Compassion DERMATOLOGY

3065 W. Southlake Blvd., Suite 140
Southlake, TX 76092
Phone: 817.380.5911 / Fax: 817.385.6579
Holly DeBuys, MD Board Certified Dermatologist
Website: compassiondermatology.com

Welcome to Compassion Dermatology!

Attached is our Patient Registration Package. Please complete these so we can maintain accurate contact and medical records. If you printed these forms from our website, please bring the completed original forms with you to your appointment along with the other items listed at the bottom of this letter.

We realize that you have a choice of where to be treated. We also realize that you place a great deal of trust in your physician to provide you with the most up to date information and treatment options regarding your skin care health. We do appreciate and value the trust you have placed in us.

Compassion Dermatology specializes in the diagnosis and treatment of skin, hair and nail disease. We provide our patients and their families with comprehensive dermatologic care. We want to help you get the best of what today's medicine has to offer. We are highly committed to quality patient care with an emphasis on individual attention for each patient. Our focus is to provide quality time for each patient. Providing the best service, in a comfortable, private atmosphere is extremely important to us. We will do our best to give you total satisfaction.

We place a high value on our relationship with our patients. We especially value patient feedback. Therefore, we will ask you to communicate to us your experiences with us. Be assured your feedback matters. It helps us continue to serve you and our other patients with the highest level of care possible. If you have any questions or concerns, please do not hesitate to ask any member of our team.

Warmest Regards,

Holly DeBuys, M.D.

REMINDERS OF REQUIRED ITEMS FOR YOUR VISIT

- **Insurance Card**
  If you have health insurance, we will need to make a copy of your card to bill your insurance
- **Written Referral** from your Primary Care Physician ***if required*** by your insurance plan or verify that it has already been faxed to us by your primary care physician.
- **Co-pay** or **Deductible** is collected at check in
- **Cosmetic procedure fees** are due at time of visit
- **Completed Patient Registration Package**
- **Parent or Legal Guardian must accompany patients who are minors**

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PATIENT INFORMATION

Last Name: _____ PCP/Family Doctor: _____

First Name: _____ MI:_____ Patient Date of Birth: _____ ❑ Male ❑ Female

Nick Name: _____ Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Legally Separated

Mailing Address: _____ Patient Social Security Number: _____

City: _____State: _____ Zip: _____ ***How did you hear about our office?*** _____

Preferred Phone: (_____)_____ ❑ Cell ❑ Home ❑ Work ❑ Other _____

How do you prefer to receive appointment reminders: ❑ Text ❑ Email

Alternate Phone: (_____)_____ ❑ Cell ❑ Home ❑ Work ❑ Other _____

Email: _____

EMERGENCY CONTACT: ***Name*** _____ ***Phone:*** _____

SEND PATIENT STATEMENTS TO: Name: _____
(**IF** different from patient)

Address:_____

INSURANCE INFORMATION ❑ Self-pay / Prompt-pay (no insurance coverage)

Primary
Insurance: _____

Member ID # _____

Group # _____

Policy Holder
Patient (if not patient, complete information below)

❑ Name:_____

DOB: _____ Relation: _____

SS #: _____

Address: _____
(if different from patient's)

City: _____State: _____ Zip: _____

Secondary
Insurance: _____

Member ID # _____

Group # _____

Policy Holder:
Patient (if not patient, complete information below)

❑ Name:_____

DOB: _____ Relation: _____

SS #: _____

Address: _____
(if different from patient's)

City: _____ State: _____ Zip: _____

Does your insurance plan require you to have a referral to see a specialist? ❑ Yes ❑ No
NOTE: *It is the patient's responsibility to get any required referrals.* Failure to do so may result in denied claims and the patient will be responsible for all services rendered.

IMPORTANT - WE ARE NOT CONTRACTED WITH ANY WORKER'S COMP OR MEDICAID PLANS.

CMS QUALITY REPORTING INFORMATION: My preferred language is: ❑ English ❑ Spanish ❑ Other _____

Race (optional): ❑ White ❑ Black/African American ❑ Asian ❑ Hispanic ❑ American Indian/Alaskan Native ❑ Native Hawaiian

Medical History: **Do you have any of the following: :** ☐ **NONE** if **YES**, please specify:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Organ Transplant
- ☐ Benign Prostatic Hypertrophy
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Dementia
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Pacemaker
- ☐ Alzheimer
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Y or N Are you pregnant?
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other: _____
- ☐ Planning Pregnancy

Surgery / Hospitalization History: ☐ **NONE** If **YES**, please specify:

Type of Surgery:_____ Date:_____ Type of Surgery:_____ Date:_____

Type of Surgery:_____ Date:_____ Type of Surgery:_____ Date:_____

Do you require "pre-medication with antibiotics" before any surgical procedures or dental work? ☐ No ☐ Yes

Skin Disease History: ☐ **NONE** Do you use sunscreen on a daily basis? If **YES**, what is the SPF? _____

- ☐ Acne
- ☐ Dry Skin
- ☐ Precancerous Moles
- ☐ Actinic Keratoses
- ☐ Flaky or Itchy Scalp
- ☐ Skin Cancer, type:_____
- ☐ Asthma
- ☐ Hay Fever / Allergies
- ☐ Blistering Sunburns
- ☐ Poison Ivy
- ☐ Other_____

Has anyone in your immediate family had: ☐ **NONE** If **YES**, please indicate which family member:

- ☐ Skin cancer (squamous cell) _____
- ☐ Skin cancer (basal cell) _____
- ☐ Psoriasis _____
- ☐ Melanoma (pigment cell) _____
- ☐ Eczema _____

List any medications, herbal supplements, vitamins etc. along with the dosage information: ☐ **NONE**

Medication:_____ Dose:_____ Medication: _____Dose:_____
Medication:_____ Dose:_____ Medication: _____Dose:_____
Medication:_____ Dose:_____ Medication: _____Dose:_____

PHARMACY: _____ Address :_____
City:_____State:_____Zip:_____Tel:_____

Are you allergic to any medications / anesthetics / latex / or products? ☐ No If **YES**, please specify :

Allergic to: _____ Reaction: _____ Allergic to: _____ Reaction: _____
Allergic to: _____ Reaction: _____ Allergic to:_____ Reaction: _____

Social History: Please check all that apply:

Smoking status: ☐ Never ☐ Former ☐ Current Daily ☐ Current Occasional Do you use smokeless tobacco? ☐ Yes ☐ No
Drink alcoholic beverages? ☐ Yes ☐ No Have you traveled outside the US in the past 3 months? ☐ Yes ☐ No
If yes, Number of alcoholic drinks/ day?_____ Do you use recreational drugs? ☐ Yes ☐ No
Do you drive at night? ☐ Yes ☐ No Have you had a Pneumovax Vaccine ☐ Yes ☐ No Flu Vaccine ☐ Yes ☐ No
Do you drive in the day time? ☐ Yes ☐ No Do you have a living will? ☐ Yes ☐ No
How often do you exercise? ☐ Once a day ☐ A few times a week ☐ A few times a month ☐ Never
Do you drink caffeine? (coffee, tea, soda, energy drinks) ☐ Once a day ☐ Several times a day ☐ Never
Do you currently use a tanning bed? ☐ Yes ☐ No or have you ever used a tanning bed? ☐ Yes ☐ No

Have you RECENTLY had or do you CURRENTLY have any of the following? ☐ **NONE** If **YES**, please specify:

- ☐ Problems with bleeding
- ☐ Problem w/healing/scarring (keloid)
- ☐ Rash
- ☐ Itching
- ☐ Mole Changes
- ☐ Immunosuppression
- ☐ Sun Sensitivity
- ☐ Chest Pain
- ☐ Fever/Chills
- ☐ Night Sweats
- ☐ Weight Loss
- ☐ Fatigue/Tiredness
- ☐ Thyroid Problems
- ☐ Sore Throat
- ☐ Blurry Vision
- ☐ Abdominal Pain
- ☐ Stool Changes
- ☐ Other _____
- ☐ Urine Changes
- ☐ Joint Aches
- ☐ Muscle Weakness
- ☐ Neck Stiffness
- ☐ Headaches
- ☐ Anxiety
- ☐ Seizures
- ☐ Confusion
- ☐ Cough
- ☐ Short of Breath
- ☐ Wheezing
- ☐ Depression

Your occupation: _____ I have completed all the above information accurately to the best of my knowledge. I will notify the office if there are any changes to my information.

Patient's Name: _____ Reason for visit: _____

Signature: _____ Date: _____

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Name: _____ Date: _____

1. Are there any areas of your body that you wish to make improvements upon (please circle one)?

   Yes No

2. Do you have a concern with stubborn areas of fat? Circle area below:

   Abdomen Flanks (love handles) Other: _____

3. Please circle the skin concerns you have and then circle the severity of the symptom(s):

a.	Fine lines	Mild *	Moderate **	Severe ***
b.	Brown spots	Mild *	Moderate **	Severe ***
c.	Redness	Mild *	Moderate **	Severe ***
d.	Skin texture	Mild *	Moderate **	Severe ***
e.	Sun damage	Mild *	Moderate **	Severe ***
f.	Acne	Mild *	Moderate **	Severe ***

4. Have you ever had liposuction or a similar invasive procedure before? Yes No

5. Have you ever had a non-invasive body contouring procedure? Yes No

6. Please check if you have ever had or are interested in any of the following procedures:

	Have Had	Interested In
Botox	☐	☐
Facial Fillers	☐	☐
Facial / Chemical Peels	☐	☐
Laser Hair Removal	☐	☐

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No Show/Cancellation Policy

Missed appointments represent a cost to us and to other patients who could have been seen in the time allotted to you. Cancellations must be made 24 hours in advance of the scheduled appointment time. You will be billed a $25 no show fee for missed appointments or cancellations with less than 24 hour notice.

At the discretion of the clinic, patients who have multiple no-show appointments or cancellations with less than 24-hour required notice, may be discharged from further care and/or asked to pre-pay copays when scheduling future appointments.

By signing below, I understand that I have read and understand the No Show Cancellation policy and the fee attached.

Signature:_____ Date:_____

Patients MUST sign and date below before medical care can be rendered.
PATIENTS WHO ARE MINORS: Parents or legal guardians must sign for patients who are younger than eighteen. A parent or legal guardian must be present at all visits for any patient younger than 18.

Privacy Practices (HIPAA)
We use the contact information that you provide for appointment reminders and to contact you regarding your appointments and care. By signing below, I acknowledge that I have read and understand Compassion Dermatology's Notice of Privacy Practices, which is included in this packet, and on our website www.compassiondermatology.com.

Financial Policy
Payment is required for all services at the time they are rendered unless the patient is in an insurance plan with which we participate. We accept payment in the form of cash, check and most credit cards. You have been provided a copy of Compassion Dermatology's financial policy in this packet, and it can be found on our website at www.compassiondermatology.com. A 25.00 fee will be assessed for each returned check.

I have read and understand the financial policy statement. I agree to make in-full prompt payment to Compassion Dermatology when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered. Further, I authorize payment directly to Compassion Dermatology for medical insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed for my treatments.

Patient Name: _____Date_____

Patient or Guardian Signature:
(if patient is younger than 18) _____Date_____

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ASSIGNMENT OF INSURANCE BENEFITS AND MEDICAL INFORMATION RELEASE AUTHORIZATION

Insurance Benefits: I authorize the release of information necessary to process any claim. I certify the information I supply is true and correct to the best of my knowledge. I authorize payment of medical benefits to be made on my behalf to Compassion Dermatology. I authorize photocopies of this form to be valid as the original.

Consent to treat: I authorize medical procedures to be performed on the patient named below at the direction of the physician(s) of Compassion Dermatology.

RELEASE OF MEDICAL INFORMATION

I authorize Compassion Dermatology to release medical information (including chart notes, lab results, pathology results) to my primary care physician and/or specific healthcare providers requesting such information in regards to my healthcare.

I also authorize my physician to release confidential medical information, on my behalf to my insurance carriers and their employees in order to evaluate my insurance, reimbursement, and coverage for office visits and treatment and also may contact my employer and/or medical provider(s), to complete my request for payment.

I assert that I am a legal adult of 18 years of age or older and that if I am signing for a minor I am a legal guardian of the identified minor. I authorize Compassion Dermatology to release medical information over the telephone to the following:

Myself Only: _____ OR

Other (List each person you wish information to be released):

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Medical information and financial information may be left on a voice mail on the following phone number:

Phone #: _____

I acknowledge that I have read and agree to be bound by the terms and office policies stated above in areas of the Assignment of Insurance Benefits and Medical Information Release Authorization. The duration of this authorization is indefinite or until it is revoked in writing.

NOTICE OF PRIVACY PRACTICES

_____ _____

Patient signature: (or legal guardian of patient) Date:

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Notice of Privacy Practices

This Notice describes how we may use and disclose your protected health information to provide treatment, obtain payment and conduct health care operations and for other purposes permitted or required by law. It also describes your rights concerning your protected health information. "Protected health information" is information about you, including demographic information that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to follow the practices described in this Notice. We may change the terms of this Notice at any time. The new Notice will be effective for all protected health information we maintain at that time including health information we created or received before we made the changes.

You may obtain a copy of our Notice of Privacy Practices at any time by calling our office or requesting one at your next appointment.

Uses and Disclosures of Health Information

Treatment: We will use and disclose your health information to provide, coordinate and manage health care and related services for you. For example we will disclose information to a specialist to whom you have been referred to ensure the provider has enough information to diagnose and/or treat you. We may also disclose information to a laboratory that, at our request, becomes involved in your treatment.

Payment: We may use and disclose your information to obtain payment for services we provided to you. For example we will send the necessary information to your health or dental insurance company to obtain payment for the treatment provided.

Healthcare Operations: We will use and disclose your health information to conduct the business activities of this office. These activities include, but are not limited to, quality assessment and improvement activities, review of the performance and qualifications of employees, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.

We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to begin your treatment. Prior to your appointment, we may call or send a postcard to remind you of the appointment. We may leave a message on your voice mail or with another member of the household.

We will share your protected health information with business associates that perform specific functions for our practice such as billing. When a business arrangement of this type requires the use of your information, we will have a written contract with the third party to protect the privacy of your protected health information.

Others Involved in Your Health Care: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree. If we determine it is in your best interest based on our professional judgment or experience with common practices, we may allow another person to pick up filled prescriptions, medical supplies, x-rays or other forms of health information.

We may use or disclose protected health information to notify or assist in notifying a family member, a personal representative or any other person responsible for your care or your location, your general condition or death. If you are present prior to the use or disclosure of your protected health information, we will provide you with the opportunity to object to such uses or disclosures. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family members or others involved in your health care.

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Emergencies: In the event of your incapacity or in emergency circumstances, we may use or disclose your protected health information to treat you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that an action has already been taken in reliance on the authorization.

Required By Law: We may use or disclose your protected health information to the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

We must make disclosures to you and, when required, to the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule, Section 164.500 et. seq.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. Additionally, we may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect.

In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws. Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Military Activity and National Security: When the appropriate conditions apply, we may disclose, to military authorities, protected health information of individuals who are Armed Forces personnel. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: we may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

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Your Rights

- Your rights with respect to your protected health information and how you may exercise those rights are outlined below.
- You have a right to obtain a copy and/or inspect your health information: Health information includes treatment records, billing records and any other records used by us to make decision about your treatment. You may obtain a form from our office to request access. A reasonable cost-based fee will be charged for expenses such as staff time, copies and postage. Contact us as indicated at the end of this Notice to obtain information about our fees or if you have any questions about your access.
- You have a right to request a restriction on the use and disclosure of your protected health information: You may ask us not to use or disclose some part of your protected health information for the purposes of treatment, payment or operations. You may also request that we not disclose some part of your information to family and others who may be involved in your care or for notification purposes as otherwise described in this Notice. We are not required to agree to the restrictions but if we do, we are obligated to abide by the agreement except in cases of emergency. You may request a restriction by sending your request in writing to our Privacy Contact.
- You have a right to request to receive confidential communications by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.
- You may have the right to request an amendment to your protected health information. You may request that we amend protected health information about you.
- Your request must be in writing with an explanation as to why the information should be amended. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures made by our Business Associates or us. It excludes disclosures for treatment, payment or healthcare operations as described in this Notice of Privacy Practices, to you, to family members or friends involved in your care, for notification purposes or as a result of an authorization signed by you. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003 for up to the previous 6 years. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. If you request an accounting more than once in a 12 month period, we will charge you a reasonable cost-based fee for responding to the additional request.
- You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Questions and Complaints

If you have any questions, concerns or want more information about our privacy practices please contact us using the information below. If you are concerned that we may have violated your privacy rights or you disagree with a decision we have made regarding your access to your health information or any other request you have made in the exercise of your rights, you may send your complaint to us using the information below. You may also submit a written complaint to the Secretary of Health and Human Services. Contact us for the address of the Department of Health and Human Services.

Contact our office:
Compassion Dermatology
3065 W. Southlake Blvd. Ste. 140
Southlake, TX. 76092
(817) 380-5911

We support your right to the privacy of your health information and we will not retaliate against you in any way for filing a complaint. **Please note: You may revoke this agreement, by writing, at any time.**

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FINANCIAL POLICY STATEMENT

Understanding your financial responsibility is an essential component in establishing and maintaining a strong patient/practice relationship. In order to achieve this, we offer the following information regarding our insurance and financial policies.

Your insurance is a contract between your insurer and you. It is your responsibility to know and understand the terms, guidelines and limitations of your plan. It is also your responsibility to advise us of any changes in your insurance, your address or your employer. Please verify, with your insurance company that Holly DeBuys, M.D. is an "in network provider" for your insurance

Medicare & Contracted Insurance Plans
If you are on traditional Medicare or are a member of a health plan that we participate with, we will submit your claim to your insurance company. Our staff will verify your benefits and collect any copayment, co-insurance, and deductible at the time of service, as required by your insurance carrier.

You will be billed in full for any services that your health plan considers a non-covered service.

Secondary/Supplemental Insurance Plans
We will file secondary and supplemental claims as a courtesy. In the case of non-contracted secondary carriers, the balance will become patient responsibility 30 days after that claim is filed.

Non-Contracted Commercial Insurance Plans
If we do not participate in your insurance plan, payment in full will be required at the time of service. You will receive an itemized statement, which you may then file with your insurance carrier. Please be aware that your out-of-pocket expenses may be higher when seeing an out-of-network provider.

Minors
A parent or legal guardian must accompany all patients under the age of 18 to authorize treatment and financial arrangements. If this is a custodial parent, we can submit the charges to another parent's insurance, however, the parent presenting the child for care will be billed for the balance not covered by the insurance. Any patient over the age of 18 will be held financially responsible for all charges incurred.

Missed Appointments
Missed appointments represent a cost to us and to other patients who could have been seen in the time allotted. Cancellations must be made 24 hours in advance of the scheduled appointment or we reserve the right to assess a fee.

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Medical Records
Copies of pathology reports are provided to you or another physician at no charge. Any additional medical records requests and/or completion of forms (e.g. disability, life insurance, cancer policies etc.) are subject to processing fees determined by state law and contractual agreements. Please be advised that medical records requests require time to be processed and cannot be provided the same day requested.

Pathology/Laboratory Fees
Compassion Dermatology sends biopsy specimens, and many tests, to outside laboratories for processing and interpretation. The laboratory will typically bill your insurance; however, you may receive a bill from the outside lab for any outstanding balance. We have no control over the laboratory billing. You must contact them directly regarding any bills. If your insurance policy only covers specific laboratories, please be sure to inform the office staff prior to the test being performed.

Cosmetic Services
Patients are financially responsible for all cosmetic procedures at the time of service. This office does not bill insurance companies for cosmetic procedures. All applicable cosmetic fees will be discussed prior to the initiation of treatment.