Welcome to The Center for Dermatology and Cosmetic Laser Surgery!

Attached is our Patient Registration Package. Please complete these forms to help us maintain accurate contact and medical records. If you printed these forms from our website, you may fax them to us at 972-985-1176 prior to your appointment, or bring the completed original forms with you to your appointment along with the other items requested below.

We realize that you have a choice of where to be treated. We also understand and respect the great deal of trust in your physician. We want 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.

The Center for Dermatology specializes in the diagnosis and treatment of skin, hair and nail disease, as well as cosmetic laser treatments and surgeries. We provide our patients and their families with full-service, comprehensive dermatological care. We desire to assist you in receiving 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. Providing the best service, in a comfortable, private atmosphere is extremely important to us. We assure you, we will do our best to give you total satisfaction.

We value highly the relationship with our patients. We especially value patient feedback. Therefore, we will ask you to communicate to us your experiences at our practice. Your feedback matters because 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,

Bryan A. Selkin, MD

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REMINDERS OF REQUIRED ITEMS
FOR YOUR VISIT

- **Insurance Cards** If you have health insurance, we cannot see you without making a copy of your insurance card.
- **Written Referral** from your Primary Care Physician if required by your insurance plan.
- **Co-pay or Deductible** is collected at the time of visit
- **Cosmetic procedure fees** are due at time of visit
- **Completed Patient Registration Package**
Patients, or legal guardians of patients under the age of eighteen, MUST sign and date below before medical care can be rendered.

Release of Medical Information

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions electronically to your pharmacy.

Signature: _____________________________________________________ Date:______/______/______

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. For those patients, applicable co-payments and deductibles will be collected for services rendered. Once our office has received payment from your insurance, if for some reason insurance decides to pay your charges at a higher benefit level than what was quoted to our office at the time of service; we will then issue the patient a refund for the over payment amount or apply a credit on the account. In an effort to ensure the most accurate refund amount please be advised that our office cannot issue any refunds until all line items have been finalized by your insurance.

We accept payment in the form of cash, check, Visa and MasterCard. In the event that your account must be turned over to collections, a $25.00 collection fee will be added to your account. For appointments which are missed or cancelled with less than 24 hour notification, there may be a $25.00 missed appointment fee added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

I have read and understand the financial policy statement. I agree to make in-full prompt payment to Nicole Reed Medical Center for 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 Nicole Reed Medical Center for 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.

In addition to the above, if I am a Medicare patient, I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature: _____________________________________________________ Date:______/______/______

Privacy Practices (HIPAA)

I have been given the opportunity to review, understand and consent to this practice’s Notice of Privacy Practices as written. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

Signature: _____________________________________________________ Date:______/______/______
Center for Dermatology & Cosmetic Laser Surgery  
5044 Tennyson Parkway Suite B  
Plano, TX 75024  
Phone 972-985-9003  
Fax 972-985-1176  

PEDIATRIC PATIENT INFORMATION

Patient (Child) Name: ______________________________________

Guardian #1 Name: _______________________________________

Guardian #2 Name: _______________________________________

Home Address: ____________________________________________
(No PO boxes)

City: ____________________________
State: _____________ Zip Code: ______________________

Number for appointment reminders and test results: (______)___________

May we leave a message at this number?  
 Yes   No

Secondary Phone: (____)_________ Work Phone: (______)____________

Preferred Language:  
 English   Spanish   French   Italian

Date of Birth: ____________________________  
 Male   Female

Marital Status:  
 Single   Married   Divorced   Widowed  
 Legally Separated   Partner

Social Security Number: ____________________________

Race:  
 Native American   African American   Asian   White  
 Hispanic   Pacific Islander   Other   Unreported/Refused

Ethnicity:  
 Hispanic/Latino   Not Hispanic/Latino   Unreported/Refused

Primary Care Physician: _______________________________________  
(First and Last Name)

Phone number: (______)______________ City: __________________

Did a doctor’s office send you to us for a specific problem?  
 Yes   No

If YES, name of referring provider: _______________________________

Responsible Party, if different from patient information above:  
(statements will be addressed to the responsible party)

Name: _________________________________________________

Address: ____________________________________________

City: ____________________________
State: _____________ Zip Code: ______________________

Date of Birth: ____________________________  
 Male   Female

Phone: (______)___________  Email: ____________________________

Relationship to patient: ________________________________

Adult Emergency Contact:

Name: _________________________________________________

Address: ____________________________________________

City: ____________________________
State: _____________ Zip Code: ______________________

Phone: (_______)____________ Alt. Phone: (_______)____________

Relationship to patient: ________________________________

INSURANCE INFORMATION: If the patient is not the primary policy holder, the Responsible Party section above must be completed.

 Self Pay (no insurance)   Patient IS the policy holder   Patient IS NOT the policy holder

Primary Insurance Co.: ____________________________________
Policy Number _________________________

Secondary Insurance Co.: ____________________________________
Policy Number _________________________

Does your insurance plan require you to have a referral to see a specialist?  
 No   Yes   I don’t know

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.

SUBSCRIBER INFORMATION (REQUIRED if patient is not the primary insurance policy holder):

Name: _________________________________________________

Social Security #: ____________________________ Date of Birth:_______________

PHARMACY INFORMATION:

Name: _________________________________________________

Location (City and Intersection):______________________________

Phone: (_______)____________

By signing below, I authorize The Center for Dermatology and Cosmetic Laser Surgery, and whoever may be employed or assistant in administration to administer care as is deemed necessary.

Responsible Party Signature of Agreement ________________________________  Date _______________
Authorization to Leave a Voicemail
Please provide number(s) ONLY IF you approve us to leave DETAILED information related to the following, on your voicemail:

- Appointments
- Billing
- Test results, diagnosis, and procedures

Primary (______) __________________  Secondary (______) __________________

Authorization to Send an Email Message
Please provide an email address below ONLY IF you approve us to send DETAILED information related to the following to your email:

- Appointments
- Billing
- Test results, diagnosis, and procedures

Email address: _____________________________________

Personal Representative Authorization for Medical Release Form
Under HIPAA requirements, we are not allowed to discuss any of your health information with anyone else without your consent.

I authorize this facility to speak to the following family members or my personal representative regarding

- All medical information, including but not limited to: appointments, billing, test results, diagnosis, and procedures.
- Only the following types of information: _________________________________________
- Do not disclose any information on file other than to patient on record.

The above medical information shall only be released to the following person(s):

1. ___________________________ Relationship: __________________ Phone number: ___________________
2. ___________________________ Relationship: __________________ Phone number: ___________________
3. ___________________________ Relationship: __________________ Phone number: ___________________

Authorization to Send a Text Message
Please provide a number ONLY IF you approve us to leave DETAILED information related to appointments, billing, test results, diagnosis, and procedures in a text message. (_______)_____________________

By signing below I understand and agree to all stated and filled in above; I also understand my rights are protected by the Privacy Act (HIPAA) and that I may request a copy of this Act at any time. I have been given the opportunity to review, understand and consent to this practice’s Notice of Privacy Practices as written.

Name (PRINTED) _____________________________________

Signature __________________________________________

Date _______________________________________________
MEDICAL HISTORY

PATIENT NAME: ___________________________________

Race:  Native American   African American   Asian   White   Hispanic   Pacific Islander   Other   Unreported/Refused  

Preferred Language:   English   Spanish   French   Italian   Hispanic/Latino   Not Hispanic/Latino   Unreported/Refused

Ethnicity:   Hispanic/Latino   Not Hispanic/Latino   Unreported/Refused

Do you have or have you had any of the following? (if yes, please check)

 None
 Artificial heart valve
 Artificial joints or metal implant
 Atopic Dermatitis
 Atypical moles
 Autoimmune disease (lupus, rheumatoid arthritis)
 Bleeding disorder
 Blood clots
 Cold Sores/Herpes
 Depression
 Diabetes
 Heartburn/Reflux
 Hepatitis Type: __________
 HIV
 Keloids or scarring problems
 Kidney disease
 Liver disease or hepatitis
 Lung disease
 Psoriasis
 Seasonal allergies/asthma
 Skin Cancer (melanoma)
 Skin Cancer (basal/squamous cell carcinoma)
 Skin Pre-Cancers (actinic keratoses)
 Thyroid trouble
 Ulcers (stomach)
 Other conditions

Please list:  ___________________

Female patients (check all that apply):  I am   pregnant   nursing   planning to become pregnant in the near future

Please list any medications, herbal supplements and/or vitamins you are currently taking:   Not taking any medications

Are you allergic to any medications/anesthetics?   Yes   No

 Others

Please list major surgeries/hospitalizations:

________________________________________________________________________
Date: _____________  ____________________________________Date: _____________

________________________________________________________________________
Date: _____________  ____________________________________Date: _____________

Please list IMMEDIATE FAMILY that have had any of the following (mother, father, grandmother, grandfather, brother, sister):

 Skin Cancer-Melanoma: ____________________________   Psoriasis: ____________________________
 Skin Cancer-Other: ____________________________   Eczema: ____________________________
 Other Cancers: ____________________________   Other: ____________________________

Occupation: ____________________________  Employer: ____________________________

(please specify job title or student/unemployment status)

Do you use sunscreen on a daily basis?   Yes   No
Do you smoke?   Yes   No  Have you traveled outside the U.S. in past 3 months?   Yes   No
Do you use smokeless tobacco?   Yes   No  Have you had at least one blistering sunburn?   Yes   No
Drink alcoholic beverages?   Yes   No  Have you ever used a tanning bed?   Yes   No
Do you use recreational drugs?   Yes   No  Do you currently use a tanning bed?   Yes   No

Have you RECENTLY had any of the following? (Please check all that apply)   None

 Other skin complaints
 Fever/chills/wt. change
 Itching
 Joint Aches
 Other systemic complaints
 Sun sensitivity
 Muscle Aches
 Ringing in ears

Patient Signature: ____________________________  Date: ____________________________

Thank you for taking the time to help us give you the highest quality care.
Surgery Cancellation Policy Effective 12/01/2010

Patients, or legal guardians of patients under the age of eighteen, MUST sign and date below before medical care can be rendered.

At the Center for Dermatology we strive to provide the best and most complete patient care. In an attempt to preserve patient care, we have a Surgery Cancellation Policy that allows us to schedule appointments for all patients. When a surgery is scheduled, that extended period of time has been set aside for you. When it is missed, that time cannot be used for surgery for another patient, or filled with appointments for patients that urgently need the care.

We request that you please give our office 24 hour notice in the event that you need to reschedule or cancel your surgery with the physician or physician assistant. This allows other patients in need of care to be scheduled in that appointment time. It also makes it possible to reschedule your appointment more efficiently. Patients failing to provide 24 hours notice that they can not make their surgery as scheduled will have a charge of $100 added to their account. Please note that this charge is the financial responsibility of you, the patient, and will not be paid by your insurance company. We thank you for your cooperation in this manner so that each patient can receive the treatment and medical attention that they need and deserve.

I have read and understand the Medical Appointment Cancellation Policy of the practice and 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.

I, ________________________________________________________ (print name), have read, understand, and will comply with the Center for Dermatology’s Surgery Cancellation Policy.

Printed Name of the Patient ____________________________ Relationship to Patient (if patient is a minor) ____________________________

Signature of Patient or Responsible Party if a Minor ____________________________ Date ____________________________
CONSENT FOR TREATMENT OF MINOR CHILD

I hereby authorize The Center for Dermatology and Cosmetic Laser Surgery, and whoever may be employed or assistant in administration, to administer care as is deemed necessary to:

CHILD’S NAME: ________________________________________

ADDRESS: _____________________________________________

CITY, STATE: ___________________________ ZIP: ___________

MEDICAL RELEASE SPECIAL AUTHORIZATION

I, ___________________________, authorize the following name person/persons to authorize (medical) treatment for my child by The Center for Dermatology & Cosmetic Laser Surgery. I understand that I am responsible for services rendered for treatment and payments authorized by my personal representatives. If I choose to terminate the authorization of this form, I understand I must do so in writing.

NAME OF PERSONAL REPRESENTATIVE    RELATIONSHIP
_____________________________________    _____________________
_____________________________________    _____________________
_____________________________________    _____________________

Signed by: ______________________
Relationship to Child: ______________________
Date: ______________________