MORRELL DERMATOLOGY, P.A.
PATIENT REGISTRATION

PATIENT NAME: _____ **SEX**: M/F
LAST FIRST MIDDLE INT.

ADDRESS: _____
STREET APT # CITY STATE ZIP CODE

HOME PHONE: _____**CELL PHONE:** _____**WORK:** _____

EMAIL: _____**PRIMARY DOCTOR:** _____

MARITAL STATUS: S/ M / D / W **DATE OF BIRTH:** _____ **AGE:** _____ **SS#** _____

EMPLOYER: _____ **RACE:** _____

HOW DID YOU HEAR ABOUT US? _____

EMERGENCY CONTACT (Nearest relative/person not living with you)

NAME: _____ **RELATIONSHIP:** _____

HOME PHONE: _____ **CELL PHONE:** _____

WORK PHONE: _____

PLEASE ENTER INFORMATION ON THE PERSON RESPONSIBLE FOR THE BILL IF OTHER THAN THE PATIENT:

NAME:_____**DOB:**_____**RELATIONSHIP:**_____

ADDRESS: _____
STREET APT# CITY STATE ZIP CODE

PHONE: _____ **SOCIAL SECURITY #** _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____

INSURED NAME _____

SUBSCRIBER DOB _____

POLICY NUMBER _____

RELATIONSHIP TO INSURED _____

SECONDARY INS _____

INSURED NAME _____

SUBSCRIBER DOB _____

POLICY NUMBER _____

RELATIONSHIP TO INSURED _____

Date _____

MORRELL DERMATOLOGY, P.A.
PATIENT AUTHORIZATION FOR TREATMENT AND OFFICE POLICIES

AUTHORIZATION FOR TREATMENT:

By virtue of my signature below, I authorize MORRELL DERMATOLOGY, P.A. and any of its employees or other authorized personnel or agents, to provide general healthcare service to me.

Date: _____ SIGNATURE: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:

I acknowledge that MORRELL DERMATOLGOY, P.A. may use health information exchange systems to electronically transmit, receive and /or access my medical information which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history, and other health care information.

Date: _____ SIGNATURE: _____

NOTICE OF PRIVACY PRACTICE:

I acknowledge that I have been provided access to the Notice of Privacy Practice for MORRELL DERMATOLOGY, P.A. (Located in the entry way of the office)

I acknowledge that the "Notice of Privacy Practices" provides information about how MORRELL DERMATOLOGY,

P.A. and its workforce may use and/or disclose protected health information about me for treatment, payment, health care operations and otherwise as allowed by law. I understand MORRELL DERMATOLGOY, P.A. cannot be responsible for use or re-disclosure of information by third parties.

Date: _____ SIGNATURE: _____

REFERRALS:

I acknowledge it is my responsibility to obtain a valid referral from my primary physician when requested by my insurance company.

Date: _____ SIGNATURE: _____

FOR ALL PRESCRIPTIONS:

I acknowledge that all prescriptions will not be sent over to the pharmacy until the end of the day.

Date: _____ SIGNATURE: _____

FOR MEDICARE PATIENTS ONLY:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Date: _____ SIGNATURE: _____

Date _____

MORRELL DERMATOLOGY

FINANCIAL POLICY OF MORRELL DERMATOLOGY, P.A

Thank you for choosing MORRELL DERMATOLOGY, P.A. for your dermatology care. We look forward to serving your dermatology needs. We want you to be an informed participant in your healthcare. For your information, we have summarized our financial policy so you will know of our expectations regarding payment of your account.

If we have a contract with your insurance company, we will be happy to bill your insurance company after verification of your coverage, including eligibility, benefits, and co-pay amount. All patients are required to bring their insurance cards with the policy ID number and phone number of insurance company. If you do not have your insurance card, you will be required to pay in full at the time of service. Patients are expected to pay in full any applicable co-payment, deductible and/or co-insurance at the time dermatology services are rendered in our office. **If we are unable to determine your financial responsibility at the time of service, payment is due in full when you receive your first statement.**

We will make every reasonable effort to collect payments that are due from your insurance company. However, you are ultimately responsible for timely payment of your account. We recommend that you follow up with your insurance company on any outstanding balance you might have with MORRELL DERMATOLOGY, P.A.

ALL laboratory tests, biopsies, or cultures obtained by the physician during your appointment, will be sent to an outside laboratory and **will not** be part of your office visit charge. You will receive a separate bill from the laboratory.

We accept Medicare assignment. If you do not have secondary insurance coverage, we are required by law to collect the 20% co-insurance of the Medicare allowable fee. We are also required to collect the annual Medicare deductible fee if you have not paid it prior to your appointment. Medicare only covers procedures that it deems are medically necessary. We will make every attempt to inform you if a requested procedure is or is not covered. However, you are responsible for payment in full of all non-covered visits and/or procedures at the time of service.

We are happy to offer the following payment options:

- We accept cash, MasterCard, Visa and Discover. **We do not accept checks**
- CareCredit® (a GE Money Company): This is an attractive payment plan that allows you up to 6 months to pay, interest free.
- **Please feel free to look at the CareCredit® brochures in the lobby or inquire at the receptionist desk regarding this payment option**.

I have read the above statement and fully understand my possible financial obligations.

_____ _____

Patient /Legal Guardian Signature **Date**

Date _____

MORRELL DERMATOLOGY, P.A.

CANCELLATION AND NO-SHOW POLICY

If you are unable to keep your scheduled appointment, we require a notice of at least 24 hours to allow us to accommodate another patient. Appointments no-showed or cancelled without a notice of 24 hours will result in a **$50 cancellation fee.**

The Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before or at the patient's next appointment.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to the Billing Department at 409-898-3900.

Please sign that you have read, understand, and agree to the Cancellation and No-Show Policy.

Patient Name (Please Print): _____

Date of Birth: _____

Patient / Guardian Signature: _____

Date: _____

Date _____

MORRELL DERMATOLOGY, P.A.

Patient Name: _____ **DOB:** _____

HIPAA Privacy Act:

As a patient of MORRELL DERMATOLOGY, P.A., I hereby give my consent to the physician and/or his/her staff to discuss my medical condition and any results from surgery, lab or x-rays or my billing account to the following people:

Name_____Phone_____Relationship_____

Name_____Phone_____Relationship_____

Name_____Phone_____Relationship_____

☐ I ELECT **NO DISCLOSURE** TO ANY PERSON. NO INFORMATION TO BE SHARED. _____
(INITIAL)

Please print the telephone number, if any, where you wish to receive calls regarding your appointments, lab/test results and /or other health care information if other than your home phone number: (___) _____
** Please be aware that a cell phone is **NOT** a secure and private line**

Can confidential messages (i.e., Appointment reminders and/or test results) be left on your telephone answering message or voicemail?

YES _____ NO _____

Patient / Guardian Signature: _____

Date: _____

Date _____

MORRELL DERMATOLOGY

HISTORY AND INTAKE FORM

Patient Name:_____DOB: _____ Age: _____ Height: _____ Weight: _____

Primary Care Physician: _____Pharmacy: _____

Reason for todays visit: _____

Previous treatments: _____

Past Medical History *(please circle all or write none)*

- Anxiety disorder
- Arthritis
- Asthma
- Atrialfibrillation
- Benign prostatic hyperplasia
- Cerebrovascular obstructive pulminary (lung disease)
- Coronary arteriosclerosis
- Depressive disorder
- Diabetes mellitus
- End-stage renal disease
- Hepatitis
- Epilepsy (seizures)
- Gastroesophageal reflux disease(GERD)
- Hypertension (high bp)
- Hearing loss
- HIV/AIDS
- Hypercholesterolemia (high cholesterol)
- Hyperthyroidism (high thyroid)
- Hypothyroidism (low thyroid)
- Inflammatory disease of liver)
- Leukemia
- Malignant lymphoma (clinical)
- Malignant tumor of lung
- Malignant tumor of breast
- Malignant tumor of colon
- Malignant tumor of prostate
- Radiation therapy treatment management
- Transplantation of bone marrow
- Other:_____
  _____
  _____

Past Surgical History *(please circle all or write none)*

- Abdominoperineal resection
- Biopsy of breast
- Biopsy of prostate
- Coronary artery bypass graft
- Kidney Transplant
- Basal Cell Carcinoma
- Squamous Cell Carcinoma
- Melanoma
- Appendectomy (appendix reomoval)
- Cholecystectomy (gallbladder removal)
- Colectomy (colon removal)
- Pancreatectomy
- Tubal Ligation
- Hysterectomy
- Kidney biopsy
- Low anterior resection of rectum
- Lumpectomy of breast (right,left)
- Masectomy (left,right,both)
- Mechanical heart valve
- Oophorectomy (ovary removal)
- Splenctomy
- Percutanrous transluminal coronary angioplasty
- Total cystectomy (bladder removal)
- Tissue graft heart valve replacement
- Kidney stone removal
- Portosystemic shunt operation
- Prostatectomy (prostate removal)
- Prosthetic arthroplasty of bilateral hips
- Biopsy of skin
- Total nephrectomy (kidney removal)
- Total orchidectomy (testicle removal)
- Total replacement of hip (left, right, both)
- Total replacement of knee (left, right, both)
- Transplantation of heart
- Transplantation of liver

Other:_____

Date _____

MORRELL DERMATOLOGY

Skin Disease History *(please circle all that apply):*

None	Dysplastic nevus of skin	Itching of the scalp
Acne	Eczema	Psoriasis
Actinic keratosis	Eczema	Squamous cell carcinoma
Asteatosis cutis	H/O: asthma	Sunburn of second degree
Basal cell carcinoma of skin	H/O: hay fever Malignant	Other: _____
Poison Ivy	Melanoma	

Health maintenance:

If patient is a minor, is he/she up to date on all vaccinations: YES or NO

Medications and Dosage *(list all present medications):*

1._____ 4. _____ 7. _____

2._____ 5. _____ 8. _____

3._____ 6. _____ 9. _____

Allergies *(please list all allergies)* **Medication allergies?** YES or NO (If YES, please specify)

1._____

2. _____

3._____

Social History *(please circle all that apply):*

Alcohol Use:	Sexual History:	Tobacco Use:	
None	Not sexually active	Smoke everyday	Drug Use: Y or N
Less than 1 drink per day	Sexually active with one partner	Former Smoker	
1-2 drinks per day	Sexually active with more than one partner	Never Smoked	IV Drug Use: Y or N
3 or more drinks per day			

Date _____

MORRELL DERMATOLOGY

Family History (please circle all that apply)

Melanoma	Psoriasis	Skin Disease	Skin Cancer
Cancer	Eczema	Dysplastic Nevus	Unknown
Relatives: _____		Other: _____	

*First degree relatives only (parents, siblings, children)

Review of Systems (please circle all that apply):

Problems with bleeding	Abdominal Pain	Allergy to adhesive
Problems with healing	Bloody stool	Allergy to lidocaine
Problems with scarring	Bloody urine	Allergy to topical antibiotic ointments
Rash	Joint Aches	Artificial heart valve
Immunosuppression	Muscle weakness	Artificial joints within past two years
Hay fever	Neck Stiffness	Blood thinners
Chest Pain	Headaches	MRSA
Fever or chills	Seizures	Pacemaker/ Defibrillator
Night sweats	Cough	Premedication prior to procedures
Unintentional weight loss	Shortness of breath	Rapid heartbeat with epinephrine
Thyroid problems	Wheezing	Pregnancy or planning a pregnancy
Sore throat	Anxiety	Other: _____
Blurry vision		

Medical Directive

*A medical power of attorney allows a person to handle someone else's health care decisions only in the chance that he or she may not be able to think for themselves. The representative may not choose any 'end of life' decisions unless the principal specifically writes in that he or she would like that as an option. If the Principal is consciously able to think for themselves then the representative has no say in their treatment.

Does the patient have a power of attorney? YES or NO (if yes please provide info below)

Name: _____ Number: _____

Does the patient have a living will? YES or NO

Emergency Contact:

Name: _____ Number: _____

Patient Name:_____ Date of Birth:_____

Social Drivers Questionnaire

___ I do not want to answer the Social Drivers questionnaire
___ I have other reasons for which I do not want to answer the Social Drivers Questionnaire

Healthcare	In the past month, did poor physical o rmental health keep you from doing your usual activities, like work, school or a hobby.	**Yes**	**No**
	In the past year, was there a time when you needed to see a doctor but could not because it cost too much.	**Yes**	**No**
Food	Do you ever eat less than you feel you should because there is not enough food?	**Yes**	**No**
Employment & Income	Do you have a job or other steady source of income?	**Yes**	**No**
Housing & Shelter	Are you worried that in the next few months you may not have housing that you own, rent, or share?	**Yes**	**No**
Utilities	In the past year, have you had a hard time paying for your utility company bills?	**Yes**	**No**
Childcare	Does getting childcare make it hard for you to work, go to school or study?	**Yes**	**No**
Education	Do you think completing more education or training, like finishing a GED, going to college, or learning a trade, would be helpful for you?	**Yes**	**No**
Transportation	Do you have a dependable way to get to work or school and your appointments.	**Yes**	**No**
Clothing & Household	Do you have enough household supplies? For example, clothing, shoes, blankets, mattresses, diapers, toothpaste, and shampoo.	**Yes**	**No**
General	Would you like to receive assistance with any of these needs?	**Yes**	**No**
	Are any of your needs urgent?	**Yes**	**No**