



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:

How did you hear about us?

- ☐ Google Search
☐ Social Media
☐ Friend or Family Referral
☐ Physician Referral
☐ Other: _____

EMERGENCY CONTACT INFORMATION

Contact First Name:

Contact Last Name:

Contact Phone Number:

Relationship to Patient:

Billing statements will be sent via text message unless a paper statement is requested:

- ☐ Please send my billing statements by mail instead.

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 recommended 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:



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: _____

NOTICE OF INSURANCE NON-COVERAGE AND PATIENT RESPONSIBILITY

The Skin Clinics of Texas is committed to providing high-quality dermatologic care. However, insurance coverage is determined solely by your insurance carrier, not by The Skin Clinics of Texas.

Your insurance may:

- Deny coverage for certain services or procedures
- Apply deductibles, copayments, or coinsurance
- Determine that a service is not medically necessary
- Require prior authorization or referrals

PATIENT ACKNOWLEDGMENT AND AGREEMENT

By signing below, I acknowledge and understand the following:

1. Insurance Billing

The Skin Clinics of Texas will submit claims to my insurance as a courtesy when applicable. Submission of a claim does not guarantee payment.

2. Non-Covered or Denied Services

If my insurance carrier denies payment in whole or in part for any reason, including but not limited to lack of medical necessity, exclusions, benefit limitations, or failure to obtain authorization, I am **financially responsible** for the outstanding balance.

3. Patient Responsibility

I agree to pay all charges not covered by my insurance, including:

- Deductibles
- Copayments
- Coinsurance
- Non-covered services
- Services deemed cosmetic or elective by my insurer

4. Estimated vs. Final Charges

Any cost estimates provided are not guarantees of insurance payment. Final patient responsibility is determined after insurance processing.

5. Payment Obligation and Practice Policy

I understand that payment may be required at the time of service and that any remaining balance is due upon receipt of a statement. I further understand that failure to keep my account current, including failure to make required payments or payment arrangements, may result in dismissal from The Skin Clinics of Texas in accordance with practice policy and applicable law.

AUTHORIZATION AND SIGNATURE

I, _____, have read and understand this notice. I accept full financial responsibility for all charges not covered by my insurance.

Patient / Responsible Party Signature: _____

Date: _____

OFFICE USE ONLY

Staff Initials: _____

Date Reviewed: _____



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last _____ First _____ Middle _____

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (____) _____ ALT. PHONE (____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____

Address _____

City _____ State _____ Zip Code _____

Phone (____) _____ Fax (____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____

Address _____

City _____ State _____ Zip Code _____

Phone (____) _____ Fax (____) _____

REASON FOR DISCLOSURE (Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- | | | | |
|---|--|---|---|
| ☐ All health information | ☐ History/Physical Exam | ☐ Past/Present Medications | ☐ Lab Results |
| ☐ Physician's Orders | ☐ Patient Allergies | ☐ Operation Reports | ☐ Consultation Reports |
| ☐ Progress Notes | ☐ Discharge Summary | ☐ Diagnostic Test Reports | ☐ EKG/Cardiology Reports |
| ☐ Pathology Reports | ☐ Billing Information | ☐ Radiology Reports & Images | ☐ Other _____ |

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes) _____ Genetic Information (including Genetic Test Results)
_____ Drug, Alcohol, or Substance Abuse Records _____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____
Signature of Individual or Individual's Legally Authorized Representative

DATE

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X _____
Signature of Minor Individual

DATE