THE WOODLANDS DERMATOLOGY ASSOCIATES

**PATIENT INFORMATION**

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt #: ____ City: _____ State: ____ Zip Code: _____

Date of Birth: _____/____/_____ Primary Phone: (_____) _____ cell / home

Alternate phone: (_____) _____ cell / home

Birth Sex: Male / Female / Unknown Marital Status: Child / Single / Married / Divorced / Widowed

Parent/Guardian Name: _____ Relationship: _____ DOB: ____/____/_____

Email: _____ Would you like to subscribe to our email list to receive announcements and exclusive offers on cosmetic services and product discounts? Yes / No

May we leave a message with benign pathology results or normal laboratory results? Yes _____ No_____

**Our office will communicate with you with the contact information you provide**

**INSURANCE INFORMATION**

Primary Medical Policy Name: _____ Member/Subscriber ID#: _____

Group #: _____ ****IS A REFERRAL REQUIRED FOR YOUR PLAN?** Yes / No

Subscriber Name and DOB (if different than patient): _____

Secondary Medical Policy Name: _____Member/Subscriber ID# :_____

Group #: _____

Subscriber Name and DOB (if different than patient): _____

**You are required to present your insurance card(s) and photo ID to the check-in staff**

**RELEASE OF INFORMATION**

Employees of this office must have your permission to relay medical information to someone other than the patient. Your personal information will not be shared unless we are authorized to do so. Please list the name(s) of those authorized to receive your medical information.

1. Name: _____ Relationship: _____ Phone: (___)_____ Emergency Contact? Y / N

2. Name: _____ Relationship: _____ Phone: (___)_____ Emergency Contact? Y / N

**PRIVACY ACKNOWLEDGEMENT**

I acknowledge that The Woodlands Dermatology/Montgomery Dermatology Associates has provided me with a written copy of the Notice of Privacy Practices. I acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Patient/Parent/Guardian Initial here _____

**ASSIGNMENT AND RELEASE**

I hereby assign, transfer, and set over to The Woodlands Dermatology/Montgomery Dermatology Associates all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy in regards to all services performed in our office. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether it is a covered benefit by my insurance or not.

Patient/Parent/Guardian Signature: _____ Today's Date: _____

THE WOODLANDS DERMATOLOGY ASSOCIATES

Patient Name:_____ DOB: _____ Physician you are seeing today: _____

Preferred Pharmacy: _____ Address/Phone: _____

**PAST MEDICAL HISTORY** (circle all that apply)

| | | | |
|---|---|---|---|
| Anxiety | Hearing loss | High Blood Pressure | Valve replacement |
| Artificial Joints | COPD | High Cholesterol | Seizures |
| Arthritis (OA, PSA, RA) | Coronary Artery Disease | Hyperthryroidism | Stroke |
| Asthma | Depression | HIV/Aids | *Bleeding Disorder Y / N |
| Atrial Fibrillation | Diabetes | Hypothyroidism | *Clotting Disorder Y / N |
| *Cancer: type of treatment? _____ | GERD/Acid Reflux | Organ transplantation: | |
| | Hepatitis | *what organ? _____ | |

**LIST SURGERIES**

_____
_____
_____
_____

**SKIN DISEASE HISTORY** (circle all that apply)

Acne Actinic Atypical Mole Basal Cell Carcinoma Eczema Melanoma
Psoriasis Rosacea Squamous Cell Carcinoma
Other: _____

- Do you wear sunscreen? Y / N If yes, what SPF? _____
- Do you tan in a tanning salon? Y / N
- Do you have a family history of skin cancer? Y / N If yes, what type and which family member? _____

**CURRENT MEDICATIONS** (please list all current medications and dosages *including* over the counter medications and supplements)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

(use reverse side of page if necessary or provide a list to the check-in staff)

**ALLERGIES** _____

**SOCIAL HISTORY**

- Do you smoke tobacco? Y / N If yes, how many per day? _____
- Do you use IV drugs? Y / N If yes, which IV drug? _____
- Do you drink alcohol? Y / N If yes, how many drinks per day? _____
- What is your occupation? _____

**QUALITY MEAURES**

- Have you received your flu shot for this flu season? Y / N If no, please state reason: _____
- Have you had your Pneumonia vaccine? Y / N

**CAUTION**

- Have you ever had difficulty to stop from bleeding? Y / N
- Do you require antibiotics prior to surgical procedures? Y / N
- Do you have an artificial heart valve? Y / N
- Have you had an artificial joint replacement? Y / N If yes, when and what body location? _____
- Do you have a pacemaker? Y / N
- Do you have a defibrillator? Y / N
- Are you pregnant or currently trying to get pregnant? Y / N

THE WOODLANDS
DERMATOLOGY
ASSOCIATES

# Office and Financial Policies

**Welcome and thank you for choosing The Woodlands Dermatology/Montgomery Dermatology Associates for your dermatology care. We are committed to providing you with the highest quality medical care, in an efficient and cost effective manner. We hope by providing you with our policies in advance, we can prevent any misunderstanding or frustration at the time of your visit.**

- Insurance
  - When making an appointment with one of our physicians, it is *your* responsibility to confirm with your insurance company that our physician is currently under contract with your plan.
  - Some plans require you to obtain a referral prior to seeing a specialist. If your plan requires a referral, you will be responsible to obtain this from your Primary Care Provider (PCP) at least 72 hours prior to your scheduled visit. **Please note: This is an electronic referral with a authorization code. This is NOT a note from your PCP stating they want you to be seen by our physicians.
  - Some procedures are NOT covered by insurance as they are considered cosmetic or not medically necessary. These procedures include but are not limited to removal of skin tags, seborrheic keratosis, spider veins, etc… You may be required to sign a waiver acknowledging understanding of your responsibility to pay for non-covered services in their entirety.
- Self Pay
  - If you do not have medical insurance you will be responsible for the entire cost of the visit at check out.
- Cosmetic Procedures
  - We require a $75-$150 deposit (depending on procedure and length of your appointment) for all cosmetic procedures. This includes but is not limited to chemical peels, laser treatments, sclerotherapy, fillers, Botox injections, etc… Cosmetic treatments are NOT covered by insurance and as such we will not file a claim to your insurance company for any visit deemed as a cosmetic procedure. In the event you cancel your appointment less with less than 24 hours notice, your deposit will be *forfeited*. In addition, you will be asked to place another deposit to schedule a future appointment.
- No Shows/Late Cancellations
  - We require 24 hours notice for all cancellations. You will receive an appointment reminder with sufficient time to cancel. All appointments cancelled with less than 24 hours will be considered a No-Show.
  - After a No-Show, you will be required to place a minimum $50 deposit to hold your next appointment. ($150 for surgical procedures). This is NOT A PENALTY. The deposit will be applied towards your next appointment. Should you No-Show the next appointment, your deposit will be *forfeited.*
  - Excessive late cancellations and/or no-shows will result in escalating deposit amounts, permanent deposit requirements, and/or dismissal from the practice.
- Late Arrivals
  - We normally allow a 15-minute grace period following your scheduled arrival time. In the event that we are able to work you in, there may be a longer than usual wait time as we will need to see the patients that arrived on time first. If you are past the 15 minute grace period you will be asked to reschedule.
- Parent/Legal Guardian of minors/Unaccompanied minor
  - Parents or Legal Guardians of minors are responsible for providing current information as well as any payment due the day of the visit.
  - Unaccompanied minors must have written authorization on file to be seen. The parent or legal guardian must sign the authorization prior to the visit. The minor is responsible for all payments due at the day of service.
  - Legal Guardians must provide legal documentation proving guardianship to place in the patient's chart.

- Labs
    - All tissue removed from your body (i.e. moles, infected skin tags, lesions, etc…) will be sent to a lab to be examined by a dermatopathologist.
    - Lab fees are *separate* from your physician visit. We will make sure to send your insurance information to the lab along with your specimen(s). The lab will file your insurance. You may receive an invoice from an outside lab or from our in-house dermatopathologist. These invoices are your responsibility

Payment Options as of March 4, 2024

- Self-pay/Cosmetic Procedures
    - Check
    - E-Check
    - Credit Card
    - Apple Pay
    - Samsung Pay
    - Allergan Coupon/ASPIRE coupon (for Cosmetic Procedures only)
- Insurance – multiple coverage
    - If you are covered by more than one insurance, you will be invoiced for anything not covered after your claim has been processed by all insurances.
- Insurance – 1 policy only
    - Option 1
        - Pay an estimated amount *in full* at check out. If the processed amount is less than what you paid we will issue a refund. If the processed amount is higher than what you paid, you will be invoiced the balance due.

    - Option 2
        - Credit Card for balances left *after* insurance processing.
            - This is a secure portal through ModMed Pay,
            - You will have the ability to present a credit card, debit card, or FSA/HSA card.
            - You decide the MAXIMUM amount that can be charged AFTER your insurance processes your claim, if there is a balance due, you will be notified of that amount and the date that your card will be charged.
                - If the amount due exceeds the maximum you authorized, you will be invoiced for the remainder. Conversely if the amount due is less than the maximum amount authorized, we will only charge the amount due.
- Payment Plans will be offered on a case by case basis depending on balance owed

---

**By signing below, I am acknowledging that I have read, understand and have agreed to The Woodlands Dermatology /Montgomery Dermatology Associates office and financial policies. I hereby attest that I have given and agree to provide current demographics, insurance information and authorize TWDA/MDA the release of my information necessary for filing claims to my insurance companies and obtaining pre-certification, when necessary.**

**Print Patient Name: _____ Date of Birth: _____**

**Patient/Parent/Legal Guardian signature: _____Today's Date: _____**