

## PATIENT INFORMATION

|                                                                                                                                  |                     |                 |
|----------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------|
| Last Name:                                                                                                                       | First Name:         | Middle:         |
| Date of Birth:                                                                                                                   | Gender:             | Preferred Name: |
| Address:                                                                                                                         |                     |                 |
| City:                                                                                                                            | State:              | Zip Code:       |
| Cell Phone:                                                                                                                      | Home Phone:         |                 |
| Email:                                                                                                                           | Preferred Language: |                 |
| Preferred Phone Communication:    Patient Portal (preferred)    Text    Phone call w/detailed message    Phone call w/callback # |                     |                 |
| Preferred Pharmacy Name:                                                                                                         | Address:            | Phone #:        |
| How did you hear about our office? <input type="checkbox"/> I am a Previous Patient    Other _____                               |                     |                 |

### PRIMARY INSURED INFORMATION (AS SHOWN ON INSURANCE CARD)

|                    |                          |           |
|--------------------|--------------------------|-----------|
| Last Name:         | First Name:              |           |
| Date of Birth:     | Relationship to Patient: |           |
| Name of Insurance: | Address:                 |           |
| City:              | State:                   | Zip Code: |
| Subscriber ID #:   | Group #:                 |           |

### SECONDARY ISSUED INFORMATION IF APPLICABLE (AS SHOWN ON INSURANCE CARD)

|                    |                          |           |
|--------------------|--------------------------|-----------|
| Last Name:         | First Name:              |           |
| Date of Birth:     | Relationship to Patient: |           |
| Name of Insurance: | Address:                 |           |
| City:              | State:                   | Zip Code: |
| Subscriber ID #:   | Group #:                 |           |

### GUARANTOR/FINANCIALLY RESPONSIBLE INFORMATION (PLEASE SEE FINANCIAL POLICY)

|                                                                                                                                                                    |                          |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--|
| Last Name:                                                                                                                                                         | First Name:              |  |
| Date of Birth:                                                                                                                                                     | Relationship to Patient: |  |
| <input type="checkbox"/> I would be interested in storing a card on file for payments <input type="checkbox"/> I would be interested in learning about Care Credit |                          |  |

### I WOULD BE INTERESTED IN INFORMATION REGARDING THE FOLLOWING (CHECK ALL THAT APPLY)

|                                     |                                                              |                                                                 |                                                                          |                                                           |
|-------------------------------------|--------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------|
| Medical Dermatology:                | <input type="checkbox"/> Dermagraphix (digital mole mapping) | <input checked="" type="checkbox"/> Blue light therapy (PDT)    | <input checked="" type="checkbox"/> Chemotherapy Cream (field treatment) |                                                           |
| Cosmetic/Aesthetics:                | <input type="checkbox"/> Neurotoxin (Botox, Dysport)         | <input type="checkbox"/> Fillers                                | <input type="checkbox"/> Body contouring                                 | <input type="checkbox"/> Skin rejuvenation                |
| Dermatology: Functional/Integrative | <input type="checkbox"/> Nutrition/Gut microbiome            | <input type="checkbox"/> Mind skin connection/Stress management | <input type="checkbox"/> IV/Hydration                                    |                                                           |
| Wellness:                           | <input type="checkbox"/> Essential Oils                      | <input type="checkbox"/> Vitamins/Supplements                   | <input type="checkbox"/> Oral collagen                                   | <input type="checkbox"/> Stem cell/growth factors in skin |

Please bring the patient's current insurance card and a valid ID, to the front desk when checking in for the appointment. The patient's insurance and ID will be scanned into the system at that time.

## HEALTH HISTORY

|                                                                                                                                                                                                                                 |                      |                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------|
| Name:                                                                                                                                                                                                                           | Date of Birth:       | Appointment Date: |
| Preferred Language:                                                                                                                                                                                                             | Occupation/Employer: |                   |
| PCP:                                                                                                                                                                                                                            | Phone:               |                   |
| Sun Exposure History : Blistering Sunburns <input type="checkbox"/> Y <input type="checkbox"/> N Tanning Bed Use (in past) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>  |                      |                   |
| Reason for Today's Visit:<br><small>***Please note: If you are coming in for Acne, Eczema, Psoriasis, Hairloss, Rash or a Cosmetic consult, please see website for supplemental questionnaire to streamline your visit.</small> |                      |                   |
| Date of Last Skin Check:                                                                                                                                                                                                        | Performed by:        |                   |
| Please list everything you are using on your skin currently if it relates to the reason for your visit today:                                                                                                                   |                      |                   |
| AM:                                                                                                                                                                                                                             | PM:                  |                   |

### GENERAL HEALTH HISTORY

- |                                     |                           |
|-------------------------------------|---------------------------|
| *Artificial Heart Valve / Infection | *Accutane (Last 6 Months) |
| *Artificial Joint (Past 2 Years)    | Canker Sores              |
| *Hepatitis, Type:                   | Diabetes                  |
| *HIV/AIDS                           | Dementia                  |
| *HSV (Fever blister) Infection      | High Blood Pressure       |
| *Organ Transplant                   | Hyperthyroid/Hypothyroid  |
| *Pacemaker/Defibrillator            | Autoimmune Condition      |
| *Staph Bacterial Infection          | Cancer (Other Than Skin)  |
| *Vasovagal Reaction (Fainting)      | Family Hx of Other Cancer |
| *Premedication Prior to Procedures  | Radiation Treatment       |

Surgical Procedures (Within the Past 2 Years):

### SKIN CANCER HISTORY

- Have **you** had **Melanoma** skin cancer ?
- Have **you** had **Basal cell carcinoma (BCC)** skin cancer?
- Have **you** had **Squamous cell carcinoma (SCC)** skin cancer?
- Has any first degree relative in your family had **Melanoma**?

Location(s) & date(s): \_\_\_\_\_

Location(s) & date(s): \_\_\_\_\_

Location(s) & date(s): \_\_\_\_\_

Who and where? \_\_\_\_\_

**Are you allergic to:** \_\_\_\_\_ **Other Drug Allergies / Reaction:** \_\_\_\_\_

### SOCIAL HISTORY

Cigarette Smoking

Alcohol Use

**CURRENT MEDICATIONS | List all current medications (including chemotherapy, over-the-counter, vitamins, supplements):**

- \*Pregnant or Planning
- Currently Breastfeeding
- Recent Biologic Med.
- History of Chemo
- Problems with Bleeding

Immunosuppression

- Abnormal blood counts
- Abnormal scarring
- Liver Disease
- Kidney Insufficiency
- Blood thinners
- Other \_\_\_\_\_

**Have you received the following vaccinations?**

Flu (Oct – Mar Only) \_\_\_\_\_

Pneumonia (65+ Years Only) \_\_\_\_\_

Shingles (50+ Years Only) \_\_\_\_\_

Covid \_\_\_\_\_

Human Papilloma Virus (HPV) \_\_\_\_\_

### SKIN HISTORY



## PATIENT CONSENTS

### CONSENT FOR TREATMENT

I authorize Intentional Dermatology and Health, its employees, and agents, including physicians, physician assistants, and other employees, to provide any healthcare services that my provider deems necessary for diagnosis and/or treatment. The duration of this consent is indefinite and continues until revoked in writing. If a biopsy is performed, I authorize the Pathologist to send my specimen for a second opinion and/or obtain special tests, if medically necessary to ensure an accurate diagnosis. I understand that additional costs may result and that I will be responsible for any remaining balance that is not covered by my insurance company, Medicare and/or supplemental policy. 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 and educational purposes. No audio taping, videotaping, or photography is allowed by non-staff members.

### CONSENT FOR FILING INSURANCE CLAIMS

I understand that to file claims and release medical information to my insurance company, Medicare and/or supplemental policy, Intentional Dermatology and Health is required to keep my signature on file. I hereby authorize Intentional Dermatology and Health to receive benefits directly from my insurance company, Medicare and/or supplemental policy when an assigned claim is filed. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I also authorize Intentional Dermatology and Health to appeal any denials to my insurance company, Medicare and/or supplemental policy, on my behalf and 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 I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to Intentional Dermatology and Health. I further understand that should my account become delinquent, I shall pay the reasonable collection and attorney's fees of Intentional Dermatology and Health, if any.

### CONSENT FOR ELECTRONIC PRESCRIPTION HISTORY

In order to offer the best patient care, Intentional Dermatology and Health will retrieve my prescription history that has been ordered and filled through an EHR system. I authorize Intentional Dermatology and Health to import the prescription history obtained through an EHR system into my electronic chart.

### CONSENT FOR APPOINTMENT REMINDERS / THIRD PARTY COMMUNICATIONS

I authorize Intentional Dermatology and Health to send me appointment reminders via automated SMS text messages, phone calls, emails, and additional information regarding dermatology, including health-related products or services and quality of care surveys provided by Intentional Dermatology and Health. I understand that message/data rates may apply to messages sent by Intentional Dermatology and Health under my cellphone plan. I authorize Intentional Dermatology and Health 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 Intentional Dermatology and Health, in compliance with federal and state laws. I understand that I am under no obligation to receive automated notifications and may opt-out of these communications at any time by following the prompts in the reminder. Further, I may revoke my consent to receive any and all communications.

\*\*\*By signing below, I certify that I have read the above information and my questions concerning these policies have been answered. My signature also

certifies my understanding and agreement with the above information. The duration of this consent is indefinite and continues until revoked in writing.

|                                          |                        |
|------------------------------------------|------------------------|
| Patient Printed Name:                    | Patient Date of Birth: |
| Parent / Legal Guardian<br>Printed Name: | Relationship:          |
| Signature:                               | Date:                  |

## FINANCIAL POLICIES

I understand that I am financially responsible for charges for services rendered on my behalf or on behalf of my dependent, regardless of if they are covered by my insurance company, Medicare and/or supplemental policy.

Payment is required at the time services are rendered. Intentional Dermatology and Health is allowed by contract with your insurance company to collect the copayment and/or co-insurance and any unmet deductible at the time of service. The amount collected is estimated based on benefit information available. Specific policy information is often limited or unavailable until after a claim has been filed.

Insurance coverage is not a guarantee of payment. I understand I am responsible for any remaining balance not covered by my insurance company, Medicare and/or supplemental policy. It is my responsibility to contact them if I have questions regarding my benefits and coverage.

I understand that if I have a surgical procedure or biopsy performed that requires further examination by a Pathologist, there are three separate charges that will occur, as required by my health insurance plan: (1) a charge by my treating provider for collecting the specimen; (2) a charge by the Pathologist, a medical doctor, to examine the specimen; and (3) a charge by the laboratory preparing the specimen for the pathologist. I understand that I will be billed separately by my treating provider, the pathologist, and the laboratory.

I understand that my insurance company, Medicare and/or supplemental policy may have a preferred lab for blood work. It is my responsibility to know which preferred lab I can use, and to inform my provider at the time of service.

I understand that a fee may be assessed for returned checks.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

### **NO REFUNDS for cosmetic services or products**

We appreciate your understanding that all cosmetic services and skincare products are non-refundable. This includes but is not limited to aesthetic procedures, injectables, and medical-grade skincare items. We encourage all patients to discuss expectations, potential outcomes, and any concerns prior to treatment or purchase.

### **Electronic Billing and Statements**

All billing statements and related communications are sent electronically via text message, patient portal or email ONLY. Physical mail statements may be sent out on occasion. Our third-party billing partner, "SYPORE", will manage these communications. Please ensure your contact information remains up to date to receive timely notifications. By signing below, you acknowledge and accept this method of correspondence.

By signing below, I certify that I have read the above information and my questions concerning these policies have been answered. My signature also certifies my understanding and agreement with the above information.

The duration of this consent is indefinite and continues until revoked in writing.

|                                       |                        |
|---------------------------------------|------------------------|
| Patient Printed Name:                 | Patient Date of Birth: |
| Parent / Legal Guardian Printed Name: | Relationship:          |
| Signature:                            | Date:                  |

## PERSONAL HEALTH INFORMATION (PHI)

### COMMUNICATION PREFERENCES

I authorize Intentional Dermatology and Health to disclose any and all details of my medical diagnoses, treatment, and billing/claims information to the individuals, as indicated below. This authorization is voluntary, and I understand that I have the right to revoke this authorization by submitting a written request to the office. I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is released. I understand that the below list may not be exhaustive and that my protected health information (PHI) may be disclosed to additional individuals based on my written authorization or as indicated in our Notice of Privacy Practices. This authorization shall remain in effect indefinitely unless revoked in writing by me.

I elect not to authorize disclosure to any individuals at this time

I elect to authorize disclosure to the below list of individuals

| First & Last Name: | Relationship: | Phone: | Medical | Billing |
|--------------------|---------------|--------|---------|---------|
|                    |               |        |         |         |
|                    |               |        |         |         |
|                    |               |        |         |         |

|                                                                                                                                   |                                                                                                     |
|-----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| Communication for benign (non-cancerous) test results                                                                             | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| I hereby allow all benign (non-cancerous) test results to be relayed as indicated in the selection above per the option selected. |                                                                                                     |

#### NOTICE OF PRIVACY PRACTICES

I have been given a copy and have read the Notice of Privacy Practices which explains how my medical information will be used and disclosed. I authorize the release of my medical information necessary to evaluate and/or treat my condition, to process insurance claims on my behalf, and for other necessary health care operations of Intentional Dermatology and Health I understand that I am entitled to receive a copy of the Notice of Privacy Policies.

#### CANCELLATION POLICY FOR APPOINTMENTS

It is my responsibility to call the office to cancel at least 24 hours prior to the scheduled appointment. Intentional Dermatology and Health reserves the right to charge a fee if the appointment is not canceled at least 24 hours in advance. Additionally, the office reserves the right to reschedule appointments for which I am late. Cosmetic appointments will require a deposit to reserve the appointment date of \$75. Intentional Dermatology and Health reserves the right to charge a fee or retain the deposit if the appointment is **not canceled at least 48 business hours in advance**.

#### COSMETIC SERVICES AND RETAIL SALES

Payment for cosmetic services is required in full prior to the provision of the service. Due to the nature of cosmetic products, exchanges/refunds may not be allowed.

By signing below, I certify that I have read the above information and my questions concerning these policies have been answered. My signature also certifies my understanding and agreement with the above information. The duration of this consent is indefinite and continues until revoked in writing.

|                                       |                        |
|---------------------------------------|------------------------|
| Patient Printed Name:                 | Patient Date of Birth: |
| Parent / Legal Guardian Printed Name: | Relationship:          |
| Signature:                            | Date:                  |

# NOTICE OF PRIVACY PRACTICES

## AS REQUIRED BY THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)

- A. OUR COMMITMENT TO YOUR PRIVACY** Our practice is dedicated to maintaining the privacy of your individually identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your protected health information (PHI). By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information: •How we may use and disclose your PHI •Your privacy rights regarding your PHI •Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will always post a copy of our current Notice in our offices in a visible location, and you may request a copy of our most current Notice at any time.

**B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:**

Intentional Dermatology and Health  
P.O.Box 2722  
Grapevine, TX 76099.

**C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:**

- 1. Treatment.** Our practice may use your PHI to treat you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment.
- 2. Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us.
- 3. Health Care Operations.** Our practice, and its affiliated entities and management company, may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.
- 4. Appointment Reminders.** Our practice may use and disclose your PHI to contact you and remind you of an appointment. We will notify you about your appointment utilizing an automated phone system, a personal call, text or by mail. This notification may involve leaving a message on an answering machine or other automated or electronic equipment for such purposes, which could (potentially) be received or intercepted by others. **5. Sign in Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
- 6. Treatment Options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
- 7. Health-Related Benefits and Services.** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
- 8. Release of Information to Family/Friends.** Our practice will routinely disclose to your responsible party(ies) the PHI directly relevant to his/her involvement with your health care, PHI related to payment of your health care, and PHI used for notification purposes. Our practice may release your PHI to another responsible party(ies) you identify, that is involved in your care.
- 9. Marketing.** We may contact you to give you information about products or services related to your treatment, or care. We will not otherwise use or disclose your medical information for marketing purposes, without your prior written authorization.
- 10. Sale of Health Information.** We will not sell your health information without your prior written authorization.
- 11. Disclosures Required by Law.** Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

**12. Breach Notification.** In the case of a breach of unsecured protected health information, we will notify you as required by law.

**13. Responding to Lawsuits.** We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**D. USE AND DISCLOSURE OF PHI IN SPECIAL CIRCUMSTANCES**

The following categories describe unique scenarios in which we may use or disclose your protected health information:

- 1. Public Health Risk Reporting.** Our practice may disclose your PHI to public health authorities that are authorized by law. For example, we are required to report certain communicable diseases to the state's public health department.
- 2. Law Enforcement.** Your health information may be disclosed to law enforcement agencies, military, and national security without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.
- 3. Workers' Compensation.** Our practice may release your PHI for workers' compensation and similar programs that provide benefits for work-related injuries or illnesses.

**E. YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding the PHI that we maintain about you. These include:

- The right to request restrictions on the use and disclosure of your protected health information, including to request that a health plan not be informed of treatment for which patient paid entirely out of pocket.
- The right to prohibit the sale of your protected health information, its use for marketing purposes, or participation in research.
- The right to request to receive confidential communications concerning your medical condition and treatment in a specific manner.
- The right to inspect and obtain copies of your protected health information.
- The right to request an amendment or corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed outside of our practice if not for treatment, payment, or health care operations.
- The right to file a complaint if you believe your privacy rights have been violated. Please file your complaint in writing. You will not be penalized for filing a complaint.
- The right to receive a printed copy of this notice.

All requests must be made in writing to  
Intentional Dermatology and Health P.O. Box 2722 Grapevine, TX, 76099. There may be a fee associated with any requests.

**F. RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES.**

Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care. If you believe your privacy rights have been violated, you may complain to the secretary of the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or to Intentional Dermatology and Health at P.O. Box 2722, Grapevine, TX 76099. There will not be retaliation against you for filing a complaint.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact:

Intentional Dermatology and Health 817-985-7685