Texas Dermatology Center, Dr. Mary Evers
Initial Patient Questionnaire

Patient's Name_____ Age _____

Today's Date _____ Referring Doctor _____

Reason for visit: _____

Medications currently taking (names only):_____

_____

Allergies: _____

Past Medical History:

Y	N		Y	N	
☐	☐	Skin Cancer	☐	☐	HIV/AIDS
☐	☐	Skin Disease or Keloid scars	☐	☐	Organ/ Bone Marrow Transplant
☐	☐	High Blood Pressure	☐	☐	Autoimmune disease/ Lupus
☐	☐	High Cholesterol	☐	☐	Arthritis
☐	☐	Heart Disease/CHF	☐	☐	Bleeding Disorders
☐	☐	Liver Disease/Hepatitis	☐	☐	Cancer
☐	☐	Kidney or Bladder Disease	☐	☐	Asthma/ Hay fever/ Sinus Trouble
☐	☐	Diabetes	Other Chronic Disease: _____		

Family History:

Y	N	
☐	☐	Skin Disease
☐	☐	Skin Cancer
☐	☐	Autoimmune Disease

Social History:

Y	N		Y	N	
☐	☐	Do you smoke	☐	☐	Do you regularly use sunscreen
☐	☐	Do you drink alcohol	☐	☐	Have you had a sunburn
☐	☐	Do you use illicit drugs	☐	☐	Occupation _____

Female Patients Only:

Y	N	
☐	☐	Currently pregnant
☐	☐	Breastfeeding
☐	☐	Planning pregnancy

Patient or Responsible Party Signature _____
Date _____

Physician Signature _____ Date _____

TEXAS DERMATOLOGY CENTER PLLC, DR. MARY EVERS, D.O.

Name:_____ Date____/____/____
Last First M.I.

Date of Birth: ____/____/____ SSN: _____ Age: _____ Sex: ☐ Male ☐ Female
insured

Mailing Address:

_____
Street City State Zip

Home Phone: ( )_____ Work Phone: ( )_____

Cell Phone: ( )_____ E-mail: _____

Referred by: _____

Have you or any family members been a patient of Dr. Evers? _____

Primary Care Physician _____ Phone ( )_____

Insurance: Primary_____ **Secondary**_____

PARENT, SPOUSE, OR RESPONSIBLE INSURED PARTY (if different from patient)

Name: _____ Date of Birth: ____/____/____
Last First M.I.

Address:_____
Street City State Zip Code

Home Phone: _____ Work Phone: _____

EMERGENCY CONTACT INFORMATION:

In case of Emergency, who should be notified?_____

Phone:_____ Relationship to patient: _____

Do you give our office permission to discuss your medical information with family members? ☐ YES ☐ NO If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____

Phone # (day): _____ Phone # (evening): _____

May we leave personal medical information on your answering machine or cell phone?
☐ YES ☐ NO

May we obtain your medication history electronically?
☐ YES ☐ NO

Do you want your lab or pathology results posted on the web portal?
☐ YES ☐ NO

Pharmacy (name and location): _____

Patient or Responsible Party Signature _____ Date_____

TEXAS DERMATOLOGY CENTER, DR MARY EVERS, D.O.

HIPAA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.
By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.
The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

☐ Protected health information may be disclosed or used for treatment, payment, or health care operations

☐ The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice

☐ The Practice reserves the right to change the Notice of Privacy Practices

☐ The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions

☐ The patient may revoke this Consent in writing at any time and all future disclosures will then cease

☐ The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: _____
Printed Name – Patient or Representative

_____ ___/___/___
Signature Date

Relationship to Patient
(if other than patient): _____

Witness: Donna BRENNER
Printed Name – Practice Representative

Donna Brenner ___/___/___
Signature Date

TEXAS DERMATOLOGY CENTER PLLC, DR. MARY EVERS, D.O.
Office Financial Policy

Patient Name: _____ Date of Birth: ___/___/___

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the patient, to please check with your insurance company prior to any testing or surgery being performed. *It is your responsibility to know your individual coverage.* Failing to comply with this suggestion could result in you, the patient, being responsible for all costs incurred. We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

LAB / PATHOLOGY: I authorize and understand that an outside laboratory is used to process and interpret the skin specimens. I understand that this is a separate charge from today's services. If your insurance company requires you to use a specific Laboratory please notify our staff today prior to the procedure. Please remember, your insurance policy is between you and you insurance company and *not with the insurance company and your doctor.*

Medicare: We are Medicare participating providers. We will bill Medicare and Medigap carriers. You will be responsible at the time of service for payment of:

a. The annual deductibles, b. Copayments, c. Charges for noncovered or cosmetic services*

* You will be asked to sign an Advanced Notice of Liability Form in the event that a service is provided which we know is not covered by Medicare. If you have Medicare, as well as secondary coverage with a commercial plan that is not Medigap or is an insurance company with which we have no contract, we will file a claim to your secondary/supplemental carrier. If no payment is received from your secondary/supplemental carrier within 60 days after we file a claim, you will be sent a bill and will be responsible for the balance.

Non-Medicare/Commercial Plans: If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for all covered, medically necessary services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible at the time of service for payment of:

a. The annual deductibles, b. Copayments, c. Charges for noncovered or cosmetic services

In the event that you, as the patient, or we, as the physicians, are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier. For non-Medicare patients who have insurance coverage with an insurance carrier with which we do not have a contractual relationship, please note the following:

a. We will file both your primary and secondary insurance. If we do not receive payment from your primary carrier within 45 days of filing, you will be billed for the entire amount. Payment is due 10 days after receipt of the statement. b. If we receive payment from the primary, we will file a claim with your secondary. If we do not receive payment from your primary carrier within 45 days of filing, you will be billed for the entire amount. Payment is due 10 days after receipt of the statement.

No Insurance: Payment is expected at the time of service. A discount will be given for those with no medical insurance and payment at the time of service.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

_____ ___/___/___

Patient or Responsible Party Signature Date