5320 N. Tarrant Parkway, Suite 200
Fort Worth, TX 76244
Phone: 817-427-3376 Fax: 817-427-3379

Patient Registration

Name: ____

Address: ____

City, State, Zip: ____

Date of birth: ________________ Age: _______ Sex: _______

Home Phone: ______________________________ Work Phone: _______________________________

Cell Phone: ____________________________ Email: ____

Driver's License: ________________________ Employer: ______________________________________

Name of Primary Doctor: ____

City, State, Phone # (of referring physician): ____

Emergency Contact: ____

Relationship to Patient: ___________________________ Phone: __________________________

How did you hear about us? ☐ Friend/Family Member ☐ Insurance Company ☐ ZocDoc ☐ Google

☐ Physician Referral ☐ Walk-in ☐ Website ☐ Mail ☐ Other: _________________________

Information of Guardian or Legal Representative, if Patient is a Minor

Name: ____

Address: ____

City, State, Zip: ____

Date of birth: ________________ Age: _______ Sex: _______ Social Security: ______________________

Home Phone: ______________________________ Work Phone: _______________________________

Cell Phone: ____________________________ Email: ____

Driver's License: ________________________ Employer: ______________________________________

Northstar Dermatology, PA
5320 N. Tarrant Parkway, Suite 200
Fort Worth, TX 76244
Phone: 817-427-3376 Fax: 817-427-3379

Privacy Policy

Our "Notice of Privacy Practices" provides information about how Northstar Dermatology may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. The Notice is available to you on our website at www.northstardermatology.com and at the front desk at your request. You may review the Notice before signing this consent. As a patient, you have the right to request restrictions on use and disclosure of your health information.

With your consent, Northstar Dermatology may call, mail, or email to your home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations such as appointment reminders, insurance items, and/or any information pertaining to your clinical care. By signing this form, you consent to our use and disclosure of protected health information about you for the purpose of treatment, coverage and payment from your Health Insurance Company, and overall health care operations.

If you change your mind after authorizing use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Telephone Communication: Please indicate if you would like for us to leave information regarding your care on your voicemail. Please *initial* by the option of your choice and include a designated phone number if you would like for us to leave a detailed message regarding your healthcare, including lab or pathology results.

_______ Leave a message with detailed information about my healthcare. Phone Number: ____________________________
_______ Leave a message with call-back number only.

Persons Authorized to Receive Information About Your Care: I authorize Northstar Dermatology to release medical, appointment, and/or financial information over the telephone or in person to the following person(s) (i.e. spouse, family member, etc.):

1. ____
Name **Relationship** **Telephone Number**

2. ____
Name **Relationship** **Telephone Number**

Signature of Patient or Legal Representative: ______________________________ Date: _______________

Name of Patient or Legal Representative: ____
(If Guardian or Legal Representative, please include relationship to patient)

Consent for Examination, Treatment and Financial Responsibility Agreement

I hereby consent to and authorize the physician(s) and employees at Northstar Dermatology to render care to me during my office visit(s). In consideration of services rendered or to be rendered, I assign and transfer to Northstar Dermatology any benefits payable to me or on my behalf under any insurance coverage or Medicare. I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I understand it is my responsibility to provide current up-to-date insurance information prior to treatment. I understand that I am financially responsible for services provided which are to be paid on the date of service. This includes copayments, deductibles and/or coinsurance with any managed care contract. I also acknowledge that the filing of an insurance claim(s) is not a guarantee of payment, and that I am financially responsible for payment if such claim(s) are unpaid or denied by the insurance company. I authorize the release of my medical information to my primary care physician, referring physician, and/or consultants as necessary to carry out treatment and to process insurance claims and/or prescriptions. I understand that photography may be necessary for planning and evaluating treatment, and hereby authorize taking photographs at the direction of the physician and/or delegate, solely for documentation purposes and recognize they will be kept confidential unless otherwise disclosed.

Signature of Patient or Legal Representative: ______________________________ Date: _______________

Name of Patient or Legal Representative: ____
(If Guardian or Legal Representative, please include relationship to patient)

Use of Email Communications Consent

At Northstar Dermatology, we are always striving to improve communication and prioritize convenience for our patients and use email for some forms of communication. It is important to note that this type of communication is not always secure. Northstar Dermatology cannot promise security and confidentiality when emailing and will not be responsible if emails are incorrectly shared and someone other than Northstar Dermatology is at fault. E-mail should not be used for emergencies. Northstar Dermatology cannot use or share your health information without your permission except by ways listed in Northstar Dermatology Notice of Privacy Practices. These emails become a part of your medical record.

During an email transmission, it may be intercepted, read and/or forwarded by someone without your permission. Information that is particularly sensitive to you should not be sent by you via e-mail. This office is not responsible if you let someone else see your emails. This office is not responsible for loss, delay or misdirect of emails. If you do not receive a response to an email, you are responsible for calling this office to follow up.

This office can change the terms of, or stop emailing you at any time. You will be told if this happens.
By signing below, you are acknowledging your understanding of the email policy and that we may send medical related correspondence and newsletter to you via email, and that we may respond to your emails to us via email.

I acknowledge that I have read the above and hereby give my consent to receive communications and updates from Northstar Dermatology.

Signature of Patient of Legal Representative: ____ Date: _______________________

Name of Patient or Legal Representative: ____
(If Guardian or Legal Representative, please include relationship to patient)

Electronic Device Usage

1. In observance of the confidentiality rights of other patients and out of respect for the privacy of our employees and physicians, the use of cameras or other video-capable recording devices are strictly prohibited within the premises of Northstar Dermatology. Photo, video or audio recordings in the office are strictly prohibited.
2. Patients are asked to please turn off cell phones or place them on silent while in the exam rooms. Patients that take calls while in the exam rooms with an employee/physician of Northstar Dermatology may need to reschedule their appointment for a later date.

Signature of Patient of Legal Representative: ____ Date: _______________________

Name of Patient or Legal Representative: ____
(If Guardian or Legal Representative, please include relationship to patient)

Phone Message Consent: As our policy in delivery complete patient care, we make every attempt to notify you of all pathology and lab results, as well as other detail pertaining to your care. Please indicate that you authorize us to:

- Leave a detailed message on voicemail/answering machine. YES ______ NO ______ (INITIAL)
- Leave a message with individual answering the phone. YES ______ NO ______ (INITIAL)
- Leave a detailed message with only the following individuals: ____

Phone # for Results: ____

Northstar Dermatology, PA
5320 N. Tarrant Parkway, Suite 200
Fort Worth, TX 76244
Phone: 817-427-3376 Fax: 817-427-3379

Office Policies & Patient Responsibilities

Updated on: February 1, 2012

Thank you for choosing Northstar Dermatology for your skin care needs. It is our goal to provide you with a positive experience. Over the past few years, the practice of medicine has become more complicated for physicians and patients alike.

Because of the growing complexity of the insurance business, we feel that we can no longer assume that patients fully understand the relationship between the insurance company, the physician, and themselves. In an effort to clarify this relationship, we have established a set of guidelines regarding financial responsibility and office policies.

We will file your insurance for you if we are in your network.

- It is your responsibility to verify if a provider/physician is in your insurance network prior to your visit. If we have a contract with your plan, we will file a claim with your insurance company. If your insurance plan is not in network or not contracted with our practice, the total cost of your visit will be your responsibility.
- With some plans, you may be required to see a Primary Care Physician (PCP) in order to see a dermatologist or other specialist. If your plan requires authorization by a PCP, you must obtain a referral prior to your visit. If a referral is not obtained by the time or your visit, you may be responsible for the total cost of the visit.
- It is your responsibility to understand your insurance plan coverage. If you do not understand your policy, you may wish to contact the number on the back of your card to review and verify your benefits. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services or diagnosis codes which they will not cover. Our office never guarantees that your insurance will pay. We will make every attempt to file your claim as straightforward and simple as possible. However, if for any reason your claim is denied, you are responsible for the amount due on your account.

A valid Picture ID and your Insurance Card are required at the time of your office visit

- If we do not receive your insurance card before you see the doctor, that visit becomes fee for service and full payment will be due at the time of service.
- It is your responsibility to notify the staff of any changes in your address, phone number and/or insurance plan, and provide a current up-to-date insurance card at each visit. Failure to do so may cause your insurance claim to be rejected, thus making it your responsibility to pay for the total cost of the visit.

Copayments, Deductibles and Co-Insurance

- A copayment is a set dollar amount you owe for each office visit. All claims are subject to a deductible if a procedure is performed (i.e. biopsy, cryosurgery, excisions, etc.). A deductible is the amount you are obligated to pay before your insurance company starts paying for your healthcare costs. Some insurance plans may also have a coinsurance, in which you may be responsible for a percentage of healthcare costs in addition to your copay or deductible. It is your responsibility to understand your plan and any associated deductible or coinsurance. Payment will be due at time of service if your deductible has not been met or if your plan requires a coinsurance payment. You may be billed for this amount should your insurance company notify us that additional payment is due from you.

We are not providers for Medicaid

- We are not providers for Medicaid and will only accept Medicaid patients as self-pay. We will not file any claims to Medicaid as primary or secondary insurance.

Not Medically Necessary or Cosmetic Procedures

- Your insurance company may deem certain procedures as not medically necessary, or cosmetic. If you and your doctor decide to continue with a procedure that falls into this category, we require payment in full at the time of service. The following are some examples:
- Removal of benign lesions (i.e. skin tags, angiomas, sun spots or liver spots, cysts, milia, sebaceous hyperplasia, or seborrheic keratoses, etc.…)
- Botox, Fillers, Chemical Peels, Scar Revisions, Cosmetic Consults or Procedures
- The cost of any procedure will be a separate fee from an office visit or consultation fee.

Laboratory and Pathology Fees

- Many times, it may be necessary to obtain a tissue sample (biopsy) or perform lab tests to confirm a diagnosis or determine a course of treatment. If a biopsy or other lab work is done, there is a separate fee for processing and interpretation of the biopsy and/or lab work. **This means that you will receive a separate bill from another doctor or laboratory for these tests.** We will attempt to use a lab which files directly with your insurance carrier. Although the lab will file with your insurance, you are responsible for any bill you may receive from the laboratory or pathology services used. If you receive a bill from the lab, please contact the lab directly to resolve any billing concerns.

Medical Record Copies

- There is a $20 flat fee for medical record copies up to 100 pages. There is an additional $20 fee for each additional 100-page increment (any number of pages up to 100).

Missed Appointments, Late Cancellations, & Non-Compliance

- Please keep in mind that appointments are time-slots reserved specifically for you. We require a 24-hour advance notice if you are unable to keep your scheduled appointment. As a courtesy, we offer appointment reminder calls which will allow you to cancel or reschedule at that time. However, it is ultimately your responsibility to keep track of your appointments whether you receive a reminder call or not.
- If you miss an appointment without a 24-hour notice or cancel/reschedule on the same day of your appointment, a fee up to $50 may be incurred to your account. This fee is not billable to your insurance.
- If you are more than 15 minutes late, your appointment may be cancelled and you will need to reschedule. We encourage new patients to show up 15 minutes early to complete their registration.
- Patients with repeat cancellations or missed appointments may be discharged from our practice.
- Please note that noncompliance with treatment plans (including medications and/or lab work) and abusive/inappropriate behavior towards staff and/or other patients will result in dismissal of your care from our practice.

Forms of Payment

- For your convenience, we accept cash, personal checks, MasterCard, Discover, and Visa.
- There is a $40 fee for all returned checks.

Collection Efforts

- We will send you three statements regarding your balance. The second statement is considered past due. If you should receive a third statement noted “Final”, the account balance will be turned over to a collection agency. The collection agency will add up to 35% to any balance turned over to them.

I have read and understand the above, and agree to comply with the financial policies of Northstar Dermatology. My signature authorizes this office to file my claims and assigns to this office all rights to my medical reimbursement benefits under my insurance policy. I understand that my signature also allows this office to release information regarding my visits to my insurance carrier. I understand that I am responsible for my bills in the event the insurance company denies any claims.

Signature of Patient/Legal Representative: ____________________________________ Date: _________________

Name of Patient/Legal Representative: ____

(If Guardian or Legal Representative, please include relationship to patient)

Missed Appointment Policy

(Updated 01/28/2017)

We require 24-hour advanced notice if you are unable to keep a scheduled appointment. It is our policy that a **single** missed appointment will *without exception* require a **$50 deposit** to book any future appointments.

Our reasoning: Unfortunately, we can only accommodate so many patients in a day, and demand to see a physician on an urgent or timely basis is high. Appointments are time slots specifically reserved for you. A missed appointment takes time that may have been otherwise dedicated to another patient requiring urgent care.

Initials: _____________

Medication Compliance Policy

Under no circumstance will medications (antibiotics included) be refilled for missed or cancelled appointments. Missed office visits while on medications requiring monitoring may lead to discontinuation of the medication and dismissal from the practice.

Our reasoning: Medications, no matter how seemingly harmless, have the potential for serious side effects. As such, it is sound medical practice to monitor patients while on these medications.

Initials: _____________

Patient Name: ____ **Date of Birth**: _______________

Pharmacy (including address or intersection): ____

____

Reason for today's visit:

____

____

Do we have the pleasure of seeing any family members? ____

Past Medical History: (please answer all questions)

	No	Yes
Eczema		
Skin Cancer		
Other Cancer		
Artificial Joints		
Artificial Heart Valves		
Mitral Valve Prolapse		
Pacemaker/Defibrillator		
Heart Disease		
High Blood Pressure		
Bleeding Tendency		
Keloids or Excessive Scarring		
Diabetes		
Thyroid Disorder		
Asthma		

	No	Yes
Tuberculosis		
Arthritis		
Lupus Erythematosus		
Chronic Pain		
Nervous or Mental Problems		
Seizures		
Liver Disorder(s)		
Hepatitis B		
Hepatitis C		
Kidney Disorder(s)		
Lung Problem(s)		
Organ Transplant		
HIV (AIDS)		
Other		

History of Skin Cancer:

	No	Yes	Location
Basal Cell Carcinoma			
Squamous Cell Carcinoma			
Malignant Melanoma			
Other			

Family History:

	No	Yes	Family Member
Eczema			
Psoriasis			
Melanoma			
Unknown – Adopted			

Social History:

	No	Yes	How Often/How Much? (Socially, Daily, etc.)
Do you consume alcohol?			
Do you smoke?			
Do you chew tobacco?			
Do you use any sun protection?			

Allergies: (if none, please write "none")

Allergy	What kind of Reaction?	Notes

Patient Current Medications: (if none, please write "none")

Drug	Dosage	Start Date

Review of Systems:

	No	Yes
Weight Loss		
Night Sweats		
Rash/Itching		
Sun Sensitivity		
Joint Pain		
Headache		
Abdominal Pain		
Depression		
Stress/Anxiety		
Bruising		
Swollen Lymph Nodes		

Women:

	No	Yes
Are you pregnant?		
Trying to get pregnant?		
Are you nursing?		