CLEAR LAKE dermatology

Narin "Dr. Joe" Apisarnthanarax, M.D.
Prapand Apisarnthanarax, M.D.
Lindsey Hunter, M.D.
Stephanie Kokolis, PA-C
David Raimer, M.D.

Patient Registration Form

Please Print Clearly and Fill in All the Blanks

PATIENT INFORMATION

First Name: _____ Middle Initial: ____ Last Name: _____ DOB:_____ Age_____

Address: _____ Apt #: _____City: _____State: _____Zip: _____

SSN: _____ Driver License Number:_____ Gender: Female / Male

Home Phone:_____Cell:_____Work:_____Marital Status: Single/Married/Divorced/Widowed

Email: _____ ***Referring Physician***:_____

How did you find our office?_____ Provide name if referral is friend or relative_____

Emergency contact_____Relationship:_____Phone:_____

If under the age of 18, parent/guardian's Name: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION (Please present insurance card & valid ID at time of check in)

PRIMARY

Ins Co. Name_____
Name of Insured _____
Date of birth_____
SSN_____ Gender: Female / Male
Insured ID#_____
Group #_____
Relationship to Insured (self / spouse / father / mother / other)
Employer Name_____

SECONDARY

Ins Co. Name_____
Name of Insured _____
Date of birth_____
SSN_____ Gender: Female / Male
Insured ID#_____
Group #_____
Relationship to Insured (self / spouse / father / mother / other)
Employer Name_____

Do you have any other insurance? ☐ Yes ☐ No If yes, please list:_____

Primary Care/ Family Doctor_____

Patient/Guardian Signature _____Date_____

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Medical History

First Name: _____ Middle Initial: ____ Last Name: _____ DOB:_____

Nickname:_____ Occupation:_____ Race:_____ Language:_____

Reason for your visit today?_____

Location?_____ How Long?_____ Symptoms?_____

Prior treatments?_____ By Whom?_____

What makes the condition better or worse?_____
Do you have a history of skin cancers? Y/N If yes, please list:_____
Do you have a family history of CANCERS? Y/N If yes please list:_____

Please select any of the following medical conditions that you currently have, or have had, below:

□ Anxiety
□ Arthritis
□ Asthma
□ Atrial Fibrillation (Irregular Heartbeat)
□ Bone Marrow Transplantation
□ BPH
□ Cancer, Type:_____
□ COPD
□ Coronary Artery Disease
□ Depression
□ Diabetes
□ End Stage Renal Disease
□ GERD
□ Hearing Loss
□ Hepatitis
□ Hypertension
□ HIV/Aids
□ Hypercholesterolemia
□ Hyperthyroidism
□ Hypothyroidism
□ Radiation Treatment
□ Seizures
□ Stroke

Are you pregnant / planning pregnancy/fertility treatments? Y/N_____
Are you breast feeding? Y/N_____
Other – please list:_____
Past surgeries – please list:_____

Are you allergic to any medications? Y/N If yes, please list:_____

Current medications with Strength (mg)/ Dose & Frequency (how many times a day taken)
1._____ 2._____ 3._____
4._____ 5._____ 6._____ 7._____

Pharmacy Name:_____ Phone Number:_____ City or ZipCode:_____
Do you wear sunscreen? Y/N SPF:_____ Alcohol Usage: Y/N Usage per day: _____
Tobacco Usage: Y/N Usage per day:_____

PHONE NUMBER TO CALL WITH ANY PATHOLOGY OR LAB RESULTS:_____
□ You have my permission to leave a message at the above number.
□ You have my permission to discuss my medical care with:_____
□ DO NOT discuss my medical care with anyone but me.

Patient/Guardian Signature:_____ Date:_

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HIPAA Authorization Form (Medical Information Release Form)

_____	_____
Patient's full name	Patient's Social Security #
_____	_____
Address	Patient's Date of birth
_____	_____
City, State, Zip Code	Patient's Telephone #

Release of Information

[ ] I authorize the release of information including the diagnosis, records, and examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

What information can be disclosed? Complete the following by indicating those items that you would want disclosed. If all health information is to be released, check only the first box.

[ ] All health information	[ ] History/Physical Exam	[ ] Past/Present Medications
[ ] Physician's Orders	[ ] Patient Allergies	[ ] Lab Results
[ ] Progress Notes	[ ] Discharge Summary	[ ] Diagnostic Test Reports
[ ] Pathology reports	[ ] Billing Information	

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional) Month _____ Day _____ Year _____

RIGHT TO REVOKE. I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "Release of Information."

Signature X _____ _____

Signature of Individual/Individuals' Legally Authorized Representative Date

Printed name of legally authorized representative (if application) _____

If representative, specify relationship to the individual [ ] Parent of minor [ ] Guardian [ ] Other _____

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Financial Policies and Information

If we participate with the insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. We will bill your primary insurance plan. You will be responsible at the time of service for the payment of:

- Annual deductibles and/or co-payments
- Charges for non- covered or cosmetic services

We will call your insurance company to verify eligibility and benefits. However, verification of benefits is not a guarantee of payment. You will be balance billed if:

- Your insurance company pays less than what we expected
- We obtain a denial from your insurance company
- We have not received payment from the insurance company within 60 days of filing your claim

We are Medicare participating providers; therefore, we will bill Medicare directly. You will be responsible at the time of service for payment of:

- Annual deductibles
- Co-insurance
- Charges for non-covered or cosmetic services
- Secondary insurance portions that are not ordinarily forwarded by Medicare

If you have no health insurance, payment is expected in full at the time of service.

If you are unable to keep your appointment, please reschedule two days prior to your visit.

Returned Checks: There will be a $50.00 service fee charged for all returned or canceled checks.

Saturday Medical Appointments: We require a **$25 deposit** for Saturday appointments that will go towards your co-pay or deductible. **The deposit will be forfeited for missed appointments or same day cancellations.**

Missed Appointment or same day cancellation fees are as follows:

- **Medical appointments:** $25.00 fee.
- **Surgical appointments:** $50.00 fee; additionally, missed MOHS surgeries will result in a $100 fee.
- **Cosmetic Appointments:** We require a $100.00 deposit on certain cosmetic procedures. (Examples: CoolSculpting, Dysport/Botox, Restylane, or Laser hair removal). Failure to show up for your appointment will forfeit your deposit.

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. We use and disclose health information about you for treatment, payment, and healthcare operations. For example:
TREATMENT: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you.
HEALTHCARE OPERATION: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner or provider performance, conducting training programs, accreditation, and certification, licensing, or credentialing activities.
YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure performed by your authorization while it was in effect. Unless you give us written authorization, we cannot use or discuss your health information for any reason except those described in this notice.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

_____ - Signature _____ - Date

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Cosmetic Interest Form

First Name: _____ Last Name: _____ Date:_____

Dear patient and friend,

We send out newsletters and **monthly specials** on our cosmetic products and procedures via email. If you would like to receive our newsletterrs and promotions treatments/procedures/products, please provide us with your current email. **Email:_____.** Please make your selections below if you would like to learn more about treatments and procedures that we offer. We will be happy to address your cosmetic concerns.

*CHECK **PROBLEMS** YOU WOULD LIKE TO DISCUSS TREATMENT OPTIONS:*

- ☐ Acne Scar
- ☐ Large pores
- ☐ Oily skin
- ☐ Dry skin
- ☐ Dullness and roughness of skin
- ☐ Brown spots / Sun spots / Aging spots
- ☐ Redness / red blood vessels
- ☐ Darkness under the eyes
- ☐ Sagging Neck and Jaw Line
- ☐ Exercise and diet resistant fat
- ☐ Cellulite and body shaping
- ☐ Aging lines and wrinkles
- ☐ Tired and aged appearance
- ☐ Facial Volume Loss
- ☐ Easy bruising
- ☐ Thinning hair and hair volume loss

*CHECK **COSMETIC PRODUCTS OR SERVICES** YOU ARE INTERESTED IN LEARNING ABOUT:*

- ☐ Chemical Peels
- ☐ Laser Hair Removal
- ☐ IPL-PhotoFacial for brown spots and redness
- ☐ Botox / Dysport
- ☐ Injectable Wrinkle Fillers
- ☐ **Ultherapy** & **Exilis** Skin Tightening
- ☐ **CoolSculpting**-Noninvasive Fat Reduction
- ☐ V-Beam Laser Treatment for Rosacea
- ☐ Laser Tattoo Removal
- ☐ Spider Veins
- ☐ Professional Skin Care and Make-up
- ☐ VISIA Skin Analysis
- ☐ **Cellfina** Cellulite Treatment

For Office Use Only **Completed by:**_____

- ☐ Consultation Same Day
- ☐ Consultation Scheduled for_____
- ☐ Telephone Consultation/Information Mailed
- ☐ Procedure Scheduled Date:_____ Type:_____

Comments:_____