RESTORATION
DERMATOLOGY

ACKNOWLEDGEMENT OF OFFICE POLICIES

Please review and sign after reading each policy listed below:

Office Hours: The office opens at 8am and closes at 5pm Monday-Thursday with a closure during lunch from 12pm-1pm. On Friday the office opens at 8am and closes at 12pm

Cancellation/No Show Policy: If a patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel within 24 hours of the scheduled appointment. Restoration Dermatology reserves the right to charge a $50 fee if the patient does not cancel his/her appointment within 24 hours. A loss of deposit for surgical or aesthetic services may occur if the patient does not cancel within 24 hours. Administrative fees incurred for failure to provide cancellation notice are not billable to insurance or any other third-party payor. These policies include appointments with all providers and aestheticians.

Late Arrivals: Rescheduling may be necessary if you arrive more than 15 late for your scheduled appointment. In the event you are running late, please contact our front desk and we will do our best to accommodate you. If time allows and your provider has the ability to work you back into the schedule, please be aware there may be a wait for you to be seen.

Appointment Reminders: You will receive a text message and email confirmation after booking any appointment. Another reminder text message will be sent out two days prior to your scheduled appointment to allow for changes to be made, if necessary. You may choose to opt-out of these types of communications at any time.

Release of Medical information: If at any time you should need a copy of your medical records, a written release is required to be signed and dated. The form is available at our front desk and can be found on our website. Please allow up to 15 business days to complete your request. If your request is urgent, please mark the request as urgent and someone from our staff will contact you to expedite your request. If a secure fax number cannot be provided, records must be mailed to your address on file. Copies of blood work and pathology reports are provided at no charge, but copies of your complete medical record or our office notes may require a fee. If you have a consulting physician you would like to have listed as an authorized recipient of your medical information, please request and complete a release for each physician you wish to receive your records.

Expiration of and Right to Revoke Authorization To Disclose Protected Health Information:
I understand that I can withdraw my permission given at any time by giving written notice stating my intent to revoke authorization to a person or organization named under "Consent for Communication". I understand that prior actions taken on this authorization by entities that had permission to access my health information will not be affected. The duration of this authorization is indefinite unless revoked with written notice.

Physician Assistant, Nurse Practitioner, & Aesthetician Information: Restoration Dermatology may staff physician assistants, nurse practitioners and aestheticians to assist in the delivery of dermatology care. A physician assistant ("PA") is not a doctor but is a graduate of a certified training program and is licensed by the Texas Physician Assistant Board. Under the supervision of a physician, a PA can diagnose, treat, and monitor common and acute diseases. Aestheticians provide services as directed by a PA, nurse practitioner or physician. I understand that I will be treated by the provider I am scheduled with and will be notified prior to my appointment if any changes to the servicing provider must be made. I have read the above and hereby consent to the services of a PA, nurse practitioner, or aesthetician for my health care needs.

By signing this Acknowledgement of Office Policies you acknowledge that you have read, understand, and accept the above policies.

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

Relation to Patient: _____

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FINANCIAL POLICY NOTICE

Please review and sign after reading each policy listed below:

Financial Responsibility: I understand that if I do not have health insurance, full payment is due at the time of service. I understand it is my responsibility to know my insurance policy coverage and benefits and to notify Restoration Dermatology of any insurance changes. A copy of the insurance card must be provided following any changes. I understand that I am responsible for any amount not covered by my insurance policy. I understand that payment is due on the date in which services are rendered, including copays, deductible or coinsurance amounts, and charges for cosmetic services. Routine, in-office procedures including biopsies, injections, and destruction of growths may be subject to my deductible or coinsurance. I agree to fulfill all policy provisions which my insurance company may require for payment. All payments are due at the time of service for all aesthetic services.

Managed Care (HMO) Plans or Health Select: I understand that it is my responsibility to obtain any and all necessary referrals if my plan requires one. Restoration Dermatology will strive to keep me informed of the status of any referral, but it is ultimately my responsibility to make the necessary arrangements through my primary care physician. I understand that failure to obtain a referral, if required by my insurance for coverage, will result in the full balance becoming my financial responsibility for any and all services received.

Benefit Verification: I understand that the staff of Restoration Dermatology will make every effort to accurately verify my insurance benefits, but this verification is not a guarantee of payment by my insurer. I understand that I have a right to refuse any services before they are rendered. I understand that the final determination regarding my benefits and any amounts owed will be made by my insurer at the time of claim processing according to the provisions of the policy contract that I have with them. Any questions regarding insurance benefits for dermatology services may be directed to the front desk.

Release of Information: I authorize the release of any medical information to my insurance company, Medicare and/or supplemental policy that is necessary for the processing of claims. I understand that this authorization may include the release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV").

Assignment of Benefits: I authorize the payment of benefits directly to the providers at Restoration Dermatology in all claims for services rendered.

Medicare/Supplemental Benefits: If covered by Medicare and a supplemental policy, I request that payment of authorized benefits be made on my behalf. I hereby authorize Restoration Dermatology to release all information necessary to secure all payments or approval of benefits.

Payment for Ancillary Services (Laboratory/Pathology): I understand Restoration Dermatology utilizes the services of outside laboratories for pathology (biopsies), microbiology (cultures) and blood chemistry. These laboratories will bill for services separately from Restoration Dermatology. I acknowledge that payments made to Restoration Dermatology are for services rendered by Restoration Dermatology and authorize the use of outside laboratories as deemed necessary and ordered by my doctor(s). I understand that this may result in a financial responsibility to the laboratory providing these diagnostic services.

Worker's Compensation: I understand that Restoration Dermatology does not accept Worker's Compensation cases.

Returned Checks: I understand that checks presented to Restoration Dermatology as payment for services rendered and subsequently returned by my bank for any reason as unpaid will be charged a returned check fee of $25. Balances must be handled by cash, credit card or money order. Restoration Dermatology reserves the right to represent returned checks electronically for their face value plus the returned check fee.

Past Due Accounts: I understand that all outstanding accounts may be turned over to a collection agency after three statements and one pre-collection letter. I acknowledge that I must contact Restoration Dermatology before this time if I wish to make other payment arrangements.

By signing this Financial Policy Notice you, the guarantor, acknowledge that you have read, understand and accept all of the above policies.

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

*Relation to Patient:*_____

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GENERAL CONSENT & PRIVACY PRACTICES

Please review and sign after reading each policy listed below:

CONSENT FOR TREATMENT I hereby authorize providers of Restoration Dermatology to render care to me during my office visits and to fulfill the orders of my physicians, including consultants, associates, and assistants of the physicians' choice. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

CONSENT FOR PHOTOS I understand that during the course of treatment, photographs may be taken for clinical documentation purposes. No audio taping, videotaping, or photography is allowed by non-staff members.

CONSENT FOR ELECTRONIC PRESCRIPTION HISTORY I understand that to offer the best patient care, Restoration Dermatology may retrieve my prescription history that has been ordered and filled through an EHR system. I authorize Restoration Dermatology to import the prescription history obtained through an EHR system into my electronic chart

CONSENT FOR COMMUNICATIONS I authorize Restoration Dermatology to send me appointment reminders via automated SMS text messages, phone calls, emails, and additional information regarding dermatology, including health-related products or services, newsletters and quality of care surveys provided by Restoration Dermatology. I understand that message/data rates may apply. I authorize Restoration Dermatology and third-party collection agents to utilize all contact information I have provided in efforts to communicate regarding my account. I agree that affiliates may contact me through text messages, ring-less calls, and emails to provide me with my bill and to remind me to pay for services provided by Restoration Dermatology, in compliance with federal and state laws. I understand I am not obligated to receive automated notifications and may opt-out of these, or any, communications at any time.

May we leave a detailed message on your answering machine or voicemail? O YES O NO

May we email personal medical information to you? (i.e. statements, labs) O YES O NO

May we speak to any other individuals regarding your medical care? O YES O NO

Please list the physicians, family members, or other individuals:

Who are we authorized to speak with? I authorize Restoration Dermatology to release verbally, electronically, and/or in writing my confidential medical information for purposes of treatment, payment of charges, quality assurance and utilization review, transfer and follow-up procedures to my insurance carrier, employer (if treatment is related to employment), any other healthcare providers:

NAME	PHONE#	RELATION
NAME	PHONE#	RELATION

NOTICE OF PRIVACY PRACTICES I certify that I have been provided with a copy of the privacy practices of Restoration Dermatology. I have reviewed how Restoration Dermatology may use and disclose protected health information about me. This includes the release of protected health information (PHI) for insurance billing purposes. The practice reserves the right to change the Notice of Privacy Practices

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

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MEDICAL HISTORY FORM

Patient Name: _____

Reason for Visit, location of problem, duration of problem: _____

Medical History (Check all that apply):

- ☐ Allergies
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Coronary Artery Bypass
- ☐ Diabetes
- ☐ Fever Blister
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Joint Replacement
- ☐ Liver Disease
- ☐ Lumpectomy
- ☐ Lupus/Rheumatoid Arthritis
- ☐ Mastectomy
- ☐ Organ Transplant
- ☐ Thyroid Disease
- ☐ NONE

Other: _____

History of skin cancer & skin conditions (Check all that apply. If none, check NONE)

- ☐ Actinic Keratosis
- ☐ Basal Cell Carcinoma
- ☐ Squamous Cell Carcinoma
- ☐ Melanoma
- ☐ Acne
- ☐ Eczema
- ☐ Hair Loss (Alopecia)
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Hyperhidrosis (Excessive Sweating)
- ☐ Nail Fungus
- ☐ Hidradenitis Suppurativa
- ☐ NONE

Other: _____

Family history of skin cancer including Melanoma: ☐ Yes ☐ No

If yes, whom: _____

Medications (List all current medications including non prescriptions and birth control.) If none mark N/A

_____

Allergies (If none, mark NKDA)

_____

Social History: ☐ Current Smoker ☐ Never Smoker ☐ Former Smoker

Do you drink alcohol? ☐ Yes, if so- how much? _____ ☐ No

65 and over ONLY- Do you have the following:

☐ Living will Advanced Directive: ☐ Yes ☐ No

Review of Systems (Check all that apply) :

☐ Problems with bleeding ☐ Fever/Chills ☐ Joint Pain ☐ Problems with healing ☐ Night Sweats

☐ Problems with scarring/keloids ☐ Unintentional weight loss

Surgical procedures in the past 2 years: _____

Alerts (Check all that apply. If none check none) :

- ☐ Allergy to adhesive
- ☐ Allergy to lidocaine
- ☐ Allergy to topical
- ☐ Allergy to latex
- ☐ Artificial heart valve
- ☐ Artificial joint replacement
- ☐ Blood Thinners
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Breastfeeding
- ☐ Require antibiotics prior to a surgical procedure
- ☐ Rapid heart beat with Epinephrine
- ☐ Currently pregnant or currently trying to get pregnant
- ☐ NONE

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NEW PATIENT DEMOGRAPHICS

Patient Name: _____ Preferred name: _____
LAST FIRST M.I.

Date of Birth: _____ SSN: _____ Sex: ☐ Female ☐ Male

Street Address: _____
STREET CITY, STATE ZIPCODE

Home: ( ) _____ Cell: ( ) _____ Work: ( ) _____

Email address: _____ Preferred Language: _____

Race: ☐ Asian ☐ Black or African American ☐ American Indian ☐ White Other: _____

Ethnicity: _____ **(Hispanic/Latino or Non-Hispanic or Latino)**

Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

How did you hear about us? ☐Referring Physician ☐Family/Friends ☐Social Media ☐Google/Internet ☐ Insurance

Occupation: _____ Employer: _____

Preferred Pharmacy: _____ Telephone: _____ City, Zip: _____

By naming my primary care physician, I authorize Gustovich Dermatology to release my medical information to the listed entity for the purpose of updates regarding treatment.

Primary Care Physician: _____ Phone Number: _____

****Complete This Section ONLY if Patient is Not Policy Holder****

The parent/guardian accompanying a child to the visit is responsible for payment due at the time of service. Our office staff will not get involved in matters involving third party personal billing as the result of custody, court order, or personal circumstances.

Last Name: _____ First Name: _____ DOB: _____

Address (if not same as above): _____

Cell Phone Number: _____ Employer: _____

Relationship to Patient: □ Parent □ Guardian □ Spouse