Brazos Valley Dermatology

Marital Status: S M W D

PATIENT REGISTRATION

Patient's Name_____ Date of Birth_____ Age:____ Sex: M F
Last First Middle

Billing Address _____ City_____ State_____ Zip_____

Telephone_____ Work Phone Number_____ Cell Phone Number_____

Email _____

Patient's Employer_____ Address_____

Spouse's Name_____ Spouse's Employer_____

Address of Employer_____ Spouse's Work Phone Number_____

Spouse's Date of Birth_____

Person Responsible for Bill_____

Address (if different from above)_____ City_____ State_____ Zip_____

Phone Number (if different from above) _____

Nearest relative or contact person: Name_____ Address _____

City _____ Telephone _____ Relationship to patient _____

INSURANCE INFORMATION - Please provide us with your insurance card(s) to copy for our records.

Medicare Number _____

Primary Insurance_____ Address _____

Insurance Telephone_____ Policy #_____ Group #_____

Insured's Name_____ Patient's relationship to insured ___Self ___Spouse ___Child ___Other

Insured's Date of Birth _____

Secondary Insurance_____ Address_____

Insurance Telephone_____ Policy #_____ Group #_____

Insured's Name_____ Patient's relationship to insured ___Self ___Spouse ___Child ___Other

Insured's Date of Birth _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize the provider or insurance company to release any information required for this claim. I authorize my insurance benefits to be paid directly to Jason M. Weaver, M.D., P.A. I understand that even though I have assigned benefits to be paid directly to Jason M. Weaver, M.D., P.A., I am still responsible for the entire bill.

Signed _____ Date:_____

Brazos Valley Dermatology
3632 Coppercrest Drive
Bryan, Texas 77802
P: 979-693-7444 F: 979-693-4549
Jason M. Weaver, M.D.

FINANCIAL POLICY

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

Please initial each of the following numbered items:

1. _____ If we participate with your managed care plan or you have a commercial insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans. You will be responsible at the time of service for the payment of:
   - The annual deductibles
   - Co-payments
   - Charges for non-covered or cosmetic services

Please be advised that anything you choose to have removed, biopsied, or injected may not be covered under your office co-pay and might be excluded from coverage or subject to your deductible. We will make every effort to contact your insurance company to verify your benefits, but in the event we are unable to reach them, you will be responsible for your co-payment as well as payment for any procedures performed. Such procedures include but are not limited to biopsies, injections, removal of warts, moles, pre- cancers, or other skin lesions. Methods of removal may include but are not limited to: cutting, freezing, burning or application of a blistering agent.

2. _____ If you have a managed care plan, you need to be aware that the plan may require you to use certain doctors or laboratories. With so many plans, it is your job as the patient to call and verify that Jason M. Weaver, M.D. is in network with your insurance plan and also to inform us if we should send your specimens to a particular lab. If you do not, you may be out of network with our practice and may be responsible for the full price of the visit or any procedures.

3. _____ If you are on an insurance plan that Brazos Valley Dermatology is not in network with, you understand that you are responsible for the full cost of your visit and payment is expected in full at the time of service. We will gladly take a copy of your insurance card to be used if any biopsies or labs are sent from our office, but you as the patient are responsible for filing your visit with the insurance if you choose to do so.

4. _____ It is your responsibility to inform our office of any changes in insurance so that we can ensure the correct insurance is being filed with. Failure to inform our office of any changes may result in your visit not being covered.

5. _____ If you are on an HMO plan, it is your responsibility as the patient to insure that you receive a referral from your primary care physician before you come in for your appointment. Failure to obtain a referral will result in either 1) you being responsible for your entire visit cost, to be paid in full at the time of service, or 2) cancellation of the appointment to be rescheduled at a later date when you can provide a referral. Understand that providing a referral does not guarantee that 100% of your visit costs will be covered by your insurance.

6. _____ We are Medicare participating providers, therefore we will bill Medicare directly. You will be responsible at the time of service for payment of:
   - The annual deductibles
   - Copayments
   - Charges for non-covered or cosmetic services

You will be asked to sign a Waiver of Liability Form in the event that a service is provided which we know is not covered by Medicare.

7. _____ If you have no health insurance, payment is expected in full at the time of service.

8. _____ There will be a $25.00 service fee charged to your account if your check is returned by your bank for any reason. Upon notification from our office of your returned check, payment of the entire balance is due immediately.

9. _____ We kindly request that you give us 24 hour notice if you are unable to keep your appointment. Failure to give 24 hour notice could result in a $35.00 missed appointment fee. This fee is not covered by your insurance plan.

For your convenience, we accept cash, check, Visa, MasterCard, Discover, and American Express.
If you have any questions, please do not hesitate to ask us. We are here to assist you in any way possible.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

_____ _____

Patient Signature Date

AUTHORIZATION/ ACKNOWLEDGEMENT

RECEIPT OF *NOTICE OF PRIVACY PRACTICES*

I, (print patient name) _____, have read a copy of Brazos Valley Dermatology's *Notice of Privacy Practices.* (This document is available at our front desk, online, and in our lobby.)

_____ _____

Signature of Patient (or guardian) **Date**

RELEASE OF MEDICAL INFORMATION

I **do/ do not** (circle one) authorize Brazos Valley Dermatology and its designated representatives to release medical information to my spouse, parent or guardian.

Signature of Patient (or guardian) **Date**

CONTACT PERMISSION

In the event that Brazos Valley Dermatology needs to contact you (patient) regarding an appointment, lab result, medication, or other reason, it is permissible to:

Check all that apply:

[ ] Leave a message on an answering machine / voice mail. [ ] Speak with persons listed below:

Listed below is the person(s) authorized to receive my protected health information.

Authorized individual (print)	Relationship to patient	Phone number
Authorized individual (print)	Relationship to patient	Phone number

_____ _____

Signature of Patient (or guardian) **Date**

AUTHORIZATION/ ASSIGNMENT/ FINANCIAL RESPONSIBILITY

I authorize the release of any medical information necessary to process an insurance claim on my behalf. I request that payment under the medical insurance program be made to Brazos Valley Dermatology. I understand that I am financially responsible for all charges. As a courtesy, my charges will be filled with my insurance carrier; however, I will be billed if the claim is denied or is not paid in a timely manner. Should my account become a collection problem, additional charges may be incurred.

_____ _____

Signature of Patient (or guardian) Date

AUTHORIZATION OF CONTACT

I authorize Brazos Valley Dermatology to contact me via current or any future phone number(s), e-mail addresses, or wireless devices regarding my delinquent account(s) I owe Brazos Valley Dermatology. I authorize and its agents, attorneys (including collection agencies) to use automated telephone dialing equipment, artificial or prerecorded voice or text messages and personal calls and emails, in their effort to contact me for purposes of collecting any portion of my account which is past due.

I/we have read this disclosure and agree to the terms described above.

_____ _____

Signature Date

Name:_____ Date: _____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation (Irregular Heartbeat)
Prostate Enlargement
Stroke
COPD
Coronary Artery Disease
Depression
Diabetes
Disease caused by Covid-19
Elevated Blood Pressure
End Stage Renal Disease
Epilepsy (Seizures)
GERD (Acid Reflux)
Hearing Loss
HIV/AIDS
High Cholesterol
High Thyroid
Low Thyroid
Hepatitis
Leukemia
Lymphoma
Lung Cancer
Breast Cancer
Colon Cancer
Prostate Cancer
Radiation Treatment
Transplantation of Bone Marrow
Other: _____

Past Surgical History: (please circle all that apply)

Colon cancer resection
Biopsy of breast
Biopsy of prostate
Coronary artery bypass surgery
Kidney Transplant
Skin: Excision of basal cell carcinoma
Skin: Excision of melanoma
Skin: Excision of squamous cell carcinoma
Colon: colostomy
Tubal ligation
Appendectomy
Gallbladder removed (cholecystectomy)
Colon: removal of large intestine
Liver removal
Heart stents (PCTA)
Heart: biological valve replacement
Bladder removed
Prostate resection (TURP)
Hysterectomy
Kidney biopsy
Low anterior resection of rectum
Lumpectomy of breast (both, left, right)
Mastectomy of breast (both, left, right)
Heart: mechanical heart valve replacement
Ovaries removed: endometriosis/ovarian cancer
Ovarian cyst removed
Pancreas removed
Kidney stone removal
Liver: shunt
Prostate removed
Spleen removed
Skin: biopsy of skin
Kidney removed (nephrectomy)
Testicles removed
Total joint replacement of hip (both, left, right)
Total joint replacement of knee(both, left, right)
Heart Transplant
Liver Transplant
Other:_____

Name:_____

Skin Disease History: (please circle all that apply)

Acne
Actinic keratosis
Dry skin
Basal cell carcinoma
Poison ivy
Precancerous moles
Eczema
Asthma
Other:

Hay fever/Allergies
Malignant melanoma
Itchy scalp
Psoriasis
Squamous cell carcinoma
Sunburn of second degree

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? _____

Medications: (please list all current medications)

_____
_____
_____
_____

Allergies: (please list all allergies)

_____
_____

Social History: (please circle all that apply)

Currently smokes- daily
Currently smokes- not daily
Has smoked in the past
Has never smoked
Drug use
None

Have you received a flu vaccination?
Yes No

Do you consume more than 5 alcoholic drinks daily?
Yes No

For patients 65 and older: Have you received a pneumonia vaccination?
Yes No

Do you have a healthcare proxy in the event you are unable to make your own medical decisions?
Yes No

Review of Systems: Are you currently experiencing or have any of the following? (please circle all that apply)

Pacemaker
Defibrillator
Artificial joints within the past two years
Artificial heart valve
Allergy to adhesive
Allergy to topical antibiotics
Allergy to lidocaine
Blood thinners or easy bleeding
Pregnancy or planning a pregnancy
GI upset with antibiotics
Problems with scarring (hypertrophic or keloid)
Immunosuppression
Changing mole
Rash