K DERMATOLOGY
& WELLNESS INSTITUTE
of Richardson

NEW PATIENT PACKET

Appointment Date:
Appointment Time:

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

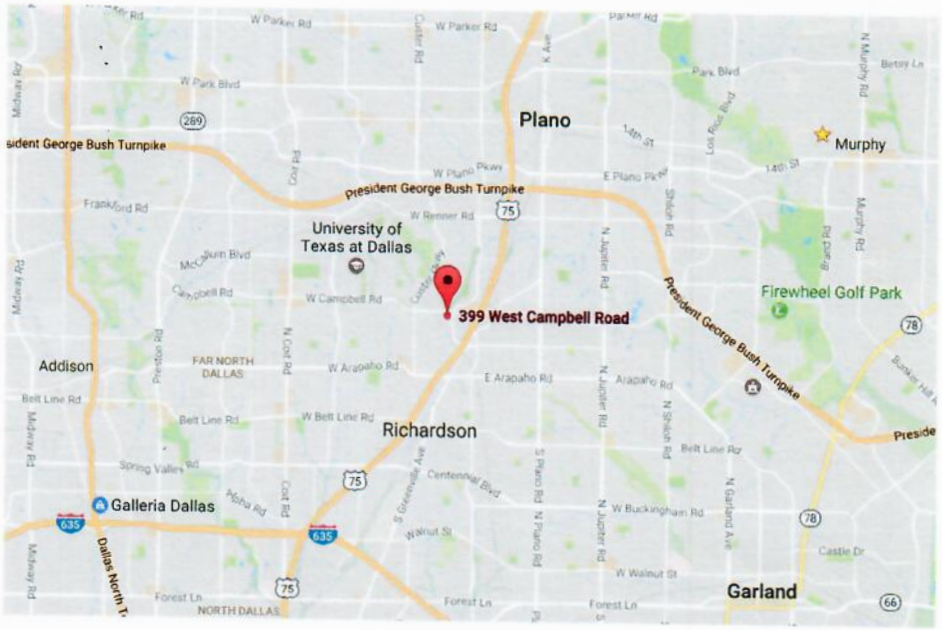
Please bring the following items to your first appointment

- ❑ 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

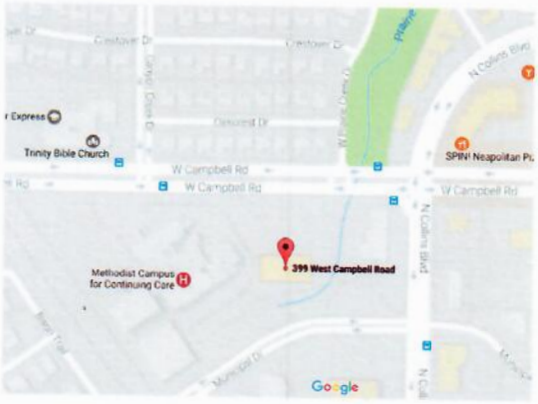
If for any reason you cannot make your appointment, please call (972) 469-3376 at least **1 FULL BUSINESS DAY** in advance to cancel or reschedule.

Methodist Campus for Continuing Care
Medical Plaza II
399 W. Campbell Rd. Suite 410
Richardson, TX 75080
Ph: (972) 469-3376



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.

399 W. Campbell Rd. Suite 410, Richardson, TX 75080
(972) 469-3376 (Telephone) / (972) 469-3288 (Fax)
www.kdermatology.com

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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? _____

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MEDICAL HISTORY

PAST MEDICAL HISTORY (please check all that apply)

☐Anxiety/Depression
☐Arthritis
☐Asthma
☐Blood clot
☐Cancer(type): _____
☐Crohn's
☐Ulcerative colitis
☐ Hepatitis, Type: _____
☐ Diabetes
☐ Hypertension (high blood pressure)
☐ Kidney Disease
☐ Lupus
☐ Liver disease
☐ Migraines
☐Radiation Treatment
☐Seizures
☐Stroke
☐Thyroid Disease
☐Organ Transplant _____
☐OTHER_____

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

PAST SURGERIES: _____

CAUTIONS

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

ALLERGIES: Medication Allergies (please list): _____

Latex Allergy: ☐Yes ☐No *Adhesive Allergy:* ☐Y es ☐No *Topical Antibiotic Allergy:* ☐Y es ☐No

MEDICATIONS: Prescription medications (please list):_____

_____

_____

Over the counter medications and supplements: _____

SMOKING STATUS □ Never smoker □Current Smoker □Former Smoker

PATIENTS 65 AND OVER:

Do you have a healthcare proxy or surrogate decision maker? ☐Y es ☐No
If yes, name: _____ Phone number: _____

What is your advanced care plan (check one):

□ Full code: wishes to have full cardiopulmonary resuscitation efforts to be made
□ Do not intubate: does NOT wish to have a breathing tube even if required for life saving measures
□ Do not resuscitate: in the event the heart were to stop, does NOT wish to have chest compressions or automated external defibrillator to restart the heart, even if for lifesaving measures

Da you have a living will? ☐Y es ☐No

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.

(CLINIC USE: REVIEWED_____

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SKIN DISEASE HISTORY

Reason for today's visit: _____

SKIN DISEASE HISTORY: (Please check all that apply)

- ☐Acne
- ☐Actinic Keratosis
- ☐Basal Cell Skin Cancer
- ☐Blistering Sunburns
- ☐Eczema
- ☐Flaky/Itchy Scalp
- ☐Hayfever/Allergies
- ☐Melanoma (Date/Stage)_____
- ☐Precancerous Moles
- ☐Psoriasis
- ☐ Rosacea
- ☐ Squamous Cell Skin Cancer
- ☐ NONE
- ☐ Other: _____

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

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

Please List _____

Patient /Guardian Signature _____ **Date** _____

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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: _____

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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 record with anyone? (Specify name, Date of Birth, & relationship):

1.

2.

3.

May we leave detailed information regarding your health information on your answering machine, voicemail, and/or e-mail?
Yes No (Specify instructions):

Signature:_____ Date:_____

Relationship to the patient (If other than patient): _____

Methodist Medical Plaza II
399 W. Campbell Rd. Suite 410
Richardson, TX 75080

www.kdermatology.com

P: (972) 469- DERM
(972) 469-3376
F: (972) 469-3288

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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 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:

- 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.
- 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.
- 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:_____