Patient Registration Form

DEMOGRAPHIC INFORMATION

First Name:

Last Name:

MI:

Date of Birth:

Social Security #:

Address 1:

Address 2:

City:

State:

ZIP:

Are you being referred by your primary care physician?

If yes, who is your primary care physician?

CONTACT INFORMATION

Home Phone:

Cell Phone:

Email Address:

EMERGENCY CONTACT INFORMATION

Contact First Name:

Contact Last Name:

Contact Phone Number:

Relationship to Patient:

PHARMACY INFORMATION

Pharmacy Name:

Pharmacy Location:

By signing below, I attest that the information provided above is true and accurate

Signature of Insured, Guardian, or Power of Attorney:

Signature:

Today's Date:

Consent to Treat Form

I hereby voluntarily consent to all healthcare services ordered/provided by Dr Elbert Marion Belk, and The Skin Clinics of Texas providers at all locations. The health care service may include, but not limited to, physical; diagnostic and monitoring tests and procedures; medical examinations; routine laboratory procedures and tests; x-rays and other imaging studies; administration of medications; procedures and treatments prescribed by The Skin Clinics of Texas healthcare providers.

My signature on this form indicates that: I certify that I have read and fully understand the foregoing consent and that the facts indicated above are true and correct.

I understand that I may be asked to sign a separate informed consent form for certain treatment(s) that require additional treatments or procedures other than routine office procedures listed herein.

I here by voluntarily give my consent to treatment at Dr Elbert Marion Belk, and The Skin Clinics of Texas. This is also granting consent to bill insurance companies and collect any payment.

Signature:

Printed Name:

Date of Birth:

Today's Date:

Insurance Information

Insurance Company:

Do you have a secondary insurance?

If yes, what is your secondary insurance?

Are you under someone's insurance?

If yes, we will need additional information.

Name of insured:

Relation to Patient:

Date of Birth of Insured:

PLEASE NOTE:
Your insurance card and photo ID are required at the time of your visit.

By signing below, I attest that the information provided above is true and accurate.

Signature of Insured/Dependent:

Today's Date:

Consent to Clinical Procedures

Patient Name: _____ Date of Birth: _____

I hereby consent to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. This may include, but is not limited to, laboratory procedures (including diagnostic testing such as lab draws and skin biopsies), medical and surgical treatment or procedure (including wart treatments, surgical removals, or excisions), skin peels, botox, fillers, or other services rendered during my visit with The Skin Clinics of Texas.

To ensure that you understand all aspects of your visit, you are encouraged to ask any questions or clarify any procedures prior to them being performed. Our dermatology providers will answer any questions and discuss any procedures, concerns, and goals with you regarding the following:

- ★ **Benefits of the proposed procedure.**
- ★ **The way the treatment or procedure is to be performed.**
- ★ **Alternative treatment options.**
- ★ **Probable consequences of not receiving the treatment.**
- ★ **The right to withdraw informed consent at any time, in writing.**
- ★ **Risk and side effects involved with the procedure.**
- ★ **Potential for additional incurred charges.**

Should a biopsy be performed, or any other procedure in which a section of your skin is removed, the specimen will be sent to a pathology lab for an accurate diagnosis, unless otherwise recomended by your clinician. This process will involve any testing necessary including special staining or outside consultations which will incur additional charges. _____ (Initials)

I acknowledge that some medical diagnoses (such as warts) will require multiple treatments with one or more methods that may change throughout the course of treatment and each office visit and procedure will be billed accordingly. _____ (Initials)

With any procedure, there are risks involved which include, but are not limited to the following:

- **Scar** – Scarring is possible with any procedure of the skin. We will do everything we can to provide you with the best cosmetic result possible, but the final cosmetic outcome is not guaranteed.
- **Infection** – The entire procedure will be done in a sterile and/or clean fashion. Still, a small number of people will get a wound infection.
- **Bleeding** – Some procedure may create some bleeding. Rarely will someone have significant bleeding after they leave such that they would have to come back to have us treat it.
- **Nerve damage** – This will be thoroughly discussed with you by your physician if it is a potential during your procedure.

I authorize pictures to be taken before, during and after the procedure. These pictures will become part of your medical record. They may also be sent to your family physician and/or referring physician. They will not be used for any other purpose without proper consent.

If a complication after the procedure would arise, there may be a charge for the medical management that will be submitted to your insurance company. I recognize that the practice of medicine is not an exact science and acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures.

Since each insurance company has its own policies regarding the coverage of procedures, I also acknowledge that I am responsible for payment in full for the charges incurred for procedures regardless of the coverage provided by my insurance carrier. If I am concerned about the cost associated with treatment, it is my responsibility to request a procedure estimate prior to starting treatment. _____ (Initials)

I have read the consent form in its entirety. I understand the risks associated with procedures that may occur during my visits to The Skin Clinics of Texas. I do not impose any limitations on The Skin Clinics of Texas and its staff. I understand that I should discuss any questions or concerns with Dr. Belk prior to any procedure and therefore, with my signature, agree to have any necessary procedures performed.

Patient signature: _____ **Date:** _____

The undersigned hereby provides consent as the parent or guardian of the above referenced minor patient.

Parent or Guardian signature: _____ **Date/Relationship to Patient:** _____

Late/No-Show Policy

We schedule our appointments so that each patient receives the proper amount of time seen by our staff, nurse practitioner(s), and physician. That is why it is very important you keep your appointment.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule an appointment, please give us at least **24 hours' notice**.

If you are running late but still plan to attend your scheduled appointment, please contact us as soon as possible so we can make appropriate accommodations. To ensure we can continue serving all our patients efficiently, we kindly request at least a **15-minute notice** if you anticipate being late. Please note that any patient arriving more than **15 minutes** after their scheduled appointment time will be considered late, and we may need to reschedule your appointment to avoid delays for other patients.

If you do not cancel or reschedule your appointment with at least **24 hours'** notice, we reserve the right to charge a **$25.00** fee for "Late" appointments or a **$50.00** fee for "No-Show" appointments to your account. This service charge is not reimbursable by your insurance company. You will be billed directly, and payment must be made with the Chief Financial Officer.

I _____ understand the "Late/No-Show" policy of The Skin Clinics of Texas and have been given the opportunity to clarify any questions I might have regarding the policy. I understand that I must cancel or reschedule the appointment at least **24 hours** in advance to avoid a potential "Late/No-Show" service charge to my account.

Signature:	Date:

PHOTO AND VIDEO RELEASE FORM

Full Name : _____ Date of Birth: _____

Email Address: _____

I, _____, hereby grant The Skin Clinics of Texas, its representatives, employees, agents, and assignees the right to take, use, reproduce, and publish photographs and/or video footage of me, including my image, likeness, and/or voice, for use in the following ways: Educational or training materials, Promotional content including social media, websites, flyers, and advertisements, Professional presentations, seminars, or events- Internal clinic use and documentation.

I UNDERSTAND AND AGREE THAT:

1. No Compensation: I will receive no financial compensation or other forms of payment for the use of my image, voice, or likeness by The Skin Clinics of Texas, now or in the future.

2. Voluntary Participation: My participation in photos or video recordings is completely voluntary and I may withdraw consent at any time by submitting a written request to the clinic. However, this will not apply to media already published or distributed.

3. Release of Liability: I hereby release and hold harmless The Skin Clinics of Texas, its employees, contractors, and affiliates from any claims, demands, or causes of action arising out of or connected with the use of these images or recordings.

4. Ownership and Copyright: All photographs, video recordings, and media created by or for The Skin Clinics of Texas will be the sole property of the clinic, and it has full rights to use or not use the content as it sees fit.

Signature: Date:

IF PATIENT IS UNDER 18:

Parent/Guardian Name: Signature:

Relationship to Minor: Date:

CONSENT FOR SUPERFICIAL RADIATION TREATMENT

Full Name: _____ Site: _____

Diagnosis: _____

I hereby request, authorize, and give my consent to Dr. Elbert Marion Belk, MD, and/or his associates or assistants, to perform Superficial Radiation and/or treatment(s) or technical procedure(s) deemed necessary or advisable in the diagnosis or treatment of my case, including but not limited to pathology, radiology, and laboratory services.

_____ Patient Initials

1. Benefits of Treatment: I understand that Superficial Radiation Therapy (SRT) is a non-invasive treatment option for non-melanoma skin cancers (e.g. basal cell carcinoma or squamous cell carcinoma), precancerous lesions, and other approved skin conditions. The goal of this therapy is to destroy cancerous cells while preserving surrounding healthy tissue, often resulting in improved cosmetic outcomes and avoiding surgery.

_____ Patient Initials

2. Procedure Description: SRT uses low-energy radiation that penetrates only the upper layers of skin. Treatments are generally administered twice a week over a span of 6-8 weeks, with a total of approximately 12-15 sessions. Each session typically lasts a few minutes and is performed in our office by licensed and trained professionals.

_____ Patient Initials

3. Alternative Treatment Options: I have been informed of alternative treatments, including surgical excision, Mohs surgery, electrodessication and curettage (ED&C), cryotherapy, and topical treatments, and I understand the risks and benefits associated with each.

_____ Patient Initials

4. Early and Late Side Effects: I understand that early side effects of radiation include irritation, redness, and ulceration of the skin, as well as possible skin infection. I understand that late effects of radiation can include skin atrophy (thinning of the skin), telangiectasia (visible small blood vessels), increased skin pigmentation (darkening), hair loss in the area treated, non-healing ulcer (rare), and/or a different type of skin cancer in the treated area (very rare).

_____ Patient Initials

5. No Guarantee of Cure: I acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained, that there is no 100% cure rate for skin cancers, and that the practice of medicine and surgery is not an exact science for which assurances regarding cure rate can be made.

_____ Patient Initials

6. Right to Withdraw Consent: I understand that I have the right to refuse or withdraw consent at any time before or during treatment without penalty or loss of future care.

_____ Patient Initials

7. Photography Consent: I consent to photographing the treatment, including appropriate portions of my body, for medical, scientific, or educational purposes.

_____ Patient Initials

8. Follow-Up Responsibility: I understand that it is my responsibility to undergo regular and periodic check-ups (at least yearly) to detect recurrent or new skin cancers, and I agree to follow instructions regarding treatment site(s).

_____ Patient Initials

9. Emergency Contact / Aftercare: I have received instructions for post-treatment care and understand whom to contact if I experience unexpected side effects or have questions.

_____ Patient Initials

10. Language Services: If I require assistance in another language, I have been offered translation or interpreter services to ensure full understanding of this consent form.

_____ Patient Initials

11. Insurance Coverage: I understand that The Skin Clinics of Texas is in network with many insurance carriers and my insurance plan my cover part or all of the treatment. I accept responsibility for any portion not covered by my insurance.

_____ Patient Initials

12. Risk Explanation Confirmation: The possible risks and complications of Superficial Radiation and the possible risks and complications of failing to undergo or delay treatment have been explained to me, and any questions I may have had have been answered to my satisfaction.

I certify that I have read and fully understand the above information. My provider has answered all my questions regarding this treatment. I give my voluntary consent to undergo Superficial Radiation Therapy (SRT).

Printed Name of Patient/Authorized:
Representative:

Signature:

Date:

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's Notice of Privacy Practices explaining:

- ☐ How this office will use and disclose my protected health information.
- ☐ My privacy rights with regard to my protected health information.
- ☐ This office's obligations concerning the use and disclosure of my protected health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request.

I also understand that if I have any questions or complaints, I may contact:

_____

_____

_____

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____

FOR OFFICE USE ONLY

We made a good-faith effort to obtain an acknowledgment of _____receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

- ☐ Patient refused to sign (date of refusal) _____/_____/_____
- ☐ Communications barriers prohibited obtaining an acknowledgment.
- ☐ An emergency situation prevented us from obtaining an acknowledgment.
- ☐ Other: _____

Attempt was made by: _____ Date: _____