Patient Forms

Please review the policies and consents, complete the applicable questions, and sign at the end.

Patient name _____ DOB _____

Minor Patient Accompaniment Policy Acknowledgment

This policy applies only to patients under age 18, subject to the exceptions below.

Elite Dermatology & Plastic Surgery requires a parent or legal guardian with legal authority to consent to the minor patient's care to accompany the minor patient to the first visit.

For appointments after the first visit, another adult may accompany the minor patient only if Elite has received and accepted the separate Authorization to Treat Minor Patient in Absence of Parent/Guardian before the appointment. This acknowledgment does not authorize another adult to accompany the minor patient or consent to care.

This policy is subject to applicable law, including exceptions for minors who may legally consent to their own care, patients with a court order or other legally recognized consent arrangement, and circumstances in which urgent evaluation or referral is clinically appropriate.

If the required parent, legal guardian, or authorized adult is not present, or the required written authorization has not been received and accepted before the appointment, Elite may postpone non-urgent services and reschedule the appointment.

You may request the form at any time. Elite must receive and accept it before another adult accompanies the minor patient to a future appointment.

☐ I acknowledge that I have read and understand this policy, as applicable to the patient.

Assignment of Benefits

I understand and agree that I am responsible for the total charges for services rendered, and that Elite Dermatology may bill my insurance company, if any, as a courtesy.

In consideration of services rendered, I hereby irrevocably assign and transfer to Elite Dermatology for myself and my "dependent," if applicable, all rights, title and interest in the benefits payable for services rendered which are provided in any insurance policy(ies) or group health plans under which we are insured or provided coverage for health benefits for the purpose of granting Elite Dermatology an independent right of recovered based upon my rights under such policies or group health plans. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

I hereby appoint Elite Dermatology as my duly authorized representative(s) and attorney-in-fact to act on our behalf, to seek payment of my benefit claims and pursue my rights to medical coverage and the benefits that flow from such coverage, to file appeals related to such claims and to request documents relevant to such claims and direct and authorize any payor to communicate with such authorized representative(s) regarding all of our benefit claims with respect to Elite Dermatology.

I hereby direct payment under any such plans, policies and programs to be made directly to Elite Dermatology for services and items provided to me and my dependents. In the event payment is made to me contrary to this agreement, I will promptly turn over payment in full to Elite Dermatology.

I further assign to Elite Dermatology and its agents all rights, claims or causes of action I may have to request and obtain documents from any health plan and its affiliated insurers, employers and third party administrators that relate to coverage or non-coverage of benefits or payment of charges for medical rendered, including, without limitation, my certificate of coverage, policy and/or summary plan description; any master policy or governing plan document that differs from the certificate of coverage, policy and/or summary plan description; copies of any policies or procedures used to decide my claim; and a complete copy of any other claims adjudication information so that Elite Dermatology can determine if a full and fair review of my claim took place.

I assign to Elite Dermatology and its agents my rights and any claims or causes of action I may have to collect any penalties for my health plan's failure to timely produce this required information.

If my account becomes delinquent and it is referred to an attorney or collection agency, I agree that I will pay all charges, interest from the due date at eighteen percent (18%) or the maximum rate allowable by law, reasonable attorney fees, costs and collection expenses.

☐ I agree

Financial Policy Form

Thank you for choosing Elite Dermatology as your health care provider. Providing quality medical care for our patients is our primary concern. The following is a summary of our financial policy. We would be happy to provide further clarification if necessary. We ask that you read and sign the following to acknowledge that you have been advised of your financial responsibility for medical services provided here.

We will bill your insurance company as a courtesy to you if we are a designated provider on your insurance plan. We accept Medicare and will file all claims for patients with Medicare as well as any secondary insurance card. If your insurance is a plan for which we are not a designated provider, we are more than willing to provide care, and you will be responsible for payment at the time of service. To properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as any change of name, address, or insurance information.

Failure to provide complete insurance and personal information may result in patient responsibility for the entire bill.

If you wish to be seen at Elite Dermatology, you are responsible for payment of all co-pays and or deductible charges at the time of service. A staff member will discuss with you our best estimate of the likely costs involved in your procedure(s) and review your financial responsibility. Since insurance is a contract between you and your insurance company, it is the insurance company that makes the final determination of your eligibility and benefits. Once your insurance claim has been processed an official decision will be sent to you in the form of an EOB (explanation of benefits). I understand that if my insurance does not pay, I am responsible for payment. Please remember that insurance policies may not cover all conditions and fees; even some care that you and your healthcare provider have good reason to think you need. To be fully aware of your schedule of benefits, please read your insurance policy or talk with an insurance representative.

Some procedures performed at Elite Dermatology are considered cosmetic and will not be covered by insurance. You will be financially responsible for these services. Any laboratory analysis that we require, but do not perform in-house will be sent to an external laboratory as required by your insurance. You may receive a separate bill for laboratory services.

We accept payment in the form of cash and credit or debit card. We do not accept checks.

Telemedicine appointments may not be covered by your insurance, if this is the case you will be responsible for the self-pay cost.

Statements and billing correspondence are sent only when you have a balance on your account. They will show whether your insurance company has fulfilled their obligation to you, the policy owner, to pay claims in a timely manner. Statements will show insurance payments and your remaining balance. In some instances, after insurance and self-pay balances have been paid, you may have a credit on your account. If you have an upcoming appointment, this credit will be left on your account to be applied to your future visits. If you do not have an upcoming appointment, a refund will be processed (via credit card or check) for all credits over $20.

Credits that are below $20 will remain on your account for future use, unless you (the patient) specifically request the funds be returned. If the balance is not used or there has been no communication from you regarding this balance in 3 years, we are required by state law to report the balance to the State as unclaimed property.

If you are not going to be able to attend a scheduled appointment, 48 hours advance notice is requested. If you do not do so, we reserve the right to charge the following “late cancellation or no-show fee:” $50.00 for an office visit | $100.00 for a procedure visit (surgery) | $100.00 for cosmetic or MOHS Surgery appointments You have a right to a copy of your medical records. A charge may be incurred upon request. To contact the billing department: # 281-742-2673.

I have read this financial policy and understand that I have financial responsibility for payment of medical services provided by Elite Dermatology and hereby assume and guarantee payment of all expenses incurred during my office visit. Should legal action be required to secure payment of this account, I agree to pay the legal expenses incurred by this office.

☐ I agree

Credit Card on File Policy

Thank you for choosing Elite Dermatology for your dermatology needs. The purpose of this policy is to ensure that all patients have a convenient and efficient way to pay for their medical care.

1. Requirements All patients are required to keep a credit card on file with Elite Dermatology. The credit card must be in the name of the patient or the patient's authorized representative (Guardian).

2. Use of Credit Card on File Following your visit with us, it may take your insurance 14-21 days to run your benefits and assign patient responsibility. After your insurance has determined that part of your bill is patient responsibility, your patient balance will be immediately charged to your Credit Card on File. You may contact us, or our billing team and we are happy to assist you in any way we can. Our billing team can be reached via phone on all weekdays (# 281-742-2673).

For additional convenience, a credit card on file can streamline refunds, as sometimes a positive balance remains following insurance claims adjudication.

If you have an upcoming appointment, this credit will be left on your account to be applied to your future visits.

If you do not have an upcoming appointment, a refund will be processed (via credit card on file or check) for all credits over $20. Credits that are below $20 will remain on your account for future use, unless you (the patient) specifically request the funds be returned.

If the balance is not used or there has been no communication from you regarding this balance in 3 years, we are required by state law to report the balance to the State as unclaimed property.

The credit card on file will also be used to cover No-Show fees, and any outstanding balances from product purchases or cosmetic services.

3. No-Show Fees/Late Cancellation Fee A Late Cancellation fee of $50 will be charged to any patient who fails to cancel their medical appointment at least 48 hours in advance. A No-Show fee of $50 can apply if patients No-show their appointment time. A surgery, cosmetic, or Mohs Late Cancellation and No-Show fee is $100.00. The No-Show and Late Cancellation fees will be automatically charged to the credit card on file.

4. Credit Card Disputes To avoid fraudulent payments disputes + cancellations a nominal fee of $25 will be assessed in all cases in which Elite Dermatology has followed all procedures and protocols.

5. Changes to Credit Card Information Patients are responsible for keeping their credit card information up to date. If the credit card on file expires or is lost, the patient must notify Elite Dermatology immediately.

6. Security Elite Dermatology takes the security of patient information very seriously. The credit card information on file will be stored electronically in a secure, PCI compliant manner and will not be shared with any third parties.

Consent:

By signing this policy, I agree to keep a credit card on file with Elite Dermatology. I consent to the credit card on file to be used to pay for any unpaid balances after insurance claims adjudication, as well as to cover fees and charges as specified above. I confirm I am personally responsible for keeping my credit card information current.

☐ I agree

Summary of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This is a condensed version of our Notice of Privacy Practices. Our full-length Notice follows this summary.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your Protected Health Information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices that follows this summary):

- For medical treatment
- For research
- To obtain payment for our services
- To avert a serious threat to health or safety
- In emergency situations
- For organ and tissue donation
- For appointment and patient recall reminders
- For workers' compensation programs
- To run our Practice more efficiently and ensure all our patients receive quality care
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our controller. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to request restrictions
- The right to amend

• The right to a paper copy of this notice

• The right to an accounting of disclosures

• The right to request confidential communications

For more information about these rights, please see the detailed Notice of Privacy Practices that follows this summary.

☐ I agree

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse protected health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

• Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.

• Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

• Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

• The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

• Most uses and disclosure of psychotherapy notes.

• Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations.

• Disclosures that constitute a sale of PHI under HIPAA; and

• Other uses and disclosures not described in this notice.

You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI:

• The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you.

We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.

• The right to reasonable requests to receive confidential communications of PHI by alternative means or at alternative locations.

• The right to inspect and copy your PHI.

• The right to amend your PHI.

• The right to receive an accounting of disclosures of your PHI.

• The right to obtain a paper copy of this notice from us upon request.

• The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI. This notice is effective as of 01/01/2018 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practices from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint. Feel free to contact the Practice Compliance Officer in writing for more information.

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.

☐ I agree

Notice of Patient Rights and Responsibilities

This document is meant to inform our patients of their rights and responsibilities while they are undergoing medical care. To the extent permitted by law, patient rights may be delineated on behalf of the patient to the patient’s guardian, next of kin, or legally authorized responsible person if the patient (a) has been adjudicated incompetent in accordance with the law, (b) is found to be medically incapable of understanding the proposed treatment or procedure, (c) is unable to communicate his, her, or their wishes regarding treatment, or (d) is a minor. If there are any questions regarding the contents of this notice, please notify any staff member.

Patient Rights 1. Access to Care. You will be provided with impartial access to treatment and services within this practice’s capacity and availability and in keeping with applicable laws and regulations. This is true regardless of race, creed, sex, national origin, religion, sexual orientation, gender identity, disability or handicap, or source of payment for care or services.

2. Respect and Dignity. You have the right to considerate, respectful care and services at all times and under all circumstances. This includes recognition of psychosocial, spiritual, and cultural variables that may influence the perception of your illness.

3. Privacy and Confidentiality. You have the right, within the law, to personal and informational privacy. This includes the right to:

• Be interviewed and examined in surroundings that ensure reasonable privacy • Have a person of your own sex present during a physical examination or treatment • Not remain disrobed any longer than is required for accomplishing treatment or services • Request transfer to another treatment room if a visitor is unreasonably disturbing • Expect that any discussion or consultation regarding care will be conducted discreetly • Expect all written communications pertaining to care to be treated as confidential • Expect medical records to be read only by individuals directly involved in care, quality assurance activities, or the processing of insurance claims. No other persons will have access without your written authorization.

4. Personal Safety. You have the right to expect reasonable safety regarding the practice's procedures and environment.

5. Identity. You have the right to know the identity and professional status of any person providing services and which physician or other practitioner is primarily responsible for your care.

6. Information. You have the right to obtain complete and current information concerning your diagnosis (to the degree known), your treatment, and any known prognosis. This information should be communicated in terms that you understand.

7. Communication. If you do not speak or understand the predominant language of the community, you should have access to an interpreter. This is particularly true when language barriers are a continuing problem.

8. Consent. You have the right to information that enables you, in collaboration with the physician, to make treatment decisions.

• Consent discussions will include an explanation of the condition, the risks and benefits of treatment, and the consequences of no treatment.

• Except in the case of incapacity or life-threatening emergency, you will not be subjected to any procedure unless you provide voluntary, written consent.

• You will be informed if the practice proposes to engage in research or experimental projects affecting its care or services. If it is your decision not to take part, you will continue to receive the most effective care the practice otherwise provides.

9. Consultation. You have the right to accept or refuse medical care to the extent permitted by law. However, if refusing treatment prevents the practice from providing appropriate care in accordance with ethical and professional standards, your relationship with this practice may be terminated upon reasonable notice.

10. Charges. Regardless of the source of payment for care provided, you have the right to request and receive itemized and detailed explanations of any billed services. 11. Rules and Regulations. You will be informed of the practice's rules and regulations concerning your conduct as a patient at this facility. You are further entitled to information about the initiation, review, and resolution of patient complaints.

Patient Responsibilities

1. Keep Us Accurately Informed. You have the responsibility to provide, to the best of your knowledge, accurate and complete information about your present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health, including unexpected changes in your condition.

2. Follow Your Treatment Plan. You are responsible for following the treatment plan recommended by the physician. This may include following the instructions of health care personnel as they carry out the coordinated plan of care, implement the physician's orders, and enforce the applicable practice rules and regulations.

3. Keep Your Appointments. You are responsible for keeping appointments and, when unable to do so for any reason, for notifying this practice.

4. Take Responsibility for Noncompliance. You are responsible for your actions if you do not follow the physician's instructions. If you cannot follow through with the prescribed treatment plan, you are responsible for informing the physician.

5. Be Responsible for Your Financial Obligations. You are responsible for ensuring that the financial obligations of health care services are fulfilled as promptly as possible and for providing up-to-date insurance information.

6. Be Considerate of Others. You are responsible for being considerate of the rights of other patients and personnel and for assisting in the control of noise, smoking, and the number of visitors. You also are responsible for being respectful of practice property and property of other persons visiting the practice.

7. Be Responsible for Lifestyle Choices. Your health depends not just on the care provided at this facility but on the long-term decisions you make in daily life. You are responsible for recognizing the effects of these decisions on your health.

☐ I agree

Cosmetic Cancellation and Refunds Policy

Elite Dermatology understands that sometimes it's necessary to postpone or cancel an appointment. Please review our guidelines for such situations and be sure to notify us as soon as possible if you have a change of plans that necessitates a rescheduling or cancellation.

Should a situation arise, that could cause you to reschedule, postpone, or cancel a cosmetic procedure, Elite Dermatology requires a 48-hour cancellation notice.

If you cancel any cosmetic procedures with less than 48 hours' notice, you will forfeit your nonrefundable deposit as a no-show charge. You will also be subject to a cancellation fee of 10% of total charge.

All pre-paid cosmetic services and procedure series/packages MUST be used within 12 months (1 year) of purchase. Any deposits or money paid toward cosmetic services that are not used within 12 months of the payment will be forfeited as a no-show charge.

Any plastic surgery deposits or payments that are unused within 12 months (1 year) of the payment will be forfeited as a no-show charge. Once services are rendered or products sold, there are no refunds. Cosmetic procedures come with no warranty (guaranteed or implied) of any certain result. Perceived lack of improvement in one's condition does not translate into any type of refund.

We appreciate your courtesy. Thank you for choosing Elite Dermatology.

☐ I agree

PA Consent

Physician Assistant Consent for Evaluation and/or Treatment: Elite Dermatology This facility has on staff a physician assistant to assist in the delivery of medical care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state 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 a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A physician assistant may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures • Formulation a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Performing minor surgeries

• Offering counseling and education

• Supplying sample medications and writing prescriptions (where allowed by law)

• Performing cosmetic procedures: dermal fillers, Botox, Dysport, Jeuveau, Daxxify, PRP injections • Making appropriate referrals I have read the above and hereby consent to the services of a physician assistant for my health care needs.

I understand that at any time I can refuse to see the physician assistant and request to see a physician.

☐ I agree

SMS Email and Communication Consent

I hereby consent and state my preference to have staff at Elite Dermatology communicate with me by email, standard SMS messaging, unencrypted text messaging and cloud based services to transmit the personal information I provide herein- and to communicate with me regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, billing, appointment reminders, information about treatment alternatives or other health related benefits, services and information, in addition to other fundraising communication, that may be of interest to you. I understand that email, standard SMS messaging, unencrypted text messaging and cloud-based services are not confidential methods of communication and may be unsecure. I further understand that, because of this, there is a risk that email, standard SMS messaging, unencrypted text messaging and cloud-based services regarding my medical care might be intercepted and read by a third party. I understand this authorization will remain effective for three (3) years after I am no longer a patient of Elite Dermatology and that I may revoke this authorization in writing at any time.

☐ I agree

Artificial Intelligence Notice and Acknowledgment

Elite Dermatology (“Elite”) uses artificial intelligence, automated systems, and related technologies (“AI”) to help provide care and run our practice. AI may help with scheduling, billing, insurance, recordkeeping, drafting or summarizing messages, translating communications, reviewing photographs, images, and test results, and assisting clinicians with diagnosis, treatment recommendations, and care coordination. By this notice, Elite is informing you that AI will be used in connection with your health care services and treatment.

AI does not replace your clinician. Your clinician remains responsible for medical decisions and will review AI-created records as required by law. AI can make mistakes or incomplete suggestions, and Elite uses human review and privacy and security safeguards.

Elite may use and disclose your health information with AI tools for treatment, payment, and health care operations as allowed by law and as described in our Notice of Privacy Practices. Vendors that handle protected health information on Elite’s behalf are required by law and by their agreements with Elite to protect it, and electronic health records containing patient information must be stored in the United States or a U.S. territory when Texas law requires.

Photos and images. Elite will use photos or images for your care, including AI-assisted review. Elite does not use AI tools to collect or store biometric identifiers, such as voiceprints or face-geometry records used to identify you.

AI-assisted recording and transcription. Elite may record and transcribe your visits and calls, including in- person, telephone, and virtual visits, so an AI scribe can help prepare clinical notes and communications.

Your clinician reviews these notes. Recordings and transcripts are used only for your care and our practice operations as described in our Notice of Privacy Practices. You may ask us not to record, or to stop recording, at any time by telling your clinician or our staff. Saying no will not affect your care, although Elite may document the visit manually.

I acknowledge that I received and read this notice. This notice does not waive your legal rights or replace any separate authorization required by law.

If you have questions or need this notice in Spanish or another language, or in another accessible format, please let our front desk staff know.

☐ I agree

Consent to Medical and Surgical Office Procedure

By my signature below, I acknowledge the following:

I consent to the recommended medical, surgical, and/or cosmetic procedures (the “Procedure”) to be performed by Elite Dermatology, PLLC.

The Procedure has been explained to me in terms I understand.

The explanation of the Procedure included:

• The nature and extent of the Procedure to be performed.

• The most frequently occurring risks of the Procedure involved, and those risks which are unlikely to occur, but which may involve serious consequences if they were to occur.

• The general risks of the Procedure, including pain, scarring, bleeding, and infection.

• The benefits of the Procedure.

• The estimated period of incapacity or convalescence related to the Procedure, if any.

• The risks and benefits of any reasonable alternatives to the Procedure, including having no treatment at all.

I had the opportunity to ask any questions regarding the Procedure, and those questions have been answered to my satisfaction.

I was given the option and opportunity to seek consultation with another provider about the Procedure.

I understand that I have may refuse any medical/surgical Procedure at any time prior to its performance.

I authorize my provider to perform such additional procedures which in his/her judgment are incidentally necessary or appropriate to carry out my diagnosis/treatment.

If any unforeseen condition arises during the Procedure which requires transportation to a hospital, additional procedures, operations, or medications, including, but not limited to, anesthesia and blood transfusions, I further request and authorize my provider to do whatever he/she deems advisable on my behalf.

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of this Procedure.

I authorize that medical photography may be utilized for medical, scientific, or educational purposes, provided my identity is not revealed in the photo or text.

I acknowledge that I have read and fully understand the above information.

I hereby authorize my provider to perform any recommended Procedure(s).

☐ I agree

Medical Information Preferences

Please complete the below information.

May we send you mobile text message reminders of your appointment?

☐ Yes ☐ No

May we leave messages regarding medical information or appointment on your: Mobile Phone?

☐ Yes ☐ No

Email?

☐ Yes ☐ No

Would you prefer a brief or detailed message?

☐ Brief ☐ Detailed

POA and PHI Contact

Please list the person you authorize to access your protected health information (PHI), such as a family member, caregiver, or your medical power of attorney (POA) contact, if applicable.

I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information to the following people (include, name, phone number and relationship to patient):

Name _____

Relationship to patient _____ Phone number _____

Emergency Contact (include name, phone number and relationship to patient):

Name _____

Relationship to patient _____ Phone number _____

MIPS Checklist

Please complete the below applicable questions:

If you are 12 or older: smoking habits (please select one of the below):

☐ Never Smoker ☐ Current every day smoker

☐ Current someday smoker ☐ Former Smoker ☐ Not Applicable

If you are 65 or older: do you have a healthcare proxy (medical power of attorney)?

☐ Yes ☐ No ☐ Not Applicable

If you turned 13 years old or turning 13 this year: have you had an HPV Vaccination?

☐ Yes ☐ No ☐ Not Applicable

If you turned 13 years old or turning 13 this year: have you had an TDAP Vaccination?

☐ Yes ☐ No ☐ Not Applicable

If you turned 13 years old or turning 13 this year: have you had an Meningococcal Vaccination?

☐ Yes ☐ No ☐ Not Applicable

If you are being seen for a rash, on a scale of 1-10, please rate your level of itchiness:

Circle one: 1 2 3 4 5 6 7 8 9 10 Not Applicable

Signature

Please print your name and date of birth, then sign and date below.

Your name _____

Your DOB MM / DD / YYYY _____

Signature _____

Date _____