Dallas Center for Dermatology and Aesthetics
8201 Preston Road, Suite 350 Dallas, TX 75225
P: 214-631-SKIN (7546) F: 214-631-8546
Lori D. Stetler M.D., P.A. * Kristel D. Polder M.D., P.A. * Jennifer Scheiderich, P.A

PATIENT INFORMATION RECORD

Name: _____ Date: _____

Address: _____
STREET CITY STATE ZIP CODE

Home Ph: (_____)_____ Work Ph: (_____)_____ Cell Ph: (_____)_____

Email Address: _____

DOB: /_____/_____ Age: _____ □ Male □ Female Marital Status: □S □M □D □W

Employer: _____ SS# _____-_____-_____ DL#_____

Preferred Communication: □ Home □ Work □ Cell □ Email

OPTIONAL PATIENT INFORMATION (please circle your selection)

Race: White / Black / African American / Other : _____
Ethnicity: □Not Hispanic / Latino □ Hispanic / Latino
Primary Language: English / Spanish / Other: _____

Spouse's Name: _____ DOB: ___/___/___ SS #_____-_____-_____

Spouse's Employer: _____ Spouse's Work Ph: _____

In Case of Emergency, Contact: _____ Phone: (____)_____

Referred by: ( )Physician ( )Family Member ( )Friend ( )Website ( )Other: _____

Preferred Pharmacy:_____ **Ph#/Address:** _____

IF PATIENT IS A MINOR OR STUDENT

Mother's Name: _____ DOB: ___/___/___ SS#: _____-_____-_____

Address: _____
STREET CITY STATE ZIP CODE

Home Ph: (_____)_____ Work Ph: (_____)_____ Cell Ph: (_____)_____

Father's Name: _____ DOB: ___/___/___ SS#: _____-_____-_____

Address: _____
STREET CITY STATE ZIP CODE

Home Ph: (_____)_____ Work Ph: (_____)_____ Cell Ph: (_____)_____

INSURANCE

Insurance Company: _____ Insured ID#: _____

Insured Name: _____(if different from patient) DOB:_____/_____/_____

RELEASE AND ASSIGNMENT OF BENEFITS: I hereby authorize the release of any & all medical information to my insurance carrier(s) or their representative, for purposes necessary in the adjudication or processing of any & all insurance claim(s) filed on my behalf & for which I am financially responsible. I further authorize all insurance benefits be paid to the provider rendering services on behalf of Dallas Center for Dermatology & Aesthetics.
CONSENT TO TREAT: I hereby consent to treatment by my dermatologist to include examination and treatment, prescribing medication and skin preparations.

_____ _____
PATIENT SIGNATURE (PARENT IF PATIENT IS MINOR CHILD) **DATE**

Dallas Center for Dermatology & Aesthetics

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MEDICAL HISTORY

Patient Name:_____ Occupation:_____

Date of Visit:_____ Referring Physician:_____

Hobbies:_____

Reason for Visit:_____

Primary Care Physician:_____ Address:_____
(if different from Referring Physician above

Telephone:_____

Do you have any drug allergies?_____ If so, please list:_____

Have you ever had any reactions to local anesthetics? Yes [ ] No [ ]

If yes, please explain:_____

List all prescription and non-prescription medications you are currently taking:_____

History of Skin Cancer? Yes or No: ❒ Melanoma ❒ Basal cell carcinoma ❒ Squamous cell carcinoma

Area of body_____ How treated?_____

Do you have a family history of any of the following?

❒ melanoma ❒ skin cancer ❒ asthma ❒ eczema ❒ hay fever ❒ psoriasis

❒ hair loss ❒ diabetes ❒ adult acne ❒ genetic diseases

Other_____

Please check appropriate box if you have a history of, or are currently under treatment for, the following conditions:
(if any are "yes". please explain on the lines below)

[ ]Yes [ ]No Heart Problems
[ ]Yes [ ]No High Blood Pressure
[ ]Yes [ ]No Pacemaker/Defibrillator
[ ]Yes [ ]No Stroke
[ ]Yes [ ]No Blood Clots
[ ]Yes [ ]No Bleeding Problems
[ ]Yes [ ]No Lung/Breathing Problems
[ ]Yes [ ]No H I V
[ ]Yes [ ]No Psychiatric Condition

[ ]Yes [ ]No Hepatitis
[ ]Yes [ ]No Diabetes
[ ]Yes [ ]No Kidney Problems
[ ]Yes [ ]No Arthritis
[ ]Yes [ ]No Epilepsy
[ ]Yes [ ]No Glaucoma
[ ]Yes [ ]No Rheumatic Fever
[ ]Yes [ ]No Artificial Joint/Valve
[ ]Yes [ ]No Mitral Valve Prolapse

[ ]Yes [ ]No Organ Transplant
[ ]Yes [ ]No X-ray Therapy
[ ]Yes [ ]No Ultraviolet Light Therapy (PUVA/UVB)
[ ]Yes [ ]No Skin Cancer
[ ]Yes [ ]No Cancer
[ ]Yes [ ]No Keloids
[ ]Yes [ ]No Currently Pregnant/Nursing
[ ]Yes [ ]No Require antibiotic prior to procedure

Other:_____

[ ]Yes [ ]No Previous Surgery? If yes, explain type of surgery and give dates (no/yr) of each surgery:_____

[ ]Yes [ ]No Alcohol Use? How much and how often?_____

[ ]Yes [ ]No Tobacco Use? Types and amounts used per day?_____

_____ _____
Signature of Patient (responsible party & relationship if patient is a minor) Date

_____ _____
Provider Signature Date

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Financial Policy

We are dedicated to providing the best possible care and service to you. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. If you have any questions about the following financial policy, please do not hesitate in discussing them with us.

Your Insurance

We make every effort to follow the guidelines required by your insurance company. However, every insurance contract is unique. If you do not inform us of any special requirements in your plan and we subsequently perform a service or test that is denied, we have no choice but to bill you directly for those charges. Every effort is made to file claims on your behalf with your insurance plan. Unfortunately, if we are unable to collect from your insurance company, you will be held financially responsible. Therefore, we encourage our patients to be pro-active in assuring that claims are paid.

If your insurance coverage changes, it is your responsibility to notify our office at least **24 hours** before your next appointment. Failure to do so may result in rescheduling of your appointment. In addition, we may not be a provider with your new insurance. You will then be treated as a cash patient and given a superbill in order to file your own claim.

You may receive a separate bill from an off-site laboratory (Ameripath, Freeman-Cockerell, LabCorp etc) for any lab tests your physician may order. Please discuss any lab billing discrepancies with that laboratory.

With the exception of our Medicare patients, we DO NOT file secondary insurance.

Cancellations and Missed Appointments

All cosmetic appointments will require a credit card number on file upon scheduling. We kindly request that you give us a minimum of 24 hours notice if you are unable to keep your appointment. Failure to do so will result in a missed appointment fee. This fee is NOT covered by your insurance plan. The missed appointment fee schedule is as follows:

Medical - $85

Cosmetic – Minimum of $100 for each provider on the same day. Higher fees may be applied to procedures including, but not limited to, Thermage, Fraxel Repair, Fraxel Restore, CoolSculpting, Sculptra, Fotofacial, Botox, and fillers. In the case of prepaid packages, one session will be deducted from the package.

Returned check fee

There will be a $35 charge for all returned checks.

Collections: If your account is turned over to our collection agency, you will be responsible for the collection fee charged us by the agency in addition to your outstanding balance.

Your insurance card and driver's license will be required at check in.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Signature of Patient or Responsible party	**Today's Date**
Printed Name of Patient	**Date of Birth**

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Cosmetic Interest Questionnaire

Patient Name: _____ Date: _____

Please check any issues and procedures of interest to you and give this form to the doctor or medical assistant during your visit.

- ❒ Skin-care advice and products
- ❒ Sunscreen advice/ Sun damage
- ❒ Botox
- ❒ Dermal fillers
- ❒ FotoFacial (IPL)
- ❒ Fraxel
- ❒ Thermage
- ❒ Lip enhancement
- ❒ Forehead wrinkles/ Frown lines
- ❒ Wrinkles around the eyes
- ❒ Laser resurfacing
- ❒ Tattoo removal
- ❒ CoolSculpting
- ❒ Redness/ Rosacea
- ❒ Brown spots/ Melasma
- ❒ Sagging skin
- ❒ Acne & other scars
- ❒ Restoring volume to the face
- ❒ Stretch marks
- ❒ Laser hair removal
- ❒ Removing facial/leg veins
- ❒ Body Contouring
- ❒ Spa services
- ❒ Chemical peels
- ❒ Birthmark correction
- ❒ Skin Tightening
- ❒ Other _____

Dallas Center for Dermatology and Aesthetics is committed to helping you achieve your healthy skin goals. With that in mind, be the first to hear about our monthly specials and upcoming events!

Your email: _____

We encourage you to get these communications from the Dallas Center for Dermatology and Aesthetics so you can stay in the know and take advantage of our monthly procedure, treatment, and product specials, as well as our wonderful and informative events. You can elect at any time to discontinue this service.

Thank you.

NOTICE OF PRIVACY PRACTICES

Dallas Center for Dermatology and Aesthetics, PLLC

Lori Stetler, M.D./Privacy Officer

Effective Date: 9/23/2013

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

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores on a computer in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

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. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

B. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an

incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

Changes to this Notice of Privacy Practices:

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

C. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202
Voice Phone (800) 368-1019
FAX (214) 767-0432
TDD (800) 537-7697

The complaint form may also be found at: **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**.

In signing this HIPAA Patient Acknowledgement form , you acknowledge and authorize, that you hold harmless this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring from this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given the opportunity to ask question; that I have received a copy of the signed authorization; that I may inspect a copy of my PHI to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated Authorization shall be as effective as the original.

Consent to release Protected Health Information (PHI)

I understand that in order to disclose my PHI, **Dallas Center for Dermatology and Aesthetics, PLLC** must have my consent, therefore, I authorize **Dallas Center for Dermatology and Aesthetics, PLLC**, to disclose my PHI as described in the above forms, to the recipients listed below:

Description of the information to be disclosed (check all that apply)

☐All Procedures☐Test Results☐Appointments☐Other☐Surgeries☐Billing/Account information

Name(s) of the person(s) authorized to obtain the above mentioned information. (e.g. Physician other than your referring doctor, family members and other specified person/persons)

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Contact Information:

I authorize Dallas Center for Dermatology and Aesthetics to contact me at the following number with results or questions:

Home_____Cell_____Work_____

Email _____

May we leave a detailed message on your answering machine or voicemail?

Yes☐No☐ Failure to check one of these boxes may delay results

By Patient: (Print and sign)_____

Date:_____

Or Patient's Representative (Print name, sign and describe authority)

_____

Date:_____