COLLEYVILLE
DERMATOLOGY
Surgical Medical Cosmetic Pediatric

Sreedevi Kodali, MD ✳ Gabriela Blanco, MD ✳ Jessica Rushing, PA

5013 Heritage Avenue Ste 100, Colleyville, TX 76034
Phone (817) 868-1616 Fax (817) 868-1617

WELCOME

Appointment Date & Time: _____

Patient's Name: _____

Welcome to Colleyville Dermatology. Thank you for choosing us for your dermatological needs. We have enclosed your new patient paperwork to allow you to complete it. Please note, if a patient is under 18 years of age, a parent or guardian must complete paperwork and attend the appointment with the minor. If the patient is 18 years of age or older, the patient must complete his/her own paperwork. We are required to update your paperwork every year even if there are no changes. We do appreciate your cooperation with this matter.

We are located at **5013 Heritage Avenue Ste 100 in Colleyville, TX 76034**. We can be reached at (817) 868-1616. Our office hours are Monday through Thursday, 7:45 AM – 5:00 PM (with lunch from 12:00 – 1:00 PM) and Friday from 7:45 AM – 12:00 PM.

After you have completed your patient paperwork, please be sure that we have your insurance information, and bring your paperwork with you to your appointment.

We are looking forward to meeting you, and if you have any questions, please don't hesitate to call us at (817) 868-1616.

Thank you,

Colleyville Dermatology

PATIENT REGISTRATION

Patient Information

Patient's Name:_____Date of Birth:_____/____/____ Age:_____
Address:_____Sex: ____M ____F Marital Status:_____
_____Patient's SS # : _____
_____Pt's Driver's License #:_____
Home # (_____)_____ Primary Doctor:_____
Office/Cell # (_____)_____Primary Dr's #: _____
Employer's Name:_____Employer's #:_____
EMAIL ADDRESS: _____
Pharmacy Information:_____

Primary Insurance Information

Name of Insurance Company: _____
Provider Customer Svc #: (_____)_____ Benefits/Claims #: (_____)_____
Claims Address listed on Insurance Card:_____

_____

ID # (member #):_____Group or Plan #:_____
Insured Party's Name:_____Relationship to patient:_____
Insured Party's Date of Birth:_____Insured Party's SS#:_____
Insured Party's Employer: _____Insured Party's phone # _____

Secondary Insurance Information

Name of Insurance Company:_____
ID or Member #:_____Group or Plan #:_____
Customer Service Phone #: (_____)_____Benefits/Claims #:_____
Claims Mailing Address listed on Insurance Card:_____

_____

ID or Member #:_____Group or plan #:_____
Insured Party's Name:_____Relationship to patient:_____
Insured Party's Date of Birth:_____Insured Party's S.S.#:_____
Insured Party's Employer:_____Insured Party's phone #:_____

Emergency Contact Information

Name of Emergency Contact: _____
Relationship to patient:_____
Home #: (_____)_____Alternate phone #: (_____)_____

Name of Second Emergency Contact:_____
Relationship with patient: _____
Home #: (_____)_____Alternate phone # (_____)_____

_____ _____
Patient/Legal Guardian or Authorized Person's (POA) Signature Date

Colleyville Dermatology Date: _____

Medical Questionnaire

Name_____ Date of Birth _____Age_____

Referred by:

Dr. (name)_____ Family Member (name) _____

Friend (name) _____ Yellow Pages_____

Newspaper_____ Other_____

Medical History: Reason for visit: _____

How long have you had this problem? _____

Symptoms (How does it bother you?) _____

Treatments you have tried:_____

Please list all medications you are currently taking, including over-the-counter medication: _____

_____

***Please list any drugs you are allergic to*:** _____

Medical problems (check if yes) ___Diabetes ___High Blood Pressure ___Heart disease ___Pacemaker

___Artificial joint/valve ___Asthma ___other Lung disease ___Thyroid disease ___Anemia

___Hepatitis, type ___ ___HIV ___other Liver disease ___Lupus ___Kidney disease

___Cancer, type___ ___Depression ___History of long-term steroid use ___X-Ray therapy

___Other (comments):_____

Past Surgeries/Medical problems _____

_____

Pregnant: _____yes _____no (_____weeks) Number of past pregnancies:_____

History of Skin Cancer? _____yes _____no: _____Melanoma _____Basal cell carcinoma _____Squamous cell carcinoma

Area of body:_____ How treated:_____

History of Skin Disease, past or current: _____

_____

When you are exposed to sunlight, do you (check most applicable one):

1. _____always burn
2. _____usually burn, rarely tan
3. _____often burn, tan slowly
4. _____sometimes burn, tan well
5. _____rarely burn, always tan
6. _____never burn, deeply tan

Review of Systems (please check which of the following symptoms you are currently having:

___Prone to infection ___Vision ___ Hearing problems ___Stuffy Nose

___Weight change ___Eyelid scale ___Sinus Pain

___Fever/Sweats ___Dizziness ___Mouth sore/throat pain

___Faint

___Chest Pain ___Shortness of breath ___Nausea/vomiting ___Penile/vaginal pain

___Palpitations ___Cough/wheezing ___Abdomen pain ___Penile/vaginal discharge

___Bowel change ___Menstrual irregularity

___Lymph node swelling ___Weakness of body parts ___Joint/muscle pain ___Painful urination

___Easy bleeding ___Numbness of body ___Back pain ___Change in urination freq.

___Blood clots ___Seizures ___Skin growths ___Other:_____

___Rash ___Itchy skin ___Bad scars (keloids)

___Dry skin ___Skin sores ___Hair/nail problems ___Skin Color changes

Past Family and Social History: Is there a family history of (please circle): melanoma, skin cancer, asthma, eczema, hay fever, psoriasis, hair loss, diabetes, adult acne, genetic diseases ? Other: _____

Patient occupation: _____Hobbies:_____

Animals in the home?_____

Smoker? Yes No If yes, how many packs per day: _____

Number of alcoholic drinks per week: _____

History of past IV drug abuse, blood transfusions, or unprotected intercourse? Yes No

Reviewed by M.D. _____

Colleyville Dermatology

Assignment of Insurance Benefits and Release of Information

I authorize the release of information necessary to process any claim. I certify that this information is true and correct to the best of my knowledge.

I authorize payment of medical benefits to be made on my behalf, to Colleyville Dermatology. I hereby authorize photocopies of the form to be recognized as valid as the original.

Consent to Treat

I authorize medical procedures to be performed on the patient named below at the direction of Dr. Sreedevi Kodali and/or Dr. Gabriela Blanco at Colleyville Dermatology.

Signature on File

I acknowledge that I have read and agree to be bound by the terms stated above. This signature shall be valid for one year, unless revoked by me in writing.

Signature: _____ Date: _____

Patient's Name: _____

Important Notice!

If this section is **NOT** filled out and signed, our office will only release information to the patient or guardian.

Release of Information to Someone Other Than Myself

I authorize Colleyville Dermatology to release medical, appointment, and/or financial information over the telephone and/or to release copies of my medical records to the following person:

Name: _____ Relationship: _____

Social Security Number: XXX - XX - _____ (required for identification purposes only)

Signature of Patient/Guardian: _____ Date: _____

Patient's Name (please print) _____

Colleyville Dermatology

Patient Financial Policy

We are committed to providing you and your family with the best possible care. In order to achieve this, we want you to understand our financial policy. Below we have provided detailed information pertaining to this policy. All, or only some of the policy may apply to you and your current situation and may also depend on what you are being seen for.

- **There will be a $25.00 charge applied to all appointments not cancelled or rescheduled at least 24 hours before the appointment.**
- **We require that a form of payment be provided before services are rendered. Credit card information is kept securely on file so that any and all balances, including but not limited to, no show balances, fees for services, procedures and/or products can be charged. If payment is not collected at the time of service, after insurance is filed, one statement is issued to the patient and the balance will be charged to the credit card that was given at the time of service. If any of the balance is paid by insurance, the patient will be reimbursed the difference. If you cannot provide a credit card, the payment for services must be paid in full at the time the service is rendered.**
- We are providers for many managed care plans. We will file claims for those plans we participate in, and will require you to pay your copay/deductible/coinsurance at the time of the visit. Please be advised, if we have not heard from your insurance company within 60 days, the balance will become the patient's responsibility. If you have a biopsy or excision, your tissue will be sent to an outside laboratory for analysis. They are a separate entity from our office and you may receive a bill for their services.
- The majority of procedures done in the office are considered outpatient surgery, and may have a different benefit than an office visit. For example, if the doctor performs a procedure, it is likely that the insurance company will first apply it to the patient's deductible, once the deductible is met, the insurance company will pay their ratio portion (e.g. 80/20), and the patient owes the balance.
- Not all services are medically necessary. Some insurance companies arbitrarily select service they will not cover. You are responsible for these services. We must emphasize that as medical care providers, our relationship is with you and not with your insurance company. It is the patient's responsibility to confirm with their insurance company, before services are rendered, that our office, doctors and any procedures done are covered by their insurance policy and benefits.
- Payment for any cosmetic procedures is due at the time the service is rendered. The doctor will inform you, to the best of her knowledge, what procedures are deemed "cosmetic" by most insurance companies. However, the doctor does get very busy and may not convey this information, therefore it is a good idea to ask the doctor before a procedure is performed.
- We make every effort to help you with your referral from your primary care physician (if one is required), however it is the patient/guardian's responsibility to confirm that we have a current valid referral. Physicians are permitted to treat ONLY the condition(s) listed on the referral.
- We will file Medicare and a secondary or supplemental policy. You will receive a bill for any services approved by Medicare , but not paid by your secondary or supplemental plan. This is true also for other primary and secondary insurances.
- Full payments for services are due at the time services are rendered for all self-paying patients (patient's with either no insurance, or we are out of network with insurance). We accept cash, checks, and credit cards. A self-pay patient will be given a detailed receipt, which includes all pertinent information for you to send to your insurance company. Credit card information is kept in a secure location so that balances can be paid automatically after one statement is issued.
- We are NOT providers for MEDICAID and will only accept MEDICAID patient's as self-pay. We will NOT file any claims to MEDICAID as primary or secondary insurance.

If you have any questions regarding this financial policy, please don't hesitate to contact us.

Signature _____ Date_____

Colleyville Dermatology
Sreedevi Kodali, M.D.
Gabriela Blanco, M.D.

Phone (817) 868-1616
Fax (817) 868-1617
5013 Heritage Avenue Ste 100
Colleyville, TX 76034

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

I, _____, have reviewed a copy of Colleyville Dermatology's Notice of Privacy Practice.

_____ _____

Signature or patient/guardian **Date**

Compliance & Disclosure under Texas Occupations Code - Section 102.006

In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation and patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor(s) and/or clinic (facility) has disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and / or facility: (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he / she will receive, directly or indirectly, remuneration for referring upon my such request and exercising my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA and the Section 102.006 of Texas Occupations Code.

Facility with affiliation and remuneration: ADG Houston Path PLLC

Colleyville Dermatology
Notice of Privacy Practices

As required by the Privacy Regulations created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. **OUR COMMITMENT TO YOUR PRIVACY** – Our practice is dedicated to maintaining the privacy of your Individually Identifiable Health Information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information: 1. Ways we may use and disclose your IIHI. 2. Your privacy rights in your IIHI. 3. Our obligations concerning the use of disclosures of your IIHI.
The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and in the future. Our practice will post a copy of our current Notice in our offices in visible location at all times. And you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT: The Office Manager

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUAL IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS – The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment**. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription. Many of the people who work for our practice, including, but not limited to the doctors and medical assistants, may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to Others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other healthcare providers for purposes related to your treatment.
2. **Payment**. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example we may contact your health insurer to certify that you are eligible for benefits (and for what range of Benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for your treatment. We also may use and disclose your IIHI – to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other healthcare providers and entities to assist in their billing and collection efforts.
3. **Health Care Operations**. Our practice may use and disclose your IIHI to operate our business. As examples of ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost management and business planning activities for our practice. We may disclose your IIHI to other healthcare operations.
4. **Appointment Reminders**. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.
5. **Treatment Options**. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health Related Benefits and Services**. Our practice may use and disclosed your IIHI to inform you of health related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friend**. Our practice may release your IIHI to a friend or family member that is involved in your care, or assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the Doctor's office for treatment. In this example, the babysitter may have access to this child's medical information, with your signed release.
8. **Disclosures Required By Law**. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES – The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:**

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
- Notifying appropriate government agencies and authorities regarding the potential abuse or neglect of an adult patient (including domestic violence); however we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.

2. **Health Oversight Activities** – Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government programs, compliance with civil rights laws and the healthcare system in general.
3. **Lawsuits and Similar Proceedings**. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceedings. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of e request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asking to do so by a law enforcement official:
- Concerning a death we believe has resulted from criminal conduct - To identify/locate a suspect, material witness, fugitive or missing people - In response to a warrant, summons, court order, subpoena or similar legal process - Regarding criminal conduct at our office
- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator).

5. D**eceased Patients**. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify a cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. **Organ and Tissue Donation**. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation, if you are an organ donor.

7. Research. Our practice may use and disclose you IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when Internal or Review Board or Privacy Board has determined that they waiver of your authorization satisfies the following: (i) the use or disclosure involves to more than a minimum risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurance that the PHI will not be used or disclosed to any other person or entity (except as required by law). For authorized oversight of the research study or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver, and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent serious threat to your health or safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of the U.S., or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. **Inmates**. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary; (a) for the institution to provide healthcare services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Worker's Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. **YOUR RIGHTS REGARDING YOUR IIHI** – You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Office Manager specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or healthcare operations. Additionally you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for you are, such as family members and friends. We are required to agree to your request however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to the Office Manager. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure or both; (c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Office Manager in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed healthcare professional chosen by us will conduct reviews.

4. Amendment. You may ask to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Office Manager. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request in writing. Also, we may deny your request if you ask us to amend information that is in our opinion; (a) accurate and complete, (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patient's have the right to request an "accounting of disclosures". This is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purpose. Us of your IIHI as part of a routine patient care in our practice is not required to be documented. For example, the doctor may share information with the medical staff; or the billing department using your information to file your insurance claims. In order to obtain an accounting of disclosures, you must submit your request in writing to the Office Manager. All requests for an "accounting of disclosures" must state a time period, which may not be longer than (6) years. From the date of disclosure and may not include dates prior to April 14, 2003. The first list you request within a 12 month period is free of charge, but our practice may charge you for additional lists within the same 12 month period. Our practice will notify you of the costs involved in addition requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of The Notice. You are entitled to receive a paper copy of our Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain paper copy of this notice, contact the Office Manager.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Manager. All complains must be submitted in writing. You will not be penalized for filing a complaint.

D. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note that we are required to retain records of your care.