BLACKBURN WOOLFOLK DERMATOLOGY

8200 Brookriver Drive Suite N705, Dallas, TX 75247
Phone: 214-630-5256 Fax: 214-630-2251

PATIENT INFORMATION			
Date: / /			
First Name	**Last Name**	**Middle Initial**	
DOB: / /	**SSN#**	**Gender:** ☐ Male ☐ Female	
Street Address	**City**	**State**	**Zip**
Home Phone( )	**Cell Phone**( )	**Work Phone**( )	
Email Address: (We will never give out your email address or send personal medical information without permission)			
Name of Referring Physician (Primary Care)			
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed			

RESPONSIBLE PARTY (if different from patient e.g. Parent or Spouse)			
Date: / /			
First Name	**Last Name**	**Middle Initial**	
DOB: / /	**SSN#**	**Gender:** ☐ Male ☐ Female	
Street Address	**City**	**State**	**Zip**
Home Phone( )	**Cell Phone**( )	**Work Phone**( )	
Email Address: (We will never give out your email address or send personal medical information without permission)			

INSURANCE INFORMATION - PRIMARY			
Insurance Company Name:			
Name of Insured:	**DOB of Insured:** / /		
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Insured Employer Name:			
Insured Employer Address	**City**	**State**	**Zip**

INSURANCE INFORMATION - SECONDARY			
Insurance Company Name:			
Name of Insured:	**DOB of Insured:** / /		
Patient's Relationship to Insured:	☐ Self ☐ Spouse ☐ Child ☐ Other		
Insured Employer Name:			
Insured Employer Address	**City**	**State**	**Zip**

EMERGENCY CONTACT INFORMATION			
First Name	**Last Name**	**Relationship to Patient**	
Street Address	**City**	**State**	**Zip**
Day Phone ( )	**Evening Phone** ( )		

PHARMACY INFORMATION			
Pharmacy Name:			
Street Address	**City**	**State**	**Zip**
Phone ( )	**Fax** ( )		

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CONSENT FOR EXAMINATION, TREATMENT, RELEASE OF INFO AND ASSIGNMENT OF BENEFITS

I hereby consent to and authorize the providers and employees to provide medical care to the patient identified above. If appropriate, 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 also acknowledge that the filing of any 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 payment of medical benefits directly to Blackburn Woolfolk Dermatology, PLLC for services(s) provided to me. I understand I am ultimately responsible for payment of services rendered. I am at least 18 years of age, or if not, I am accompanied by a legal guardian. Delinquent accounts are subject to a collection fees, and reasonable attorney's fees.
If patient is a minor, I hereby consent that the Parent / Legal Guardian who brings in the minor child will be responsible for all copays and deductibles. I hereby affirm that I am the legal parent or guardian of patient and have authority to make decisions regarding medical treatment.

I authorize Blackburn Woolfolk Dermatology, PLLC to fax my records to any physician or pharmacy for the purpose of coordinating or managing my healthcare. I understand that photography may be necessary for planning and evaluating treatment, and hereby authorize the taking of photographs at the direction of the physician and/or delegate, solely for documentation purposes and recognize they will be kept confidential unless otherwise disclosed.

Responsible Party Signature:	Date / /

HIPAA PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how Blackburn Woolfolk Dermatology, PLLC 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.bwderm.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.

Disclosures of your health information or its use for any purpose other than those listed in our “Notice of Privacy Practices” and/or consent require your specific written authorization. If you change your mind after authorizing a 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.

Persons Authorized to Receive Information About Your Care:
I authorize Blackburn Woolfolk Dermatology, PLLC to release all information regarding my financial account, appointments, pathology results, treatment and/or other information pertinent to my healthcare provided by Blackburn Woolfolk Dermatology, PLLC over the telephone or in person to the following person(s) (i.e. spouse, family member, etc.):

Name of Person:	Relationship to Patient	Telephone Number

I do not authorize the following information to be disclosed to any other parties except to me as the patient. (Please specify):

COMMUNICATION

I authorize Blackburn Woolfolk Dermatology, PLLC to leave detailed messages in reference to any items that assist in carrying out healthcare operations including appointment reminders, biopsy results, and billing issues.

Home Phone: ☐ Yes ☐ No

Work Phone: ☐ Yes ☐ No

Cell Phone: ☐ Yes ☐ No

By signing this form, you acknowledge that you have read and understand our Notice of Privacy Practices and 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. You have the right to revoke this consent in writing with your signature.

Patient/Legal Representative Signature	Date / /

Printed Name of Patient/Legal Representative

Signature of Staff Member:	Date / /

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History and Intake Form

PATIENT INFORMATION		
Date:		**Account Number:**
First Name	**Last Name**	**Middle Initial**
Email:		
Race/Ethnicity: ☐ American Indian or Alaska Native ☐ Asian ☐ Black ☐ Hispanic or Latino ☐ Native Hawaiian and Other Pacific Islander ☐ White ☐ Other_____		
Preferred Language ☐ **English** ☐ **Spanish** ☐ **Other** _____		

Past Medical History: (Please check all that apply)		
☐ Anxiety	☐ Depression	☐ Thyroid Problems
☐ Arthritis	☐ Diabetes	☐ Leukemia
☐ Asthma	☐ End Stage Renal Disease	☐ Lung Cancer
☐ Atrial fibrillation	☐ GERD	☐ Lymphoma
☐ Bone Marrow Transplantation	☐ Hearing Loss	☐ Prostate Cancer
☐ Breast Cancer	☐ Hepatitis	☐ Radiation Treatment
☐ Colon Cancer	☐ High Blood pressure	☐ Seizures
☐ COPD	☐ HIV/AIDS	☐ Stroke
☐ Coronary Artery Disease	☐ High Cholesterol	☐ NONE
☐ Other _____		

Past Surgical History: (Please check all that apply)		
☐ Appendix Removed	☐ Coronary Artery Bypass	☐ Ovaries Removed: Endometriosis
☐ Bladder Removed	☐ Mechanical Valve Replacement	☐ Ovaries Removed: Cyst
☐ Mastectomy (Right, Left, Bilateral)	☐ Biological Valve Replacement	☐ Ovaries Removed: Ovarian Cancer
☐ Lumpectomy (Right, Left, Bilateral)	☐ Heart Transplant	☐ Prostate Removed: Prostate Cancer
☐ Breast Biopsy (Right, Left, Bilateral)	☐ Joint Replacement, Knee (Right, Left, Bilateral)	☐ Prostate Biopsy
☐ Breast Reduction	☐ Joint Replacement, Hip (Right, Left, Bilateral)	☐ TURP (Prostate Removal)
☐ Breast Implants	☐ Joint Replacement within last 2 years	☐ Spleen Removed
☐ Colectomy: Colon Cancer Resection	☐ Kidney Biopsy (Nephrectomy)	☐ Testicles Removed (Right, Left, Bilateral)
☐ Colectomy: Diverticulitis	☐ Kidney Removed (Right, Left)	☐ Hysterectomy: Fibroids
☐ Colectomy: IBD	☐ Kidney Stone Removal	☐ Hysterectomy: Uterine Cancer
☐ Gallbladder Removed	☐ Kidney Transplant	☐ NONE
☐ Other_____		

Skin Disease History: (Please check all that apply)		
☐ Acne	☐ Dry Skin	☐ Poison Ivy
☐ Actinic Keratoses	☐ Eczema	☐ Precancerous Moles
☐ Asthma	☐ Flaking or Itchy Scalp	☐ Psoriasis
☐ Basal Cell Skin Cancer	☐ Hay Fever/Allergies	☐ Squamous Cell Skin Cancer
☐ Blistering Sunburns	☐ Melanoma	☐ NONE
☐ Other _____		

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History and Intake Form

Pharmacy Name:	**Pharmacy Phone:**	**Pharmacy Zip:**

Do you wear sunscreen?	☐Yes	☐No
If yes, what SPF? _____		
Do you tan in a tanning salon?	☐Yes	☐No
Do you have a family history of Melanoma?	☐Yes	☐No
If yes, which relative(s)?		

Medications: (Please enter all current medications)		
Name	Dose	Strength

Allergies: (Please enter all allergies)		

Social History: (Please check all that apply)	
Cigarette Smoking:	**Alcohol Use:**
☐Currently Smokes	☐ETOH- None
☐Has smoked in the past	☐ETOH- less than 1 drink per day
☐Never smoked	☐ETOH-1-2 drinks per day
☐Former Smoker	☐ETOH-3 or more drinks per day
☐Other _____	

Family History (Only first degree relatives)	
Relation	**Medical Conditions**
Mother	
Father	
Brothers/Sisters	

Review of Systems: Are you currently experiencing any of the following? (Please check yes or no for the following)		
Problem with bleeding ☐ Yes ☐No	Unintentional weight loss ☐ Yes ☐No	Neck stiffness ☐ Yes ☐No
Problems with healing ☐ Yes ☐No	Thyroid problems ☐ Yes ☐No	Headaches ☐ Yes ☐No
Problems with scarring (hypertrophic or keloid) ☐ Yes ☐No		Sore throat ☐ Yes ☐No
Rash ☐ Yes ☐No	Blurry vision ☐ Yes ☐No	Seizures ☐ Yes ☐No
Immunosuppression ☐ Yes ☐No	Abdominal pain ☐ Yes ☐No	Cough ☐ Yes ☐No
Hay fever ☐ Yes ☐No	Bloody stool ☐ Yes ☐No	Shortness of breath ☐ Yes ☐No
Chest pain ☐ Yes ☐No	Bloody urine ☐ Yes ☐No	Wheezing ☐ Yes ☐No
Fever or chills ☐ Yes ☐No	Joint aches ☐ Yes ☐No	Anxiety ☐ Yes ☐No
Night sweats ☐ Yes ☐No	Muscle Weakness ☐ Yes ☐No	Depression ☐ Yes ☐No

ALERTS: (Please check all that apply)	
☐Allergy to Adhesive	☐Defibrillator
☐Allergy to lidocaine	☐MRSA
☐Allergy to topical antibiotics	☐Pacemaker
☐Artificial heart valve	☐Require antibiotics prior to a surgical procedure
☐Artificial joint replacement	☐Rapid heartbeat with epinephrine
☐Blood thinners	
Are you pregnant or currently trying to get pregnant? ☐ Yes ☐No	

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Office /Financial Policy

Thank you for choosing Blackburn Woolfolk Dermatology, PLLC to care for your dermatological needs. We are dedicated to providing the best care and service to you. Outlined below are our office/financial policy.

INSURANCE INFORMATION

Identification Requirements

Federal regulations require us to ensure the identity of anyone presenting medical insurance. You must present both valid government issued picture identification and insurance card.

Insurance Coverage

Each insurance contract is unique and it is your responsibility to understand your insurance policy. Please check with your insurance carrier to determine benefit restrictions you may have prior to your appointment. If you do not inform us of any special requirements in your plan and we perform a service/test that is denied, you will be held financially responsible.

Filing Your Insurance

We will file your insurance. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

PATIENT PAYMENT RESPONSIBILITITES

Types of Charges/ Payment Responsibility - PAYABLE AT TIME OF VISIT

Most insurance companies do not cover 100% of the cost of services and there is a portion that the patient is responsible for. Here are a few examples:

- **Co-Payment** – A set dollar amount per office visit the patient is responsible for paying
- **Co-Insurance** – A percentage of total charges the patient is responsible for paying
- **Deductible** – A set annual amount the patient is responsible for paying

Procedures Considered Cosmetic or not medically necessary by your Insurance Company - PAYABLE AT TIME OF VISIT

Your insurance company may deem certain procedures as not medically necessary, or cosmetic. If you and your doctor/provider 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** (skin tags, angiomas, liver spots, cysts, milia, sebaceous hyperplasia, or seborrheic keratoses, DPNs, etc.)
- **Some injections** & **earlobe repairs**
- **Acne surgery** - Insurance companies define "surgery" as any time the skin is pierced.
- **Cosmetic procedures** such as Botox and fillers, scar revisions, chemical peels, laser hair removal, etc.
  The cost of any procedure will be a separate fee from an office visit or consultation fee.

Medicare - PAYABLE AT TIME OF VISIT

Daneeque Woolfolk, MD FAAD and her physician assistants participate with Medicare. This means Medicare pays 80% of their allowed amount after you have paid your annual deductible. You are responsible for 20% of Medicare's allowed amount and your annual deductible. If we participate with your secondary coverage, we will send to your secondary insurance for co-insurance to be paid, otherwise **all co- payments, co-insurance, and deductibles must be paid at the time of service.**

Referrals – MAY BE PAYABLE AT TIME OF VISIT

If your insurance plan requires you use referrals for a specialist you must obtain a referral prior to scheduling your visit from your Primary Care Physician. If you do not have a referral in place for your visit, you will be required to reschedule your appointment or pay in full prior to being seen.

Payment Requirements

Your insurance contract requires us to collect payment from you for your portion of the balance. All co-payments, co-insurance and deductibles must be paid for in full at the time of service. We accept cash, credit cards, and checks/money orders with in-state ID.

Cash Patients - PAYABLE AT TIME OF VISIT

All uninsured patients are required to pay in full at the time of treatment.

Deposits- PAYABLE WHEN BOOKING APPOINTMENT

Surgical appointments require a $50.00 deposit which will be applied towards my co-insurance/ copayment at the time of my surgery. Cosmetic appointments require a $200 deposit or 50% of procedures less than $400 which will be applied towards the cost of the treatment at the time of the visit.

Failure to cancel or reschedule in 48-business hours may result in forfeiting the deposit**.**

Returned Checks- PAYABLE WITH STATEMENT

A $25 fee will be charged for any returned checks, and we will be unable to accept your checks for any services thereafter.

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GENERAL POLICIES AND INFORMATION

Billing Questions and Refunds
Ask for a billing representative to help you if you have questions regarding your account, insurance claim, or feel an error appears on your statement. Refund determinations are processed within 30 days of the request.

Receipts
You will be offered a receipt at each visit. It is your right to have a receipt for all services rendered during your visit. If we forget to offer you a receipt, kindly request one.

Record fees
All medical records, forms, letter, and duplicate receipts are available for a fee.

Minors
The parent(s) or guardian(s) of minor patients must accompany the child for the **initial evaluation** and sign an informed consent to treat the child. Future visits will be covered under this consent**. Unaccompanied minors must have payment arrangements made with the office prior to the visit**. The parent or guardian must provide current insurance information. In cases of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those charges. If the divorce decree requires the other parent to pay all or part of the costs, it is the authorizing parent's responsibility to collect from the other parent.

Policy on Electronic Devices
In observance of the confidentiality rights of other patients and out of respect for the privacy of our employees and providers, turn off your cell phone or place it on silent. Video or audio recordings in this office are strictly prohibited.

Prescription Refill Policy
Blackburn Woolfolk Dermatology requires that you be seen at least once a year in order to maintain any prescription given by our providers. For your safety, some conditions/medications require a visit prior to additional refills. Oral medications require an office visit and Blackburn Mixture requires a visit at least every 6 months.
Keep your follow-up appointments and plan ahead to avoid being without your medication. We do not give prescription extensions if you fail to keep your recommended visits. The Texas State Board of Medical Examiners prohibits physicians from prescribing for a condition for which they have not been consulted.

Missed Appointments, Late Cancellations and Deposits
Appointments are time-slots reserved specifically for you. Reminder text, email, and calls are provided as a courtesy at least 72 –hours in advance with options to cancel or reschedule your appointment.
We require 24-business hours advanced notice to cancel/ reschedule medical appointments.
We require 48-business hours advanced notice to cancel/ reschedule cosmetic and surgical appointments.

No Show Fee – effective 1/1/2018
We reserve the right to charge a fee of $50.00 for all missed appointments ("no shows") and appointments not cancelled with a 24-hour advance notice. "No Show" fees are billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment.

Failure to cancel or reschedule a cosmetic / surgical appointment may result in forfeiting your deposit on file.

Late Arrivals and Non-Compliance
When a patient arrives late, it is impossible to stay on schedule. If you arrive more than 15-minutes past your scheduled appointment time, you may be rescheduled so other patients are not inconvenienced.

Dismissed
We sincerely hope to have a long and mutually beneficial relationship with you. From time to time issues will arise that will cause our relationship to become strained. It is then that we feel it is best to part ways rather than to maintain an unpleasant relationship.

- Non-compliance with treatment plans
- Abusive/inappropriate behavior or language towards staff and/or patients
- 3 or more failures to cancel/ reschedule appointments in a timely manner

I have read and understand Blackburn Woolfolk Dermatology's Office/Financial Policy. I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Responsible Party Signature:	Date / /