CYPRESS DERMATOLOGY

27700 Northwest Freeway Suite 490
Cypress, Texas 77433
281.895.3376
cypressderma@gmail.com
www.cypressdermatology.com

Dr. Lauren Campbell M.D. Board Certified Dermatologist

Intake and History Form

Name: _____ Date: _____

Street Address: _____ City/State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Phone number (Day): _____ Phone number (Night): _____

Email Address: _____ Social Security: _____

Emergency Contact: _____ Relationship: _____

Phone number: _____ Preferred Language: _____

Race: _____ Ethnic Group: _____

Referring Physician: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

Address: _____ City/Zip Code: _____

Primary Insurance Holder Name: _____ DOB: _____

Address: _____

Insurance Name: _____ Member Id: _____ Group: _____

Relation to Patient: _____

Secondary or Supplemental Insurance: _____

Member ID: _____ Group Number: _____

Insurance Phone Number: _____

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COSMETIC INTEREST SURVEY

Cypress Dermatology is very pleased to offer aesthetic as well as medical and surgical dermatology services to our patients. Most of our patients inquire about our free complimentary cosmetic face or body consultation while they are already on site for medical or surgical reasons.
Would you be interested in a free complimentary consultation while you are here today?
If so, please select all potential cosmetic services or products of interest:

- ◯ DYSPORT OR BOTOX
- ◯ FILLER
- ◯ KYBELLA/DOUBLE CHIN REDUCTION
- ◯ COOLSCULPTING
- ◯ PHOTOFACIAL
- ◯ SKINPEN/MICRONEEDLING
- ◯ CHEMICAL PEELS
- ◯ DERMAPLANING/HAIR REMOVAL
- ◯ SPIDER VEINS
- ◯ LASER GENESIS/LASR FACIAL
- ◯ PRP HAIR RESTORATION or FACIAL REJUVENATION
- ◯ SKINCARE PRODUCTS/REGIMEN CONSULT
- ◯ I DON'T KNOW, I JUST WANT TO LOOK BETTER- HELP!

If you have any questions or are unfamiliar about any of these services, please ask one of our Licensed Medical Aestheticians who will share their expert opinions with you.

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Patient Name: _____ **D.O.B.:** _____

****FAILURE to provide pharmacy information may result in a delay of prescriptions****

Pharmacy Name: _____ **Phone number:** _____

Address: _____

MEDICAL HISTORY:

Select any of the following medical conditions that you currently have.

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Bone Marrow Transplantation
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension (high blood pressure)
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism (overactive)
- ☐ Hypothyroidism (underactive)
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other:

  _____

  _____

  _____
- ☐ None

Past Surgeries

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Both/Left/Right)
- ☐ Breast: Mastectomy (Both/Left/Right)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Both/Left/Right)
- ☐ Joint Replacement: Knee (Both/Left/Right)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate: Prostate Biopsy
- ☐ Prostate: Prostatectomy
- ☐ Prostate: TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ Other_____

  _____

  _____
- ☐ None

Have you had any of the following skin conditions?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous cell skin cancer
- ☐ Other: _____ _____
- ☐ None

Do you wear Sunscreen?

- ☐ Yes, What SPF? _____
- ☐ No

Do you tan in a tanning salon?

- ☐ Yes
- ☐ No

Family History

Do you have a family history of **Melanoma**? If yes, which relative?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter
- ☐ Other: _____
- ☐ None

Current Medications (List ALL medications): _____

_____

_____

☐ NONE

Allergies to Medications (list All allergies and reactions if known): _____

_____

_____

☐ NO KNOWN MEDICATION ALLERGIES

Smoking Status (please choose one):

☐ Never smoker
☐ Unspecified
☐ Unknown if ever smoked
☐ Current every day smoker (Tobacco/Cigarette/Both)
☐ Current someday smoker (Tobacco/Cigarette/Both)
☐ Former smoker

*Start Smoking (mm/dd/yyyy _____)

*Quit Smoking (mm/dd/yyyy _____)

*Number of packs per day? _____

*Total years smoking? _____

Alcohol intake (please choose one):

☐ None
☐ 1 or less per day
☐ 1-2 per day
☐ 3 or more per day
☐ Other _____

☐ Unspecified
☐ Several times a day
☐ Once a day
☐ A few times a month
☐ Never
☐ Other _____

How often for you exercise?

☐ Unspecified
☐ Several times a day
☐ Once a day
☐ A few times a month
☐ Never
☐ Other _____

Advance Care:

- Do you have a health care proxy in the event you are unable to make your own medical decisions?
  YES OR NO
- Have you had your influenza vaccination within the last year?
  YES OR NO
- Have you had your Pneumonia Vaccination?
  YES OR NO

What is your caffeine use?

Review of Systems

Have you had any of the following symptoms recently? Please **circle and explain**.

- ☐ Problems with Bleeding/Healing/Scarring: _____
- ☐ Rash: _____
- ☐ Immunosuppression: _____
- ☐ Hay Fever: _____
- ☐ Fever chills or Night sweats: _____
- ☐ Unintentional weight loss: _____
- ☐ Thyroid problems: _____
- ☐ Sore throat: _____
- ☐ Blurry vision: _____
- ☐ Abdominal pain: _____
- ☐ Bloody stool or urine: _____
- ☐ Joint aches: _____
- ☐ Muscle weakness: _____
- ☐ Neck stiffens: _____
- ☐ Headaches: _____
- ☐ Seizures: _____
- ☐ Coughs: _____
- ☐ Shortness of Breath: _____
- ☐ Wheezing: _____
- ☐ Anxiety: _____
- ☐ Depression: _____

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HIPAA AUTHORIZATION FORM

(permission from patient/patient's legal guardian to share personal medical information)

Patients Name: _____
DOB: _____
Street Address: _____
City, State, Zip: _____

I_____, hereby authorize Cypress Dermatology And/or any medical facility to release any and all medical information and test results that pertain to me, to the following individual(s):

Name: _____**Phone#:(____) _____-_____Relationship to pt.**_____
Name: _____**Phone#:(____) _____-_____Relationship to pt.**_____
Name: _____**Phone#:(____) _____-_____relationship to pt.**_____

I authorize Cypress Dermatology or the medical facility to contact the individual(s) listed above to convey any pertinent information to me.

I understand that I may revoke/cancel this authorization by notifying Cypress Dermatology in writing of my intent to revoke authorization or change the name(s) of the individuals to whom information is to be released.

_____ _____
(Signature of patient) **Date**
Or if applicable-

_____
Signature of Legal Guardian or Personal Rep of Patients Estates _____
Date

_____
Description of Authority to Act for the Patient _____
Date

_____ _____ _____
Name of Witness **Witness Signature** **Date**

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General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risk and hazards involved. At this point in your care, a nonspecific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions. I voluntarily request a physician and other health care providers, or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which brough me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I also understand that Cypress Dermatology is customer obsessed and constantly improving and would like to hear about better ways to serve my dermatological needs and would appreciate my review of the practice online. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Name (Print):_____

Signature:_____

Date:_____

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ASSIGNMENTS OF BENEFITS, ASSIGNEMNET OF RIGHTS TO PURSEU ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable by to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider all plan documents, summary benefit description, insurance policy, and or settlement information upon written request from the above-named healthcare provider or it's attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort fees or insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all my rights to claim) or place a lien on) the medical benefits related to the services treatments, therapies, and/or mediations provided by the above-named healthcare provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from Erisa breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may file suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (healthcare reform legislation), Erisa, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I have read and fully understand this agreement.

_____

Patient Signature

_____

Date

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cypressderm@gmail.com
www.cypressdermatology.com

Patient Name: _____ **DOB:** _____

FINANCIAL POLICY

We strive to provide the best dermatological care in the region. As a courtesy, if you wish to use your medical insurance, our office will file your medical claim with your insurance company on your behalf. Our staff will make best efforts to assist in obtaining your benefit, but we cannot force your insurance company to pay for services we have provided to you. Payment is expected and required for all services rendered regardless of your insurance coverage. Patients are required to provide a government issued ID and an up-to -date insurance card every visit.

- Patient payment obligation: I understand that insurance coverage is a contract between myself and my insurance company and not a guarantee of payment. Claims may be denied due to "non eligibility", "non-covered service", or "pre auth/certification not obtained" amongst many other reasons. I understand that regardless of coverage I am fully responsible for any balances not covered by my insurance company for ALL charges for services rendered to me or to my dependents at Cypress Dermatology. If required by my insurance, I remain responsible and agree to obtaining any referrals, pre-authorizations, and/or pre-certifications prior to any visits or services. I am responsible for payment of balances resulting from lack of such documents shall my insurance deny the claim(s).
- Copays/Deductible/Co-insurance: I understand that Cypress Dermatology is required by contract with insurance companies to collect any co-payment, co-insurance, and any unmet deductible **up front** on the day of service. The amount collected at time of service is an estimate based on benefit information available. Once my claim is processed, I may owe additional amounts for my patient portion which will be due immediately and charged to my credit card on file.
- No Coverage: If I do not have insurance, or unable to provide valid insurance, I agree to be treated as a cash pay patient and must pay for all services rendered at time of service. In this case, I will be responsible for filing any paperwork for the claim on my own account if I wish to do so.
- Procedures: I understand that **biopsies** and other surgical procedures will result in 2 charges: one for physician performing biopsy, the 2nd for the pathologist (an unaffiliated physician) for processing and examining the specimen. I understand that I will be billed separately by the pathologist rendering histopathological diagnosis. I acknowledge that it is impossible for Cypress Dermatology to know the details of my coverage/amounts owed for unaffiliated pathology services and should I want to know this information I will need to contact my insurer directly. I understand that pathological examination of removed specimens is **ALWAYS** required for any lesions removed at Cypress Dermatology aside from skin tags (diagnosed by the dermatologist) **for my own medical safety**. I understand that procedures such as liquid nitrogen, canthacur, I&D, injections, curettage, Mohs surgery or other procedures may have separate and additional charges **due at time of the procedure**. A copy of this notice will be maintained with your medical records.
- **Cancellation or No Show: I understand a minimum fee will be charged if my medical appointment is cancelled less than 24 hours prior to its time (before noon on preceding Friday for Monday appointments) for any reason or if I do not show for my appointment.** All surgeries require a $100 minimum deposit to schedule and this deposit will serve as my cancellation/no show fee if my surgery is cancelled within seven calendar days or if I do not show up to my appointment. Cosmetic fees vary based on procedure and are all nonrefundable.
- **Upfront fees:** Fees due upfront on the day of my appointment include but are not limited to copay/coinsurance/deductible and cash/cosmetic services. If the amount due up-front is under-collected, I agree to provide payment by the end of day or my card on file will be charged for balance.
- **Cosmetic & Cash/Self Pay/Rewards membership**: I understand full payment for all cosmetic procedures, products, and/or self-pay services are due at the time of service. Self-pay services are any elective services that I choose to receive for cosmetic purposes or medical services which are not billed and fully covered with insurance. **All product, cosmetic, and self-pay sales are also final sale (no returns/exchanges), including for fees paid by a third party payor such as Care Credit.** Membership fees are non-refundable and subject to change at any time.
- **Nonpayment**: If we are unable to receive due payment for medical, cosmetic, or products provided to you for any reason including but not limited to failure to provide payment, card denial, dispute/chargeback of payments, or any other reason, your account will be sent to collections, locked, and subject to administrative fees, collection costs, and attorney involved in your account.

Chargeback attempts for medical or cosmetic charges will result in involvement of Cypress Dermatology legal team and patient discharge from the practice.

CREDIT CARD ON FILE

We are committed to a simple and convenient billing process. You will be required to provide a credit/debit card on file with our office. Your card will be stored in a secure, PCI compliant system with only the last four digits visible. Card on file will be used to pay the following if we are unable to collect directly from you: any outstanding account balances, no show or same day cancellation fees, statement balances due, due upfront fees for deductible/copay/coinsurance/cosmetics if not collected or under-collected on date of service. You are not obligated to use this card for payments at our office, however if we do not receive payment from you when due, we will attempt to contact you and run the card on file for the full amount owed. If your payment is declined, we will attempt to reach you again. If we are unable to contact you, your balance will be sent to collections and your account locked, and subject to collection, administrative, and attorney fees.

I have read, fully understand, and agree with the financial policy above. I give Cypress Dermatology permission to charge my credit card for any balance(s) on my account for services or products rendered to myself or my dependent. By signature below, I hereby guarantee payment in full to Cypress Dermatology for all charges for services rendered and charges exceeding third party payment.

Signature: X_____ **Date** _____

CONSENT FOR TREATMENT OF MINORS

I understand that I am legally required to be present for the first visit of my child or any minor under my care, under the age of 18. I hereby authorize Cypress Dermatology and its staff to continue evaluation, diagnosis, and treatment of my child, dependent or foster child without my presence in the office after the first visit. I consent to in-office procedures for my dependent minors that include, but are not limited to, cryotherapy, cautery, biopsies, and injections which are deemed advisable by our physicians. I understand that while this authorization shall remain in effect, effective immediately and indefinitely, I may revoke this authorization at any time and for any or no reason by submitting a written request to the office.

_____ _____

Signature of Parent or Guardian **Date**

HIPAA & AUTHORIZATION FOR TREATMENT

I have read and understood the Notice of Privacy Practices. (full detailed version is found on website (www.cypressdermatology.com) and consent to use and disclosure of protected health information about myself or my dependent(s) for the purpose of treatment, coverage, and payment from my health insurance company. I will list the names and relationships of persons with whom we may discuss your medical care (if any) and whether messages can be left on your phone on the new patient packet that is provided below. I understand this list can be revoked at any time with my written authorization. I authorize examination, diagnosis, and treatment (including, but not limited to, the use of skin biopsies, labs, and other non-invasive procedures such as diagnostic tests) to be performed by physicians and staff of Cypress Dermatology, PA.

I authorize the physicians at Cypress Dermatology, PA to prescribe new or refilled medications as deemed necessary for treatment of my conditions. I allow Cypress Dermatology to file for insurance benefits to pay for the care that myself or my minor receives. I authorize Cypress Dermatology to release all necessary medical records to government agencies, insurance carriers, and others (including independent utilization review or organizations) that are financially liable for the services in order for preauthorize services, determine or challenge medical necessity, and to determine the extent and/or amount of liability.

By signature below, I acknowledge that I understand and agree with above.

Patient Printed Name: _____

Signature: X _____ **Date** _____

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Complaints

If you believe your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

Cypress Dermatology, PA
Attention: HIPAA Officer
27700 Northwest Freeway
Suite 490
Cypress, Texas 77433
Phone: (281)- 895-3376

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA officer at the address or phone number listed above.

Acknowledgement and Required Restrictions

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being rendered to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.
I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

_____

Patient Name: _____ (*please print*)
Patient Date of Birth: _____

Signatures:

Patient/Legal Representative: _____ Date: _____
If Legal Representative, relationship to Patient: _____
Witness (optional): _____ Date: _____