

NEW PATIENT PACKET

Methodist Campus for Continuing Care

Medical Plaza II

399 W. Campbell Rd. Suite 410

Richardson, TX 75080

Ph: (972) 469-3376

Appointment Date:

Appointment Time:

Please arrive 20 minutes prior to your appointment to complete the registration process.

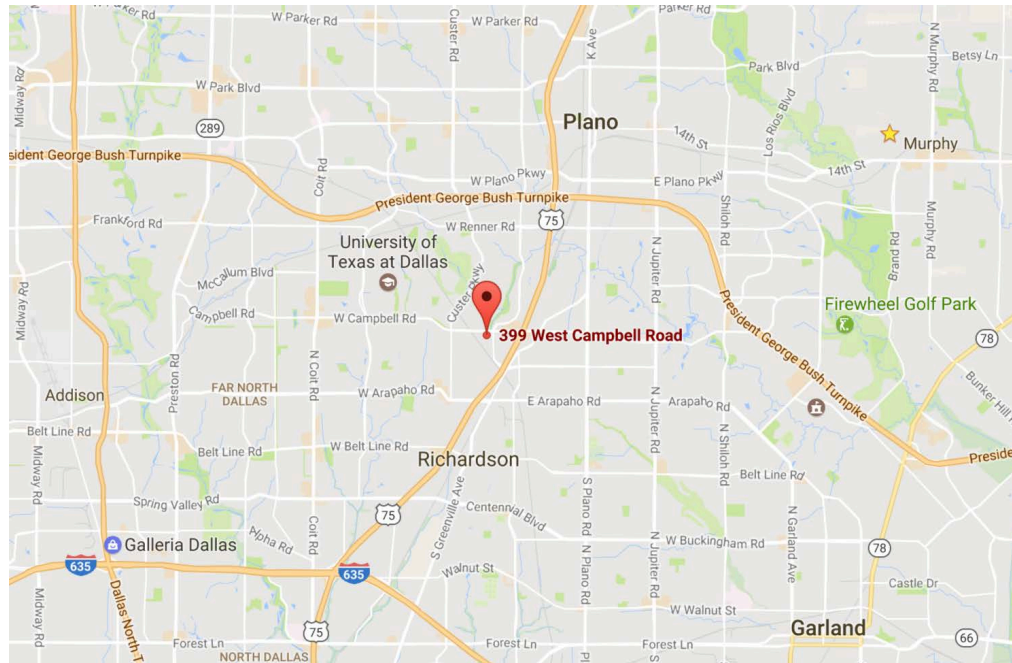
Please bring the following items to your first appointment

- ☐ Completed New Patient
- ☐ Packet
- ☐ Photo identification card
- ☐ Insurance cards
- ☐ All medication bottles
- ☐ (Prescribed and/or over the counter/herbal supplements)
- ☐ Medical records & diagnostic
- ☐ studies

CANCELLATION POLICY & FEE

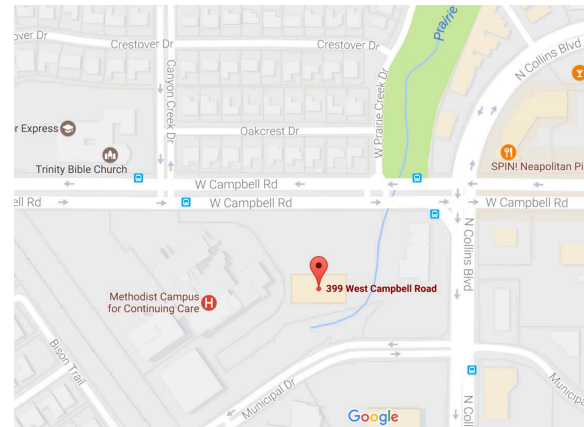
If for any reason you cannot make your appointment, please call (972) 469-3376 at least **1 FULL**

BUSINESS DAY in advance to cancel or reschedule.



DIRECTIONS **Coming from Hwy 75:**

- **WEST** on W. Campbell Rd
- **LEFT** on Canyon Creek Dr into Methodist Campus for Continuing Care
- **Immediate LEFT** towards Medical Plaza II



HAVE QUESTIONS?

Feel free to contact our scheduling department at (972) 469-3376 with any questions relating to the information contained within this packet.



PATIENT INFORMATION

PATIENT DEMOGRAPHICS

Last Name: _____ First Name: _____ MI: _____

Preferred Called Name: _____ Age: _____

Date of Birth: _____ Social Security: _____

CONTACT

Home: _____ Work: _____ Cell: _____

May we leave a detailed message? ☐ Yes ☐ No IF YES, please circle preferred number.

Email: _____

May we email you for appointment reminders, confidential results, promos, etc? ☐ Yes ☐ No

Address: _____

City: _____ State: _____ Zip: _____

EMERGENCY CONTACT

Last Name: _____ First Name: _____

Phone Number: _____ Relationship to Patient: _____

May we discuss your health information with this person? ☐ Yes ☐ No

FINANCIALLY RESPONSIBLE PARTY (Complete if NOT SELF/Patient is a MINOR/NOT the main policy holder.)

Last Name: _____ First Name: _____

Relationship to Patient: _____ Date of Birth: _____ Social Security: _____

Address: _____ Phone: _____

PRIMARY INSURANCE

Insurance Name: _____

Name/DOB of Insured: _____

Member ID# _____

Group # _____

Insured Employer: _____

SECONDARY INSURANCE (if applicable)

Insurance Name: _____

Name/DOB of Insured: _____

Member ID# _____

Group # _____

Insured Occupation: _____

PRIMARY PHYSICIAN

Physician Name: _____ Physician Phone: _____

Physician Address: _____

May we send a referral note to your primary physician? ☐ Yes ☐ No

PREFERRED PHARMACY

Pharmacy Name: _____ Address: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

May we import your prescription history from Surescripts health information network? ☐ Yes ☐ No

REFERRAL How did you hear about us? _____

MEDICAL HISTORY

PAST MEDICAL HISTORY (please check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Hepatitis, Type: _____ | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood clot | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer(type): _____ | <input type="checkbox"/> Lupus | <input type="checkbox"/> Organ Transplant _____ |
| <input type="checkbox"/> Crohn's | <input type="checkbox"/> Liver disease | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> Ulcerative colitis | <input type="checkbox"/> Migraines | |

Other Health Conditions: _____

Current Weight: _____ Current Height: _____ Most Recent Blood Pressure: _____

PAST SURGERIES: _____

CAUTIONS

- | | | |
|--|---|--|
| <input type="checkbox"/> On Blood Thinners / Bleeding | <input type="checkbox"/> Artificial Joint in last 2 years | <input type="checkbox"/> (Females) Pregnant |
| <input type="checkbox"/> Antibiotic for Dental Procedures | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> (Females) Trying to Get Pregnant |
| <input type="checkbox"/> Fainting with Procedures | <input type="checkbox"/> Rapid heartbeat with epinephrine | <input type="checkbox"/> (Females) Breastfeeding / Nursing |
| <input type="checkbox"/> Reaction to Lidocaine /Local Anesthetic | <input type="checkbox"/> Stomach Ulcer History | <input type="checkbox"/> Keloid Scarring |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Cold Sores / Oral Herpes |
| | <input type="checkbox"/> Defibrillator | <input type="checkbox"/> MRSA |

ALLERGIES: Medication Allergies (please list): _____

Latex Allergy: ☐ Yes ☐ No Adhesive Allergy: ☐ Yes ☐ No Topical Antibiotic Allergy: ☐ Yes ☐ No

MEDICATIONS: Prescription medications (please list): _____

Over-the-counter medications, herbals, vitamins (please list): _____

SOCIAL HISTORY (please check all that apply)

- ☐ Currently Smokes
 ☐ Alcohol Daily/Weekly/Monthly/Occasion
 ☐ Drug Use: _____

Patient/Guardian Signature: _____ **Date:** _____

Patient/Guardian Name (Print): _____

I certify I have completed this form in its entirety, and the above is true and correct.

Reason for today's visit: _____

SKIN DISEASE HISTORY: (Please check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Flaky/Itchy Scalp | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Actinic Keratosis | <input type="checkbox"/> Hayfever/Allergies | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Melanoma (Date/Stage)_____ | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Precancerous Moles | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis | |

GENERAL SKIN QUESTIONS:

Wear Daily Sunscreen? ☐ Yes ☐ No SPF: _____

History of blistering sunburns? ☐ Yes ☐ No

History of Tanning Salon Use: ☐ Yes ☐ No []CURRENT How often:_____

Has a First Degree Relative Had Melanoma? ☐ Yes ☐ No If yes, which relative(s): _____

REVIEW OF SYSTEMS: (Are you currently experiencing any of the following? Please circle all that apply)

- | | |
|---|---------------------------|
| New hair growth on face, chest, abdomen | Unintentional weight loss |
| New moles | Thyroid problems |
| Changing moles | Blurry vision |
| Problems with bleeding/bruising | Sore throat |
| Problems with healing | Abdominal pain |
| Problems with scarring | Bloody stool |
| Rash | Blood urine |
| Sensitivity to light | Muscle weakness |
| Itching/burning of the skin | Joint Pain |
| Currently having menstrual periods | Neck stiffness |
| Irregular menstrual cycle | Headaches |
| Hay fever | Seizures |
| Immunosuppression | Cough |
| Chest pain | Shortness of breath |
| Palpitations/irregular heartbeat | Wheezing |
| Fever of chills | Anxiety |
| Night sweats | Depression |

ANY CHANGES IN MEDICAL CONDITIONS, MEDICATIONS, OR ALLERGIES SINCE LAST VISIT? ☐ Yes ☐ No

Please List _____

Patient /Guardian Signature _____ **Date** _____



HIPAA Acknowledgement and Consent Form

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

- ❖ **For treatment:** This includes the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.
- ❖ **For payment:** This includes any activities we must undertake in order to get reimbursed for the services provided to our patients, including such things as organizing PHI and submitting bills to insurance companies (either directly or through a third party), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review and collection of outstanding accounts.
- ❖ **For health care operations:** This includes quality assurance activities, licensing and training programs to ensure that our personnel meet our standards policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes, fundraising and certain marketing activities.

I have been informed of and offered a copy of the *Notice of Privacy Practices* for *K Dermatology & Wellness Institute* containing a more complete description of the uses and disclosures of my health information. I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge a clear understanding of the Privacy Practices. I understand that *K Dermatology & Wellness Institute* has the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to protected health information (PHI) that has been maintained by *K Dermatology & Wellness Institute*. Any material changes to the Notice will be promptly posted in the office or on the *K Dermatology & Wellness Institute* website. I will be given a copy of the latest version of this Notice at my next visit or I can contact *K Dermatology & Wellness Institute* at the address above.

I understand that I may request in writing that *K Dermatology & Wellness Institute* restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. However, if the information is needed to provide emergency treatment, then *K Dermatology & Wellness Institute* may use or disclose my PHI to a healthcare provider to provide me with emergency treatment. I understand that I may restrict the right to disclose my PHI to a health plan for payment if I pay in full for the services and items provided at the time of the visit.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has already taken action relying on this consent.

*Do you give us permission to discuss your medical records with anyone? (Specify name, Date of Birth, & relationship):

- 1.
- 2.
- 3.

Print Name

DOB (mm/dd/yyyy)

Signature (Patient or Legal Representative for Patient)

Date

Legal Representative's Relationship to Patient



CONSENT FOR EVALUATION, EXAMINATION, AND TREATMENT

By signing below, I authorize the evaluation, examination, and treatment by Dr. Koriakos and her staff. I consent to treatment necessary for my dermatologic care. Skin growths may be treated by freezing, injections, snip removal, extractions, application of a topical or intralesional medication, and/or electrocautery with a heated needle. A skin biopsy (taking a small sample of skin under local anesthesia) may be used for diagnosis. I understand I can refuse any procedure.

I understand that there are risks to any procedure, including, but are not limited to:

- Allergic reaction
- Bleeding
- Pain
- Infection
- Skin discoloration (lighter or darker) or scarring
- Nerve Injury (rare)
- Lesion recurrence
- Wound dehiscence

I consent to having these procedures done as part of my evaluation and treatment.

By my signature below, I also understand the following:

- Total body examinations for skin cancer screening are performed if specifically scheduled in advance or if time permits as this requires additional time.
- I understand that most clinic visits are scheduled for consultation of a specific skin condition. Procedures, even minor removals, may need to be scheduled at a separate time. *K Dermatology & Wellness Institute* will try to accommodate procedures if time permits.
- I am aware that there are potential risks to any treatment or medication (oral or topical) prescribed. Dermatological conditions are often chronic in nature and may require ongoing care and the need for me to schedule follow up appointments.
- I understand that all tissue removed is sent to a pathology lab for analysis. Removals will not be performed without tissue analysis. The pathology lab will charge a fee for tissue analysis separate and independent of the procedure charge. In your insurance company does not cover this charge, it is the responsibility of the patient or guardian to cover this expense.
- **I understand that ANY PROCEDURE including but not limited to freezing/cryosurgery, application of topical or intralesional medication, biopsy, surgical excision, drainage of abscess, wart removal, etc. will be a procedural charge applied to my deductible. I may request cost prior to procedure.**

_____ (Initials) Consent for Treatment: I authorize *K Dermatology & Wellness Institute* to provide any healthcare services that my provider deems necessary for treatment and/or diagnosis including biopsies. I also understand that, in the course of that treatment, photographs may be taken for clinical purposes. If photographs will be used for commercial or educational purposes, I will be provided an additional authorization. No videotaping or photography is allowed by non-staff members.

_____ (Initials) Consent for Filing Insurance Claims: I understand that, in order to file claims and release medical information to any insurance company(s) I have listed in my financial record, *K Dermatology & Wellness Institute* is required to keep my signature on file. I hereby authorize *K Dermatology & Wellness Institute* to receive benefits directly from my insurance company when an assigned claim is filed. I also authorize *K Dermatology & Wellness Institute* to appeal any denial to my insurance company on my behalf and authorize the release of any medical information to my insurance company(s) that is necessary for the processing of claims.

_____ (Initials) Consent for Appointment Reminders: I understand that *K Dermatology & Wellness Institute* will send appointment reminders and information on services via telephone, email and/or text message based on the contact information I have provided. I further understand that I will have the option to opt out of future text/email reminders.

_____ (Initials) I hereby state that the above information is true and correct to the best of my knowledge.

_____ (Initials) I have been offered a copy of the Notice of Privacy Policies for *K Dermatology & Wellness Institute*

This authorization and consent shall remain in force for this and all future visits to K Dermatology & Wellness Institute.

Patient/Guardian Signature: _____ Patient/Guardian Name (print): _____
Date: _____

Financial Policy

Payment is required for all services at the time they are rendered unless you have an insurance plan with which we participate. Applicable co-payments, co-insurances, and deductibles will be collected at the time of your visit. Private insurance billing will be performed as a courtesy to our patients. Additional tests run either in the office or at an outside facility, i.e. pathology, laboratory, radiologic or other diagnostic tests may be billed separately in addition to the office visit. Payment is required at time of service for all cosmetic procedures. For your convenience, we accept cash, checks, Visa, MasterCard, American Express, and Discover. At your request, a copy of this document can be made available to you.

Regardless of insurance coverage, verification of benefits, or contracts with insurance, THE PATIENT IS ULTIMATELY RESPONSIBLE FOR PAYING for the services rendered. This contract is between you, the patient, and K Dermatology & Wellness Institute. Claims that are denied for lack of authorization/coverage/eligibility, or lack of medical necessity as determined by your insurance or out-of-network benefits will be the responsibility of the patient. It is the patient's responsibility of notifying the office of changes in insurance eligibility or coverage.

Any outstanding balance not paid by insurance is expected to be paid in full within 30 days. All unpaid balances over 90 days will be turned over to a collection agency.

Cancellation Policy: If you need to cancel or reschedule your appointment we need to know at least one (1) full business day before your regular appointment or two (2) full business days before your surgical or cosmetic appointment. For example, if you have to cancel a regular appointment on Monday at 9 am, we need to know by the previous Friday before 9 am. This allows us to offer the appointment to another patient. **A \$50 charge will be assessed for no-shows or cancellations with less than 1 full business day notice for regular clinic appointments, and \$100 charge for any surgical or cosmetic appointments with less than 2 full business days notice.** Our ability to meet the needs of patients is quickly compromised by individuals who regularly fail to keep their appointments or reschedule with high frequency. Patients no-showing or canceling three (3) times without notice will be considered for dismissal from the practice.

Returned Checks: The charge for a returned check is \$25. This will be applied to your account in addition to the insufficient funds amount.

Your signature below:

- ³⁵₁₇ Signifies your understanding and agreement to above policy, and your responsibility to pay for all applicable fees on the day of service and any balances not covered by insurance.
- ³⁵₁₇ Authorizes the release any information, including the records of all visits provided at K Dermatology & Wellness Institute, for the purpose of processing your claims to insurance.
- ³⁵₁₇ Authorizes your insurance company to assign benefits directly to Dr. Angie Koriakos or her associates, the amount due in your pending claim.

Your signature also authorizes the payment of insurance benefits to be made on your behalf to K Dermatology & Wellness Institute or Dr. Angie Koriakos for services furnished to you by Dr. Koriakos and her staff. Your signature authorizes medical information about you needed to determine these benefits to be released to insurance, CMS and/or its agents. Co-insurance and deductibles are based on the determination of your insurance.

Patient/Guardian Signature _____

Patient/Guardian Name (printed) _____ Date: _____



Cosmetic & Wellness Questionnaire (Optional)

Our goal is to make every patient look and feel as radiant as possible. *K Dermatology & Wellness Institute* is committed to a no-pressure atmosphere where we partner with you to achieve overall health and wellness.

Tell us if you are interested . . .

- | | |
|---|--|
| <input type="checkbox"/> Acne Scars | <input type="checkbox"/> Hyperpigmentation or Melasma |
| <input type="checkbox"/> Age Spots/Liver Spots/Pigmentation | <input type="checkbox"/> Kybella Treatment for Double Chin |
| <input type="checkbox"/> Botox or Other Wrinkle Relaxer | <input type="checkbox"/> Medical Weight Loss |
| <input type="checkbox"/> Chemical Peels | <input type="checkbox"/> Skin Care Advice |
| <input type="checkbox"/> Cosmetic Fillers (Juvederm) | <input type="checkbox"/> Spider Vein Treatment |
| <input type="checkbox"/> Hair Loss Treatments | |

Share with us any specific concerns or areas for improvement . . .

Let us know your current skincare products:

AM Regimen

Cleanser: _____

Serum: _____

Moisturizer: _____

SPF: _____

Topical Rx: _____

PM Regimen

Cleanser: _____

Serum: _____

Moisturizer: _____

Eye Cream: _____

Topical Rx: _____