type="radio"/> Artificial joint replacement | <input type="radio"/> Currently pregnant or currently trying to get pregnant | |
| <input type="radio"/> Blood thinners | <input type="radio"/> Breastfeeding | |



MAGNOLIA

DERMATOLOGY

GENERAL CONSENT & PRIVACY PRACTICES

CONSENT FOR TREATMENT

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. 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 documentation purposes. No audio taping, videotaping, or photography is allowed by non-staff members.

CONSENT FOR ELECTRONIC PRESCRIPTION HISTORY

I understand that to offer the best patient care, *Magnolia Dermatology* may 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 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, newsletters and quality of care surveys provided by *Magnolia Dermatology*. I understand that message/data rates may apply. 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 I am not obligated to receive automated notifications and may opt-out of these, or any, communications at any time.

May we leave a detailed message on your answering machine or voicemail? YES NO

May we email personal medical information to you? (i.e. statements, labs) YES NO

May we speak to any other individuals regarding your medical care? YES NO

Please list the physicians, family members, or other individuals:

NAME	PHONE #	RELATION
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NAME	PHONE #	RELATION
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NAME	PHONE #	RELATION
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By naming my primary care physician, I authorize Magnolia Dermatology to release my medical information to the listed entity for the purpose of updates regarding treatment.

Primary Care Physician: _____ Phone: _____

NOTICE OF PRIVACY PRACTICES

I certify that I have been provided with a copy of the privacy practices of Magnolia Dermatology. I have reviewed how Magnolia Dermatology may use and disclose protected health information about me. This includes the release of protected health information (PHI) for insurance billing purposes.

The practice reserves the right to change the Notice of Privacy Practices.

Patient/Guardian Signature: _____ Date: _____



FINANCIAL POLICY NOTICE

Thank you for choosing Magnolia Dermatology. If you have any financial questions about your visit, please contact our billing department as soon as possible. We accept cash, checks, Mastercard, Visa, Discover, and American Express.

Please review and sign below:

Financial Responsibility: I understand that if I do not have health insurance, full payment is due at the time of service. I understand it is my responsibility to know my insurance policy coverage and benefits and to notify Magnolia Dermatology of any insurance changes. A copy of the insurance card must be provided following any changes. I understand that I am responsible for any amount not covered by my insurance policy. I understand that payment is due on the date in which services are rendered, including copays, deductible or coinsurance amounts, and charges for cosmetic services. Routine, in-office procedures including biopsies, injections, and destruction of growths may be subject to my deductible or coinsurance. I agree to fulfill all policy provisions which my insurance company may require for payment.

Managed Care (HMO) Plans or Health Select: I understand that it is my responsibility to obtain any and all necessary referrals if my plan requires one. Magnolia Dermatology will strive to keep me informed of the status of any referral but it is ultimately my responsibility 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 the full balance becoming my financial responsibility for any and all services received.

Benefit Verification: I understand that the staff of Magnolia Dermatology will make every effort to accurately verify my insurance benefits, but this verification is not a guarantee of payment by my insurer. I understand that I have a right to refuse any services before they are rendered. 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. Any questions regarding insurance benefits for dermatology services may be directed to the front desk.

Release of Information: I 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 this authorization may include the release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome (“AIDS”) and Human Immunodeficiency Virus (“HIV”).

Assignment of Benefits: I authorize the payment of benefits directly to the providers at Magnolia Dermatology in all claims for services rendered.

Medicare/Supplemental Benefits: If covered by Medicare and a supplemental policy, I request that payment of authorized benefits be made on my behalf. I hereby authorize Magnolia Dermatology to release all information necessary to secure all payments or approval 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 ordered 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 may 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: _____

Patient/Guardian/Guarantor Signature: _____ **Date:** _____

Relation to Patient: _____