

**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.**

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Patient Signature

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

#### Past Surgical History: (please circle all that apply)

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

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**Allergies: (please list all allergies)**

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**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

## **INFORMED CONSENT FORM: GENERAL MINOR PROCEDURES NECESSARY TO THE PRACTICE OF DERMATOLOGY**

Your doctor has recommended you undergo medical treatment, administration of local anesthesia and the performance of procedures and/or minor surgery. Please read this document carefully. Before signing this document, please ask your provider about any aspect of this document, or procedure, that you do not understand.

\_\_\_\_\_ I do hereby authorize the use of and the administration of such drugs, anesthetics, and other treatments, including the performance of a skin biopsy, the use of cryosurgery with liquid nitrogen, and the injection of intralesional or intramuscular corticosteroid (a steroid) should any of these be deemed advisable, desirable, or necessary for diagnostic, therapeutic, or investigational purposes by any physician, physician extender or appropriately trained and/or licensed health care personnel on the staff of the Brazos Valley Dermatology, for or upon me, an individual to which I am designated the guardian or guarantor, or my minor dependent child.

\_\_\_\_\_ I further consent to the examination for diagnostic, investigational purposes, and disposal by authorities of Brazos Valley Dermatology or its designates herein, of any tissue or parts which may be removed.

\_\_\_\_\_ I understand that the skin biopsy involves removal of a piece of skin and that such removal may result in a permanent scar or in discoloration of the skin at the site of the biopsy.

\_\_\_\_\_ I further understand that more than one biopsy may occur during this visit. I understand that all specimens removed are sent for dermatopathologic analysis and that the charges for dermatopathology will be billed to my insurance from a separate lab. However, I understand that in certain cases, I may be responsible for a portion or all of the charges.

\_\_\_\_\_ I understand that the destruction with liquid nitrogen of precancerous lesions, which are also known as actinic keratoses or solar keratoses may be deemed necessary by a member of the medical staff of Brazos Valley Dermatology, to prevent the risk that these lesions evolve into squamous cell carcinomas or basal cell carcinomas. I understand that the destruction by liquid nitrogen of warts or molluscum may be advised, but these types of lesions are not cancerous and do not necessarily have to be treated. I recognize that because they may be contagious, there may be a recommendation to treat such lesions. Should a member of the medical staff of Brazos Valley Dermatology recommend destruction of these lesions by liquid nitrogen, cantharadin or other destructive method, I consent based on that advice. I am aware that these lesions may require more than a single treatment.

\_\_\_\_\_ I understand that the injection of corticosteroids for the treatment of scars, cysts, acne, and inflammatory conditions like psoriasis, atopic dermatitis, and alopecia areata, may be deemed necessary, advisable or desirable by a member of the medical staff of Brazos Valley Dermatology.

\_\_\_\_\_ I understand that any of the above procedures may have some unwanted effects, which include, but are not limited to permanent scarring, permanent discoloration of the skin at the site of treatment, atrophy (thinning or depression of the skin), infection, bleeding, nerve damage resulting in temporary or permanent numbness or temporary or permanent loss of function of certain muscles (paralysis). I recognize the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures.

\_\_\_\_\_ This facility does have on staff Physician Assistants (PAs) to assist in the delivery of dermatologic care. A Physician Assistant is not a doctor. A Physician Assistant is a graduate of a certified Master's level training program and is licensed by the state medical board. Under the supervision of a physician, a Physician Assistant can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. "Supervision" does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical service provided. A Physician Assistant may provide such medical services that are within his/her education, training and experience. I have read the above and hereby consent to the services of Physician Assistants (PAs) for my health care needs.

\_\_\_\_\_ I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of the procedures and/or treatments.

\_\_\_\_\_ I grant this consent without duress, confusion, or pressure from my physician and/or his or her staff, associates, or colleagues.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date