MORRELL DERMATOLOGY, P.A.
PATIENT REGISTRATION

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

ADDRESS: _____
STREET APT # CITY STATE ZIP CODE

HOME PHONE: _____ CELL PHONE: _____ WORK: _____

EMAIL: _____ PRIMARY CARE DOCTOR: _____

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

EMPLOYER: _____ RACE: _____

HOW DID YOU HEAR ABOUT US? _____

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

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

MOBILE PHONE: _____

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

NAME: _____ DOB: _____ RELATIONSHIP: _____

ADDRESS: _____
STREET APT # CITY STATE

PHONE: _____ SOCIAL SECURITY # _____

INSURANCE INFORMATION

PRIMARY CARRIER *(Company)* _____ SECONDARY CARRIER _____

INSURED NAME _____ INSURED NAME _____

SUBSCRIBER DOB _____ SUBSCRIBER DOB _____

POLICY NUMBER _____ POLICY NUMBER _____

GROUP NUMBER _____ GROUP NUMBER _____

YOUR RELATIONSHIP TO INSURED _____ YOUR RELATIONSHIP TO INSURED _____

****PLEASE PRESENT INSURANCE CARDS AND PHOTO ID TO THE RECEPTIONIST****

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: _____

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.

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**_____

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**

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:_____

Name_____ Age____ DOB_____ Height____ Weight____

Primary Care Physician_____ Pharmacy_____

Reason for today's visit_____

Previous treatment_____

History and Intake Form

Past Medical History *(please circle all that apply):*

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

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

Abdominoperineal resection	Tubal ligation	Kidney Stone removal
Biopsy of breast	History of percutaneous transluminal coronary angioplasty	Portosystemic shunt operation
Biopsy of prostate	History of tissue graft heart valve replacement	Prostatectomy (prostate removal)
Coronary artery bypass graft	History of total cystectomy (bladder removal)	Prosthetic arthroplasty of bilateral hips
Kidney Transplant	Hysterectomy	Splenectomy
Basal cell carcinoma	Kidney biopsy	Biopsy of skin
Squamous Cell Carcinoma	Low anterior resection of rectum	Total nephrectomy (kidney removal)
Melanoma	Lumpectomy of breast (left, right, both)	Total orchidectomy (testicle removal)
History of appendectomy (Appendix removal)	Mastectomy (left, right, both)	Total replacement of hip (left, right, both)
History of cholecystectomy (Gallbladder removal)	Mechanical heart valve replacement	Total replacement of knee (left, right, both)
History of colectomy (removal of colon)	Oophorectomy (ovary removal)	Transplantation of heart
	Pancreatectomy	Transplantation of liver

Other surgical procedures: _____

Date:_____

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	Other: _____
Poison Ivy	Malignant Melanoma	

Health maintenance: *(please list most recent date)*

Flu vaccine: _____

Pneumococcal vaccine: _____

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:	**Tobacco use:**	**Sexual History:**	**Drug Use**
None	Current every day smoker	Not sexually active	**IV Drug Use**
Less than 1 drink per day	Former Smoker	Sexually active with one partner	
1-2 drinks per day	Never Smoker	Sexually active with more than partner	
3 or more drinks per day			

Date:_____

Family History *(please circle all that apply)* ***First degree relatives only** *(parents, siblings, children)*

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

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	Depression	

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: _____