Derm*Laser* Institute of Dallas

Ellen Turner, M.D.
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Last Name	First Name	MI	Maiden
Address	City	State	Zip
Phone ( )	Work# ( )	Cell# ( )	
SS #	Sex: M F	Birthdate / /	
Marital Status:	Sing. / Mar. / Div. / Widowed		
Referred By/How did you hear about us?		Driver's License #	
Email address:			
Emergency Contact:	Relation:	Phone ( )	

Employer Information (Please Provide Policy Holder's employment information).

Employer	Work Phone ( )	Cell # ( )
Employer Address	Occupation	

Insurance Information

Primary Ins. Co	Insured	
Relationship of Patient to Insured	Insured's DOB	Insured's SS #
Secondary Ins. Co.	Insured	
Relationship of Patient to insured	Insured's DOB	SS#

PAYMENT POLICY: All professional services rendered are charged to the patient. The patient is responsible for payment regardless of insurance coverage. Full payment is expected at time of each office visit unless arrangements have been made in advance. Billing information will be provided to expedite patient reimbursement from private insurance carriers.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Your Pharmacy Name:____ **Phone:**___________________________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

THE UNDERSIGNED AUTHORIZES THE RELEASE OF ANY INFORMATION RELATING TO ALL CLAIMS FOR BENEFITS SUBMITTED FOR MYSELF OR DEPENDENTS AND AGREE THAT MY SIGNATURE BELOW AUTHORIZES CLAIMS SUBMITTED FOR SERVICES RENDERED. I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY AND ASSIGN DIRECTLY TO DERM*LASER* INSTITUTE OF DALLAS ALL REIMBURSEMENT BENEFITS PAYABLE UNDER MY INSURANCE POLICY.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED, AND IF THE INSURANCE DOES NOT PAY WITHIN 45 DAYS, THE BALANCE IS DUE FROM ME. IF MY INSURANCE IS AN HMO AND I DO NOT PRESENT A REFERRAL FROM MY PCP AT THE TIME OF SERVICE, I AGREE TO BE RESPONSIBLE FOR ANY CHARGES DENIED BY MY INSURANCE COMPANY DUE TO NON-PRESENTATION OF A REFERRAL FROM MY PRIMARY CARE PHYSICIAN OR PRE-AUTHORIZATION FROM MY WORKERS COMPENSATION INSURANCE COMPANY (IF I PRESENT AS A WORKERS COMPENSATION PATIENT).

I HEREBY AUTHORIZE DERM*LASER* INSTITUTE OF DALLAS TO RELEASE BY MAIL, TELEPHONE, FAX ANY MEDICAL OR INCIDENTAL INFORMATION THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR PROCESSING APPLICATIONS FOR FINANCIAL BENEFITS.

I CERTIFY THAT THE INFORMATION GIVE BY ME IS CORRECT. I UNDERSTAND THAT FEES FOR ALL SERVICE PROVIDED BY DERM*LASER* INSTITUTE OF DALLAS ARE DUE AT THE TIME SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

X____

(AUTHORIZED SIGNATURE OF PATIENT, INSURED AND.OR GUARDIAN) (DATE)

Derm*Laser* Institute of Dallas

Ellen O. Turner, MD

FINANCIAL POLICY

Payments for services are due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, and most major credit cards. The only exception is for our Medicare and participating HMO/PPO patients; we will file a claim directly with your insurance carrier.

INSURANCE: Plan provisions require HMO/PPO patients present a current insurance card at time of service otherwise, payment is due in full, and no adjustment will be made later. If we are not a participating provider with your insurance plan, a claim will not be filed and full payment is expected at the time service is rendered.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier.
   This applies only to companies that pay a percentage (such as 50% or 80%) of "U.C.R." "U.C.R." is defined as usual, customary, and reasonable.
   This statement does not apply to companies that reimburse based on an arbitrary "schedule" or fees, which bear no relationship to the current standard of cost and care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. In the event your insurance carrier does not cover your service, you will be responsible for payment of that service and will be billed accordingly.

We must emphasize that, as a medical care provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the service is rendered. We realize that temporary financial problems may affect timely payment on you account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

COSMETIC/LASER CONSULTATIONS: The fee for all cosmetic and laser surgery consultations with Dr. Turner are $100.00 (one hundred dollars) and are due at the time of service. Cosmetic consultations with a Medical Assistant or with the Aesthetician are free.

NO-SHOWS: A patient will be considered a "No-Show" if they are more than 15 minutes late for their scheduled appointment time or do not cancel their appointment at least 24 hours prior to their scheduled visit. We understand that appointments can sometimes not be kept. However, we request that if you cannot keep an appointment for any reason, kindly call us at least 24 hours in advance so that someone else may have your appointment time. Many patients need to see Dr. Turner as soon as possible, and it is not fair for a patient to be denied treatment because another patient did not call to cancel their appointment in advance.

If you miss your appointment for a laser or cosmetic procedure, arrive more than 15 minutes late, or simply choose not to attend it and have **NOT** called 24 hours prior to the time of the appointment to reschedule, you will be charged $100.00 (one hundred dollars) for the missed visit. This will be debited from your credit card on the day of the missed service.

SURGERIES: For medical surgeries that are 30 minutes in length or longer, we ask that you leave your credit card number on file with the receptionist. If you miss your surgery, arrive more than 15 minutes late, or simply choose not to attend it and have **NOT** called 24 hours prior to the time of the appointment to reschedule, you will be charged $50.00 (fifty dollars) for the missed surgery which is non-refundable.

BE HERE EARLY: No one likes to be kept waiting, and it is our goal to stay on schedule so that neither your time nor our time is wasted. If you are late for your appointment we will see if we can work you in but there are no guarantees. You may be asked to re-schedule your appointment for another day. Please understand that if you are late, it makes everyone else late for their appointment, too!

I have read the above and as the patient or his or her duly authorized representative understand and accept these terms.

SIGNATURE: ______________________________ DATE: ____________________

To Our Patients:

As any of you who have checked into a hotel lately know, you are asked for a credit card at the time you check in. This is an advantage for both you and the hotel, since it makes checkout faster and more efficient. Starting the beginning of 2010, we are going to implement a similar policy.

You will be asked for a credit card at the time you check in and information will be held securely until your insurance(s) have paid and made their determination of the amount of your co-pay, co-insurance, and deductibles. At that time any remaining balance owed by you will be charged to your credit card, and a copy of this letter along with a receipt will be mailed to you.

This will be an advantage to you, since you will no longer have to write and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. For any amount that is $50.00 or greater, we will call you prior to charging your credit card.

This in no way will compromise your ability to dispute a charge or an insurance company's determination of payment.

Any office co-pays, co-insurances, and deductibles due at the time of the visit will still be due at the time of visit.

Sincerely,

Ellen Turner, M.D.
Derm*Laser* Institute of Dallas

I am requesting that any outstanding balance on my account greater than $50.00 be charged to my credit card in the manner selected below. Amounts less than $50.00 will be paid in one payment.

- o Balance due in one payment
- o Evenly over 3 payments
- o Evenly over 6 payments

I authorize Derm*Laser* Institute of Dallas to charge outstanding balances on my account to the following credit card:

Card type__________CreditCard #__________________________________Exp______3 digit code______

Name (please print) ____

Signature_______________________________________Date____________________________

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214.373.SKIN (7546)

Acknowledgment of Review of Notice of Privacy Practices

I have received this office's Notice of Privacy Practices, Which explains how my medical information will be used and disclosed

____________________________________ ____________________________

Signature of Patient or Guardian of Patient Relationship to Patient

____

Date

Note:
Please list additional family members we may disclose biopsy results, lab results, or other confidential information to if you are unavailable.

1. __________________________________ 2. _________________________________

This authorization will remain in effect unless you specify written changes.

____________________________________ _________________________________

Signature of patient or guardian of patient Relationship to patient

____

Date

____

Name of Patient or Personal Representative

____

Description or Personal Representative's Authority

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will be released to anyone without your authorization to do so.

NAME OF DRUG	MG DOSE	NAME OF DRUG	MG DOSE

PAST MEDICAL, FAMILY & SOCIAL HISTORY

LIST ANY **PERSONAL** PAST ILLNESS AND / OR SURGERIES AND WHEN THEY OCCURRED.

ILLNESS or SURGERY	**DATE**

ALCOHOL?	❑ YES ❑ NO
❑ 1 DRINK /WK ❑ 3 DRINKS /WK ❑ >5 DRINKS /WK	
ARE YOU PREGNANT / PLANNING TO BECOME PREGNANT?	❑ YES ❑ NO
SMOKING	❑ YES ❑ NO
ARE YOU HIV POSITIVE?	❑ YES ❑ NO
SUNSCREEN USE?	❑ YES ❑ NO
UTILIZE A TANNING BED?	❑ YES ❑ NO
ARE YOU PLANNING A HOLIDAY IN THE SUN?	❑ YES ❑ NO

MARK YOUR SKIN TYPE (WHEN EXPOSED TO THE SUN FOR AT LEAST ONE HOUR WITHOUT PROTECTION):

- ❑ I ALWAYS BURN NEVER TANS
- ❑ II ALWAYS BURNS SOMETIMES TANS
- ❑ III SOMETIMES BURNS SOMETIMES TANS
- ❑ IV ALWAYS TANS
- ❑ V ASIAN HISPANIC MEDITERRANEAN MIDDLE EASTERN
- ❑ VI AFRICAN AMERICAN

PLEASE ANSWER EITHER **YES** OR **NO** FOR ALL QUESTIONS. **PLEASE CHECK** THE APPROPRIATE CIRCLE.

ACTINIC KERATOSIS ❑ YES ❑ NO	DIABETES ❑ YES ❑ NO
CANCER, SQUAMOUS CELL ❑ YES ❑ NO	ARTHRITIS ❑ YES ❑ NO
CANCER, BASAL CELL ❑ YES ❑ NO	GERD (acid reflex) ❑ YES ❑ NO
MELANOMA ❑ YES ❑ NO	MIGRAINE HEADACHE ❑ YES ❑ NO
HISTORY OF KELOID/ SCARRING ❑ YES ❑ NO	ANEMIA ❑ YES ❑ NO
HERPES/COLD SORES ❑ YES ❑ NO	SEIZURES ❑ YES ❑ NO
PSORIASIS ❑ YES ❑ NO	TUBERCULOSIS ❑ YES ❑ NO
ATRIAL FIBRILLATION ❑ YES ❑ NO	HEPATITIS C ❑ YES ❑ NO
ARTIFICIAL VALVES ❑ YES ❑ NO	THYROID DISEASE ❑ YES ❑ NO
PACEMAKER ❑ YES ❑ NO	OSTEOPOROSIS ❑ YES ❑ NO
ENVIRONMENTAL ALLERGIES ❑ YES ❑ NO	CANCER ❑ YES ❑ NO
ASTHMA ❑ YES ❑ NO	TATTOOS ❑ YES ❑ NO
HTN (high blood pressure) ❑ YES ❑ NO	

I WAS EXPOSED TO THE SUN FOR AT LEAST ONE HOUR WITHOUT SUNSCREEN:

❑ WITHIN THE LAST 3 DAYS ❑ WITHIN THE LAST 2 WEEKS ❑ WITHIN THE LAST MONTH

FAMILY HISTORY

MOTHER:	❑ MELANOMA	❑ SQUAMOUS CELL CARCINOMA	❑ BASAL CELL CARCINOMA
FATHER:	❑ MELANOMA	❑ SQUAMOUS CELL CARCINOMA	❑ BASAL CELL CARCINOMA
SIBLINGS:	❑ MELANOMA	❑ SQUAMOUS CELL CARCINOMA	❑ BASAL CELL CARCINOMA
GRANDPARENTS:	❑ MELANOMA	❑ SQUAMOUS CELL CARCINOMA	❑ BASAL CELL CARCINOMA

ETHNICITY

❑ CAUCASIAN ❑ MEDITERRANEAN ❑ AMERICAN INDIAN ❑ ASIAN

❑ HISPANIC ❑ MIDDLE EASTERN ❑ AFRICAN AMERICAN

DO YOU HAVE ALLERGIES? ❑ YES ❑ NO (IF YES, PLEASE EXPLAIN):

Review of Systems

Do you now or have had any problems related to the following systems? Check YES or NO

INTEGUMENTARY	
Suspicious Moles	❑ YES ❑ NO
Rash	❑ YES ❑ NO
Suspicious Lesions	❑ YES ❑ NO
Acne	❑ YES ❑ NO
CONSTITUTIONAL	
Weight Change	❑ YES ❑ NO
Loss of appetite	❑ YES ❑ NO
Fever	❑ YES ❑ NO
OPHTHALMOLOGY	
Eye Irritation	❑ YES ❑ NO
ENT	
Difficulty Swallowing	❑ YES ❑ NO
Hearing Loss	❑ YES ❑ NO
CARDIOLOGY	
Palpitations	❑ YES ❑ NO
Pacemaker	❑ YES ❑ NO

RESPIRATORY	
Shortness of Breath	❑ YES ❑ NO
Asthma	❑ YES ❑ NO
HEMATOLOGY / LYMPH	
Easy Bruising	❑ YES ❑ NO
GASTROENTEROLOGY	
Nausea	❑ YES ❑ NO
Vomiting	❑ YES ❑ NO
Heartburn	❑ YES ❑ NO
PSYCHOLOGY	
Depression	❑ YES ❑ NO
Suicidal Ideation	❑ YES ❑ NO
NEUROLOGY	
Seizures	❑ YES ❑ NO
Headaches	❑ YES ❑ NO

COSMETIC HISTORY	
HAVE YOU EVER RECEIVED A COSMETIC PROCEDURE?	❑ YES ❑ NO
IF YES, PLEASE CHECK THE APPROPRIATE BOXES IF APPLICABLE:	
BOTOX	❑ YES
FILLERS	❑ YES
LASER HAIR REMOVAL	❑ YES
FACIAL RESURFACING	❑ YES
PHOTOREJUVENATION/PDT	❑ YES
CHEMICAL PEELS	❑ YES
SKIN TIGHTENING	❑ YES
SCLEROTHERAPY	❑ YES
LASER REMOVAL OF FACIAL/LEG VEINS	❑ YES

IF YOU WOULD LIKE MORE INFORMATION ON THE COSMETIC SERVICES WE OFFER, PLEASE CHECK THE APPROPRIATE BOX.	
INTERESTED IN BOTOX	❑ YES
INTERESTED IN FILLERS	❑ YES
INTERESTED IN LASER HAIR REMOVAL	❑ YES
INTERESTED IN FACIAL RESURFACING	❑ YES
INTERESTED IN PHOTOREJUVENATION/PDT	❑ YES
INTERESTED IN CHEMICAL PEELS	❑ YES
INTERESTED IN SKIN TIGHTENING	❑ YES
INTERESTED IN SCLEROTHERAPY	❑ YES
INTERESTED IN LASER REMOVAL OF FACIAL/LEG VEINS	❑ YES