SKIN CANCER CONSULTANTS

elevate
MEDICAL SPA AND COSMETIC SURGERY

DALLAS SURGI CENTER

Name: _____ Age: _____ Weight: _____ Height: _____

Past Medical History

Do you have any of the following medical conditions?

□ Anxiety
□ Arthritis
□ Asthma
□ Atrial Fibrillation (Irregular Heartbeat)
□ Benign prostatic hyperplasia
□ Bone Marrow Transplantation
□ Breast Cancer
□ Colon Cancer
□ COPD
□ Coronary Artery Disease
□ Depression
□ Hearing Loss □ Hepatitis
□ Hypertension
□ HIV / AIDS
□ Hypercholesterolemia
□ Hyperthyroidism
□ Hypothyroidism
□ Leukemia
□ Lung Cancer
□ Lymphoma
□ Prostate Cancer
□ Radiation Treatment
□ Seizures
□ Stroke
□ None

Past Surgeries

Have you had any surgeries?

□ Appendix (Appendectomy)
□ Bladder (Cystectomy)
□ Breast: Mastectomy (Right Breast)
□ Breast: Mastectomy (Left Breast)
□ Breast: Mastectomy (Both Breasts) □
□ Breast: Lumpectomy (Right Breast)
□ Breast: Lumpectomy (Left Breast)
□ Breast: Lumpectomy (Both Breasts)
□ Breast: Breast Biopsy
□ Breast: Breast Reduction
□ Breast: Breast Implants
□ Colon (Colectomy): Colon Cancer Resection
□ Colon (Colectomy): Diverticulitis
□ Colon (Colectomy): Inflammatory Bowel Disease
□ Gallbladder (Cholecystectomy)
□ Heart: Stent
□ Heart: Mechanical Valve Replacement
□ Heart: Biological Valve Replacement
□ Heart: Heart Transplant
□ Joint Replacement: Knee (Both)
□ Joint Replacement: Hip (Right)
□ Joint Replacement: Hip (Left)
□ Joint Replacement: Knee (Left)
□ Joint Replacement: Hip (Both)
□ Joint Replacement: Knee (Right)
□ Kidney: Kidney Biopsy
□ Kidney: Kidney Transplant
□ Kidney: Nephrectomy
□ Ovaries (Oophorectomy): Endometriosis
□ Ovaries (Oophorectomy): Ovarian Cyst
□ Ovaries (Oophorectomy): Ovarian Cancer
□ Prostate (Prostatectomy): Prostate Cancer
□ Prostate (Prostatectomy): Prostate Biopsy
□ Prostate (Prostatectomy): TURP
□ Skin: Skin Biopsy
□ Skin: Basal Cell Carcinoma
□ Skin: Squamous Cell Carcinoma
□ Skin: Melanoma
□ Spleen (Splenectomy)
□ Testicles (Orchiectomy)
□ Uterus (Hysterectomy): Fibroids
□ Uterus (Hysterectomy): Uterine Cancer
□ Other _____
□ None
□ **Cosmetic Surgery:** _____
□ **Cosmetic Procedures:**
  □ Botox
  □ Fillers: _____
  □ Lasers: _____
  □ Facials/Peels: _____
□ Other: _____

8230 Walnut Hill Lane, Suite 808, Dallas, TX 75231 | Phone: (214) 696-8828
Send paperwork to: Email: skincancerconsultants@gmail.com | Fax: (214) 696- 1444

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Skin Disease History

Have you ever had any of the following skin conditions?

□ Acne
□ Actinic Keratosis
□ Basal Cell Skin Cancer (Year(s): _____)
□ Blistering Sunburns
□ Dry Skin
□ Other: _____
□ Eczema
□ Melanoma (Year(s) :_____)
□ Precancerous Moles
□ Psoriasis
□ Squamous Cell Skin Cancer (Year(s): _____)
□ None

Do you wear sunscreen? □ Yes □ No

If yes, what SPF? _____

Do you tan in a tanning salon? □ Yes □ No

Do you have a Family history of Melanoma?

□ Yes □ No

If yes, which relative?

□ Mother
□ Father
□ Sister
□ Brother
□ Daughter
□ Son
□ Uncle
□ Other: _____
□ Aunt
□ Nephew
□ Niece
□ Grandmother
□ Grandfather
□ Grandson
□ Granddaughter

Pharmacy name: _____

Pharmacy address: _____

Pharmacy phone number: _____

Free Prescription Delivery Service

As a free service, Doughtery's Pharmacy will fulfill and deliver your prescriptions to our office when you are having a procedure performed. If you agree, then expect to get a phone call from Dougherty's Pharmacy to confirm your insurance information. Applicable copays and deductibles apply.

☐ Yes, I am would like this service

☐ No, I do not want this service

List all medications you are currently taking (including over-the-counter). **If none, please write none. Please print:** _____

_____

_____

_____

Please list any drug allergies and your reaction. **If none, please write none. Please print:**_____

_____

_____

_____

Other Allergies (Iodine?/ Latex?)_____

Smoking Status (check one)

□ Current every day smoker
□ Current some day smoker
□ Former smoker
□ Never smoker

Alcohol Status (check one)

□ Less than 1 drink per day
□ 1-2 Drinks per day
□ 3 or More drinks per day
□ None

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Reason for visit: Please place a checkmark by the choices below that apply:

□ Skin Cancer/ Mohs Surgery_____
□ Skin Check/ Mole Check_____
□ Cosmetic Surgery_____
□ Cosmetic Non-Surgical (skin care, laser, botox, fillers) _____
□ Cyst/ Lipoma/ Wart_____
□ Other (Please specify) _____

Unfortunately, skin cancer sometimes occurs in areas where the sun does not shine. We would like to give you the most thorough exam possible. If there are any areas **you do not** want examined please indicate below:

□ Back, Chest, Abdomen
□ Breast
□ Genitalia
□ Legs

Additional comments or questions:

_____
_____
_____

Are you experiencing any of the following today?:

□ Chest pain
□ Difficulty breathing
□ Abdominal pain
□ Bloody stool
□ Bloody urine
□ Immunosuppression
□ Autoimmune suppression
□ Problems with scarring (hypertrophic or keloid)
□ Changing mole
□ Cold sores
□ Dentures
□ Dentures
□ Fevers or chills
□ Unintentional weight loss
□ Headaches
□ Seizures
□ Blurry vision
□ Glasses or contact lenses
□ Anxiety
□ Depression
□ Require walker or wheelchair
□ None

Please check if any of the following apply to you:

□ Pacemaker
□ Defibrillator
□ Artificial joints within past two years
□ Artificial heart valve
□ Premedication prior to procedures
□ Allergy to adhesive
□ Allergy to topical antibiotic ointments
□ Allergy to lidocaine
□ Rapid heartbeat with epinephrine
□ GI upset with antibiotics
□ Blood thinners
□ Problems with bleeding
□ Pregnant or planning a pregnancy
□ West Africa: Travel or contact in last 21 days
□ Fever > 100.4 degrees (F)
□ Traveled to country with wide spread Ebola in 21 days
□ Contact with Ebola patient in last 21 days
□ Flu-like symptoms in last 21 days
□ None

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CONDITIONS OF ADMISSION

For your convenience we have consolidated our new patient paperwork into this single document to cover the three distinct entities which comprise our "practice": The practice (D.B.A. Skin Cancer Consultants), Elevate Medical Spa and Cosmetic Surgery, and the Dallas Surgi Center, Inc..

Patient Financial Responsibility

Although patients are ultimately responsible for all charges, as a courtesy, assignment is accepted for most insurance carriers. Applicable estimated copays and deductibles are to be paid at the time of service, as well as uncovered or cosmetic procedures. Some operations/procedures may incur charges for BOTH professional services rendered by Thornwell H. Parker, III, M.D., P.A. (DBA Skin Cancer Consultants), as well as facility fees from the Dallas Surgi Center, Inc.

Assignment of insurance Benefits and Financial Agreement:

The below signed irrevocably assigns and transfers to the center the Contract Rights, and orders and directs such insurer(s) specified on the registration to pay all monies due or to become due hereunder directly to the practice. The practice has irrevocably constituted power, to collect and settle any claim under the Contract Rights as insured without further notice or approval of insured and to endorse in the name of insured any check or other instrument for payment of monies hereunder. If the insured receives monies direct from the insurer, same shall be held in trust for and immediately transferred to The practice for amount due. This assignment is irrevocable until full and complete payment of all monies due The practice from this event of admission or otherwise. Money received by The practice from insurer(s) or other third party sources, less the expense in procuring same, shall be deducted from the principal amount due for services rendered Patient. It is the policy of The practice to comply with all Federal, State, and Department of Insurance regulations related to collection of co-pays and deductibles. You may be responsible for higher co-pays and deductibles. The practice may or may not be in-network for your insurance. If your insurance company does not pay the amount within 90 days, you will be responsible for the payment in full. We do not determine payment of a claim, the insurance company does. Please contact your insurance company for any questions regarding your claims. Any deviation from this standard procedure must have arrangements made in advance.

Medicare Assignment:

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Professional Services Agreement:

To the extent that fees for professional services rendered to the patient are payable, the undersigned hereby assigns to said physicians and authorizes payment directly to said physicians all insurance benefits, including major medical, for professional services rendered to the patient.

Patient Rights/Responsibilities:

I acknowledge that I have been given a copy of the Patient rights and Responsibilities at the time of admission.

Personal Valuables:

The practice will make its best effort to protect Patient valuables but will not be responsible for any loss.

Physician Disclosure of Ownership:

Pursuant to Texas Law please note that Dr. Thornwell H. Parker III, M.D. has financial agreements with Dallas Surgi Center, Inc. If you are referred to this entity, Dr. Thornwell H. Parker III, M.D. will receive direct remuneration. If you have any questions regarding this paragraph, please discuss it with Dr. Thornwell H. Parker III, M.D. directly.

Authorization for Release of Information:

The practice is authorized to furnish from the patient's record requested information or excerpts to the referring physician, primary care physician and to any insurance company or third party payer for the purpose of obtaining payment of the account of The practice or any physician for services provided to the patient. The practice is authorized to release information from my medical record to any health care facility to which I may be transferred.

Verification of Third Party Benefits:

The below signed authorizes the verification of third party benefits, any item referenced herein, statements and other data obtained from Patient and/or below signed and all other persons pertaining to the respective credit and financial responsibilities, understanding that an investigative consumer report may be made whereby information is obtained through personal interviews with third parties. The practice or its contractor is authorized to investigate all information given by the below signed verbally and other such areas as reasonable connected with The practice efforts in collection, now or in the future. Below signed hereby releases from liability, indemnifies from loss and specifically authorizes any requesting entity to make such disclosure to The practice or its agents as they deem necessary in considering and verifying any application for credit. Below signed acknowledges that a complete and accurate disclosure of the nature and scope of the investigation will be given upon written request and herby declares that all information furnished hereon and subsequently is and shall be true.

Newsletter and Specials

Would you like to receive periodic emails from Elevate or Skin Cancer Consultants?

Elevate Medical Spa & Cosmetic Surgery

- ☐ Yes, I give permission to email me specials/info
- ☐ No, I do not give permission to email me specials/info

Skin Cancer Consultants

- ☐ Yes, I give permission to email me specials/info
- ☐ No, I do not give permission to email me specials/info

Email: _____

Note: appointment reminders may be emailed as a normal course of business.

_____ _____

Patient's Signature **Date** **Witness** **Date**

_____

OR Guardian Signature **Relationship** **Date**

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Notice of Privacy Practices Acknowledgement

I understand that, under the **Health Insurance Portability & Accountability Act of 1996** (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare Providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have been provided the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Initial: ___ I acknowledge that my medical information/records may be released from the practice to my primary care provider, referring/consulting providers, and to my insurance company to process insurance claims

Initial: ___ I **do** authorize use of my photographs for academic medical teaching, education, & research

Circle One: I [**Do**] [**Do Not**] authorize use of my photographs for patient education (album used in office)

Circle One: I [**Do**] [**Do Not**] authorize use of my photographs for advertising (website or brochure) I also allow

release of my medical information to the following individuals: (i.e. family, caregivers, etc.)

Name: **Relationship:**

_____ _____

_____ _____

_____ _____

Patient's Signature **Date** **Witness** **Date**

_____

OR Guardian Signature **Relationship** **Date**

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