Patient Health History Form

PATIENT INFORMATION

Patients Legal Name: _____

Name that child likes to be called (Nickname):_____

DOB: _____ **Current Age:** _____

SOURCES OF INFORMATION

Name of Person Providing Information: _____

Relationship to child: _____

Best Phone # parent may be reached during the day:

_____

Primary/Preferred Language: ☐ ENGLISH ☐ SPANISH ☐ OTHER: _____

CHIEF COMPLAINT: *Please be as specific as possible*

Reason(s) for today's visit: _____

_____

_____

HISTORY OF PRESENT ILLNESS AND REVIEW OF SYSTEMS

Is your child having any of the following problems **TODAY**?

Itching	No___/ Yes ___	
Blisters	No___/ Yes ___	
Fever	No___/ Yes ___	
Hair Loss	No___/ Yes ___	
Sores	No___/ Yes ___	
Warts	No___/ Yes ___	
Pain/ Tenderness	No___/ Yes ___	
Birthmarks	No___/ Yes ___	
Eye/ Ear symptoms	No___/ Yes ___	
Nose/ Throat Symptoms	No___/ Yes ___	
Weight Gain	No___/ Yes ___	
Weight Loss	No___/ Yes ___	
Headaches	No___/ Yes ___	
Fatigue	No___/ Yes ___	
Nausea/ Vomiting	No___/ Yes ___	
Diarrhea	No___/ Yes ___	
Abdominal Pain	No___/ Yes ___	
Swollen Lymph Nodes	No___/ Yes ___	
Changes in Vision	No___/ Yes ___	
Cough	No___/ Yes ___	
Shortness of Breath	No___/ Yes ___	
Pain/ Difficulty Urinating	No___/ Yes ___	
Depression/ Anxiety	No___/ Yes ___	

PAST HISTORY

Are immunizations UP TO DATE? No___/ Yes ___

Is your child allergic to any medications or to LATEX? No___/ Yes ___

If yes, please List: _____

_____

Does your child have a genetic condition or syndrome? *If yes, please list:*

_____

_____

****REFERRED BY:** Doctor _____

PAST MEDICAL AND SOCIAL HISTORY

Has child ever been hospitalized or had any serious illnesses or injuries?
If yes, *please list*: _____

Has your child ever had any operations? If yes, *please list:* _____

_____

Does child have an artificial heart valve or require antibiotics before dental work or other procedures? No__/ Yes ___

***Adolescents**: **Is your child sexually active?** No__/ Yes ___

Does your child smoke/use alcohol? No__/ Yes ___

*** Female Patients: Has she started menstrual cycles?** No__/ Yes ___

If menstruating: When was last cycle _____

Is there any chance she could be pregnant? No___/ Yes ___

PATIENT MEDICAL HISTORY

Check the appropriate box that applies to the ***PATIENT*** or ***IMMEDIATE*** family members that have or have had any of the following conditions:

CONDITION	CHILD	FAMILY
Arthritis	☐	☐
Acne	☐	☐
Blood Disorder	☐	☐
Asthma	☐	☐
Cancer or Leukemia	☐	☐
Liver Disease	☐	☐
Diabetes	☐	☐
Eczema	☐	☐
Heart Disease	☐	☐
Hepatitis	☐	☐
High Blood Pressure	☐	☐
HIV/AIDS	☐	☐
Immune Suppression	☐	☐
Kidney Disease	☐	☐
Melanoma	☐	☐
Non-Melanoma Skin Cancer	☐	☐
Pneumonia	☐	☐
Organ Transplant	☐	☐
Psoriasis	☐	☐
Seasonal Allergies	☐	☐
Seizures	☐	☐
Psychiatric Problems/Depression	☐	☐
Stroke	☐	☐
Thyroid Disease	☐	☐

Do any other skin disorders run in the family? No__/ Yes___

If yes, please List: _____

_____

MEDICATIONS

Is your child taking any medications: No___/ Yes ___

If yes, please List: **(include topical creams or herbal medications)**:

_____

_____

_____

Pediatric Dermatology OF DALLAS

TODAY'S DATE: _____

Patient Demographics Form

Please complete the following information:

PATIENT'S INFORMATION

PATIENT'S NAME_____
Last First Middle

PRIMARY ADDRESS_____
Street Apt City State Zip Code

DATE OF BIRTH _____/_____/_____ AGE _____ MALE_____ FEMALE _____ E-MAIL: _____

PARENT'S INFORMATION

Child ***PRIMARILY*** lives with? **____ Both Parents ____ Mother ____ Father ____ other _____**

Parent's Marital Status: ___ Divorced____ Married ____Single ____Separated

Who is legally/court appointed to make medical decisions? _____

GIVE BOTH PARENTS INFORMATION – INSURED FIRST:

Insured Parent Name: _____	**Other Parent Name**: _____
Insured Parent DOB: _____	Other Parent DOB: _____
Insured Parent Phone #: _____	Other Parent Phone #:_____
Insured Parent Employer: _____	Other Parent Employer: _____
Insured Parent Occupation: _____	Other Parent Occupation: _____

EMERGENCY CONTACT: _____**PHONE**_____
Name & Relationship to patient

PATIENT'S PRIMARY CARE DOCTOR_____
Name **City/State** **Phone**

Which Doctor referred you to our office? _____

PHARMACY NAME: _____ PHARMACY PHONE #: _____

Consent for Care: I give permission for the following people to bring my child to his/her appointments.
(Responsible for medical decisions and payment at the time of visit)

_____ _____
_____ _____

***In case of emergency, parent can be reached at _____.**

I hereby state that the above information is current and correct, and authorize the release of any information required to complete this or any future claim and also authorize payment of medical benefits to me, for professional services to K. Robin Carder, MD of Pediatric Dermatology of Dallas, PA. I further authorize a copy of this authorization to be used in place of the original.

BY SIGNING BELOW, I AGREE TO PAY ALL EXPENSES REGARDLESS OF INSURANCE RESPONSIBILITY.

_____
Signature Date

Office Policy

Please read completely

Your medical insurance is designed to assist you, the policyholder, with your medical fees. However, few policies provide complete coverage. Payment of our fee is your responsibility and is due in full at the time of service. As a courtesy to you, we will file insurance for medical care with the following understanding:

1. Patient agrees to pay any portion of our fee that the insurance company will not cover. This would include deductibles, uncovered expenses and co-payment. ***It is the patient's responsibility to ensure that all necessary referrals/authorizations are obtained for medical care.** If these are not obtained, the patient is responsible for all charges.

2. **As a courtesy to you,** we will file your claim(s) with the sufficient information given. If for any reason, you are unable to provide us the insurance within a timely manner with all necessary and correct information, you will be billed for the services rendered to you. It is the patient's responsibility to provide the office correct/current information.

3. **Patient agrees to monitor his or her own claims** filed with the insurance company, by calling and checking the status of claims until the claim has been paid.

4. **Assignment of benefits is accepted for a period of 60 days** from the date our office submits the initial claim to your carrier. Should your insurance company fail to provide benefits within this period of time; your remaining balance will become due and payable. If payment is not received within a timely manner your account could be turned over for collection with possible interest and collection fees added to your balance due. If payment arrangements are needed, please call the office immediately so that we may assist you and avoid in further action.

5. **Certain medical conditions such as: scars, hair loss, skin tags** may be considered ***COSMETIC*** by your insurance plan and may **NOT** be covered by you insurance carrier and evaluation/treatment of these conditions **MAY NOT BE COVERED**.

6. **E-MAILS**: To protect your privacy, our office does **NOT** accept medical questions, photos, appointments or refill requests via email. Our e-mail is **NOT** encrypted **(NOT SECURED).**

7. **A returned check fee of $35.00 will be posted to your account and may be turned over for collection.**

8. **NO SHOW/LATE CANCELLATION**: We understand that appointments may need to be rescheduled on occasion due to emergency or illness, however our office requires **24 hour notice *(1 FULL BUISNESS DAY PRIOR)*** of cancellation. If an appointment is not kept, or is not cancelled 24 hours prior to the scheduled appointment time ***(regardless of reason)***, you will be subject to a **$50 fee**. ****NOTE: Monday appointments MUST call to cancel/reschedule by the preceding Friday to avoid fee.***

9. **Some insurance plans consider procedure (including skin scrapings, wart or molluscum treatment) to be a surgery. *As such, these procedures may be subject to a separate deductible*.**

We appreciate the opportunity to participate in your care and hope this explanation of policy will eliminate any misunderstandings associated with your insurance benefits.

As the responsible party, I accept the terms of this insurance office policy and authorize payment of insurance benefits to the doctor in charge of my care.

Signature: _____ Date: _____

PATIENT HIPAA AUTHORIZATION FORM

Please read completely

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you acknowledge our use and disclosure of protected health information about you for treatment payment health care operations. You have the right to revoke this disclosure, in writing, signed by you. However such a revocation shall not affect any disclosures we have already made in reliance on your prior Acknowledgement. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient or their parent or guardian understands that:
Protected health information may be disclosed or used for treatment, payment or health care operations

- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this authorization in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Authorization.

I acknowledge that I have read the above authorization and have had access to read Pediatric Dermatology of Dallas' full Notice of Privacy Practices (upon request):

_____ _____

Printed Name-Patient or Representative | Relationship to patient

_____ _____/____/_____

Signature | Date

Email, text messaging and voice mail consents:

Email and text messaging allows health care providers to exchange information efficiently for the benefit of our patients. At the same time, we recognize that email and text messages are not a completely secure means of communication and that the information sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the internet. In addition, once the email is received by you, someone may be able to access your email account. As email is a very popular and convenient way to communicate, the federal government has provided HIPPA guidelines on email use. The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

Similarly, detailed voice mail messages allow clinicians to provide test results, medical and referral information to you in a timely manner but if the voice mail system is shared, the information could be heard by others.

If you would like us to send you email and/or text messages or leave detailed voice mails that contain your health information, please check the appropriate boxes and sign this consent below. You are not required to authorize the use of email, voice mail and/or text messaging. A decision not to sign this authorization will not affect your health care in any way. If you prefer not to authorize the use of email, voice mail and/or text messaging we will continue to use U.S. mail or telephone to communicate with you.

____ I understand the risks of unencrypted email and do hereby give permission to Pediatric Dermatology to send or receive personal health information via unencrypted email

____ I do not wish to send or receive personal health information via email

Please read and authorize the use of the following communication methods when communicating with me and my authorized individual (check all that apply)

_____ Email address that may be used to send information to you: _____

____ Phone number to send text messages to you: _____

____ Phone number for detailed voice mail to you: _____

Name of Patient: _____

Signature of Parent/Legal guardian: _____ Date _____

Relationship to Patient: _____

Telemedicine Informed Consent
Pediatric Dermatology of Dallas, PA

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting Pediatric Dermatology of Dallas, PA at 214-580-1011.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____ _____

Patient/Parent/Guardian Printed Name Patient/Parent/Guardian Signature

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Please Notice This

WARTS AND/OR MOLLUSCUM OFTEN REQUIRE MORE THAN ONE TREATMENT

TREATMENT OF WARTS AND/OR MOLLUSCUM BY "BEETLEJUICE" (CANTHARONE)/ FREEZING, ETC IS CONSIDERED AS AN IN OFFICE SURGICAL PROCEDURE BY MOST INSURANCE COMPANIES

THIS MEANS THE PROCEDURE COST MAY HAVE A COINSURANCE OR BE APPLIED TO YOUR DEDUCTIBLE. THIS AMOUNT WILL BE DUE AT THE TIME OF VISIT. WE HAVE A LIST OF INSURANCE ALLOWABLE COSTS AT THE FRONT DESK, AND CAN NOTIFY YOU OF THE COST PRIOR TO THE PROCEDURE.

FYI--THERE ARE PRESCRIPTION AND OVER THE COUNTER PRODUCTS AVAILABLE, IF YOU CHOOSE NOT TO HAVE AN IN-OFFICE TREATMENT DONE.

**Remember there are *no guarantees* when it comes to treating warts and/or molluscum. Multiple treatments may be needed.

PLEASE NOTIFY DR. CARDER WHICH OPTION YOU PREFER.

THANK YOU,

DR. CARDER'S STAFF