Charmaine Browne, M.D.
The Dermatology Institute of South Texas
3330 N. McColl Road, Suite 102
McAllen, Texas 78501

Phone 956-661-0500 *Fax 956-661-0510*

Treatment of Minors

Many times parents find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

I hereby grant _____ permission to treat my minor child

_____ when they arrive at the office unaccompanied.

_____ _____ Date _____
Printed name of Parent/Guardian Signature of Parent/Guardian

Credit Card Authorization

This agreement is required if you wish your unaccompanied child to be seen and charge services rendered.

My minor child will be coming for treatment of his/her dermatological condition unaccompanied, I hereby authorize the above physician to charge my credit card listed below under the following conditions.

_____ I understand that I am responsible for payment at the time services are rendered for any deductible, co-payment, non-covered medically necessary services, and insurance balance not covered by my insurance company.

_____ For whatever reason, should my account become 45 or more days delinquent (from the date of service, I authorize this office to use the credit card listed below to bring my account current without any further permission or notice.

_____ Please provide a receipt for any charges/payments charged to my credit card.

_____VISA _____MC _____AMEX _____Discover _____Other

Credit Card #_____ Exp. Date: _____

Name as it appears on the card: _____

Billing Address: _____

_____ Date: _____
Signature of Card Holder

The Dermatology Institute of South Texas

Charmaine F. Browne, M.D.

3330 N. McColl Rd. Ste. 102

McAllen, TX 78501

Office Phone: (956)661-0500 Office Fax: (956)661-0510

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Medical Records #: _____ Social Security #: _____

A. I authorize: _____
(Provider / Facility)

To release my confidential medical information to:

Name: _____

Address: _____

Phone #: _____

The extent (dates/type) of the information to be released is:

_____

_____

B. Other release information:

1. _____ I do authorize transmission of my medical information by fax machine.
2. _____ I do authorize the release of information/correspondence from another facility or provider found in my record.
3. _____ I do authorize reciprocal release of ongoing information between the two listed providers/facilities:
   _____ and _____

This authorization is effective for (12 months or ____ months) after the date it is signed. I understand that I may revoke this authorization at any time, except to the extent that action that has already been taken in reliance upon it, by giving written notice to the healthcare provider or record keeper. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as this original.

I hereby authorize the release of the information as indicated above. I understand that I have a right to inspect the disclosed information at any time.

I acknowledge that I may receive a copy of this document if requested.

Signature: _____ Date: _____

Relationship to Patient: _____

Record Release Date: _____ Staff Name: _____

The Dermatology Institute of South Texas

Charmaine Browne, M.D.
FRCPC, FAAD, Dip Derm (U.K.), Dip GUMed (U.K.)
Clinical Assistant Professor in Dermatology
UT Southwestern Medical Center, Dallas, TX
UT Health Science Center, San Antonio, TX

3330 N. McColl Road, Suite 102 McAllen, Texas 78501
Phone 956-661-0500 Fax 956-661-0510

IMPORTANT INFORMATION:

BRING THE FOLLOWING TO YOUR APPOINTMENT: (1) Referral (2) Insurance, Medicare and/or Medicaid Card (if any) (3) Picture ID (4) List of medications (5) or reports (if any).

INFORMACION IMPORTANTE:
NECESITA: *(1) Su Referencia (2) Lista de Medicamentos (Si acaso toma alguno) (3) Una Identificación (ID) (4) Su TARJETA DE ASEGURO, MEDICARE y/o MEDICAID (5) Las placas o reportes de radiografías o exámenes*

PATIENT INFORMATION

APELLIDO DEL PACIENTE
PATIENT NAME: _____
LAST FIRST MIDDLE INITIAL

FECHA DE NACIMIENTO *NUMERO DE SUGURO SOCIAL*
DOB: _____ **SSN#:** _____

NUMERO DE TELEPHONO EN CASA *NUMERO DE TELEPHONO CELULAR*
HOME PHONE #: _____ **CELL #:** _____

NUMERO DE CONTACTO EN CASO DE URGENCIA *NOMBRE Y RELACION*
EMERGENCY CONTACT PHONE#: _____ **NAME & RELATION:** _____

DOMICILIO DE CORREO
MAILING ADDRESS: _____

DOMICILIO
PHYSICAL ADDRESS: _____

CUIDAD/ESTADO *CODIGO POSTAL*
CITY/STATE: _____ **ZIP CODE:** _____

OCUPACION *TEL. NEGOCIO*
OCCUPATION: _____ **BUSINESS#:** _____

SITIO DE TRABAJO
EMPLOYER: _____

DIRECCION DEL TRABAJO
EMPLOYER'S STREET ADDRESS: _____

CUIDAD, ESTADO Y CODIGO POSTAL
CITY, STATE AND ZIP CODE: _____

NOMBRE DE CONYUGE *NUMBERO DE SEGURO SOCIAL ESPOSO(A)*
SPOUSE'S NAME: _____ **SPOUSE'S SSN#:** _____

FECHA DE NACIAMENTO ESPOSO(A) *ESPOSO(A) TEL TRABAJO*
SPOUSE'S DOB: _____ **SPOUSE'S WK#:** _____

The Dermatology Institute of South Texas

SI EL PACIENTE ES MENOR DE EDAD O ESTUDIANTE
IF THE PATIENT IS A MINOR OR A STUDENT:

NOMBRE DE MADRE *FECHA DE NACIMIENTO DE MADRE*

MOTHER'S NAME: _____ **MOTHER'S DOB:** _____

NUMERO DE SEGURO SOCIAL *SITIO DE TRABAJO/NUMERO TELEFONO*

SSN#: _____ **MOTHER'S WORK PHONE #:** _____

NOMBRE DEL PADRE *FECHA DE NACIMIENTO*

FATHER'S NAME: _____ **FATHER'S DOB:** _____

NUMERO DE SEGURO SOCIAL *SITIO DEL TRABAJO/NUMERO TELEFONO*

SSN#: _____ **FATHER'S WORK PHONE #:** _____

INFORMACION DE REFERENCIA
REFERRAL INFORMATION

RAZON POR LO CUAL SOLICITA TRATAMIENTO
FOR WHAT REASON ARE YOU SEEKING TREATMENT? _____

_____

FECHA DE PRIMEROS SINTOMAS *REFERENCIA*

DATE OF FIRST SYMPTOMS: _____ **REFERRED BY:** _____

The Dermatology Institute of South Texas

ASIGNACION DE BENEFICIOS Y RESPONSABILIDAD
ASSIGNMENT OF BENEFITS AND RESPONSIBITTY

SU CUENTA DEBERA SER PAGADA AL TIEMPO DE RECIBIR SUS SERVICIOS MEDICOS
ALL SERVICES ARE PAYABLE AT THE TIME SERVICES ARE RENDERED.

SU ASEGURANCA NOS A PROPORCIONADO UN CUOTA DE SUS BENEFICIOS DE POLIZA, PERO COMO ESTOS NOS SON GARANTIZADOS POR SU ASURANCA NO SEREMOS RESPONSABLES SI ESTOS BENEFICIOS QUE SE NOS HAND DADO NO SON CORRECTOS.

WE WILL GET BENEFITS FROM YOUR INSURANCE COMPANY. HOWEVER, SINCE THE QUOTE OF BENEFITS IS NOT A GUARANTEE OF PAYMENT, WE ARE NOT RESPONSIBLE FOR ANY DIFFERENCES.

YO TENGO ____ NO TENGO ____ ASEGURANZA PARA PAGAR LOS SERVICIOS RECIBIDOS.
I DO ____ DO NOT ____ HAVE MEDICAL INSURANCE TO COVER SERVICES RENDERED.

Yo, el otorgado tengo la cobertura de seguros con _____ (nombre de aseguranza) y asigno directo a Charmaine Browne, M.D., P.A. todas las ventajas médicas si alguno de otra manera pagado a mi para los servicios dados. Entiendo que soy responsable por todos los gastos, si mi aseguro paga o no paga y que seré responsable del cualquier costo adicional incluido en la colección de los gastos. Por lo presente autorizo a The Dermatology Institute of South Texas liberar toda la información necesaria de asegurar el pago de ventajas. Autorizo el uso de esta firma sobre todas mis sumisiones de seguros.

Autorizo a Charmaine Browne, M.D., P.A. a iniciar una queja ante mi nombre al comisionado de seguras para cualquier razón. Una fotocopia de esta asignación será considerada eficaz y valido como la original.

I, the undersigned have insurance coverage with _____ (name of insurance company) and direct to Charmaine Browne, M.D., P.A. all medical benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not paid by my insurance, and that I will be responsible for any additional fees incurred in the collection of the charges. I hereby authorize The Dermatology Institute of South Texas to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. This payment will not exceed my indebtedness to Charmaine Browne, M.D., P.A., and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I also authorize Charmaine Browne, M.D., P.A. to initiate a complaint on my behalf to the insurance commissioner for any reason. A photocopy of this assignment shall be considered effective and valid as the original.

_____ _____
SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN **DATE**
FIRMA DEL PACIENTE/PADRE/APODERADO LEGAL *FECHA*

HIPAA Privacy Rule of Patient Authorization Agreement

Dermatology Institute of South Texas

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____ (Patient's Name) understand that as part of my health care, Dermatology Institute of South Texas , originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review Dermatology Institute of South Texas notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review Dermatology Institute of South Texas Notice of Information practices prior to signing this consent;
- That Dermatology Institute of South Texas , reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Dermatology Institute of South Texas , is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that Dermatology Institute of South Texas , has already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness .....

Printed Name of Patient or Legal Representative Witness .....

Date: .....

HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Dermatology Institute of South Texas

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I, _____ (Patient's Name) understand that as part of my health care, Dermatology Institute of South Texas originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that Dermatology Institute of South Texas **Notice of Privacy Practices** provides a complete description *of* the uses and disclosures of my health information. I understand that:

- I have the right to review Dermatology Institute of South Texas Notice *of* Privacy Practices prior to signing this acknowledgement;
- That Dermatology Institute of South Texas reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature *of* Individual or Legal Representative Witness..... ....

Printed Name of Individual or Legal Representative Witness.....

Date: .....

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Others (please specify)

_____

_____

Diana Ochoa
Privacy Official

Date

Patient Intake Form Meaningful Use Measures

*Our practice is r using an electronic health record called Dr RcopiaMU. We are participating in the meaningful use incentive program sponsored by the federal government. We are collecting this data to be compliant with the program in an effort to increase patient safety, improve patient care and create a complete patient record. We appreciate your assistance with providing our practice this information about your health information.**

*Please fill out completely and return to the Receptionist

Required Information	Please fill in information in the area below
Full Name	
Date of Birth	
Gender	
Email Address	
Race	*Please indicate your race (circle):* Other American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Unavailable Declined/Unable to Determine
Ethnicity	*Please indicate your ethnicity (circle):* Other Hispanic/Latino Arab-American Declined/Unable to Determine Non-Hispanic/Latino Unavailable
Preferred Language	*Please select your preferred language (circle):* English Chinese Arabic Spanish Japanese Asian/Pacific Island Language French Italian Other Indo-European Language Portuguese Russian Declined Unavailable(unknown) Other(Please Specify)_____
Smoking Status	*Please select your current smoking status (circle):* Current every day smoker Heavy Tobacco smoker Current some day smoker Light Tobacco smoker Former smoker Never smoked Smoker, current status unknown Unknown if ever smoked Secondhand Smoke
Height	
Weight	
Do you have allergies?	*If yes, what are you allergic to?*
Are you taking any medications?	*If yes, which medications?*
Family Diagnosis History	*If yes, which family member and what condition?*
Pharmacy you would like to use for your prescriptions	

MEDICAL HISTORY RECORD

Patient's Name: _____ DOB: _____ Age: _____

Occupation: _____ Primary Care Physician: _____

PERSONAL MEDICAL HISTORY

Asthma	Yes No _____	Injuries	Yes No _____
Arthritis	Yes No _____	Kidney Disorder	Yes No _____
Back Problems	Yes No _____	Nervous Disorders	Yes No _____
Cancer	Yes No _____	Osteoporosis	Yes No _____
Diabetes	Yes No _____	Paralysis	Yes No _____
Dizziness	Yes No _____	Pneumonia	Yes No _____
Epilepsy	Yes No _____	Rheumatism	Yes No _____
Heart Disorder	Yes No _____	Stomach Disorder	Yes No _____
Hepatitis	Yes No _____	Thyroid Disorder	Yes No _____
Hospitalization	Yes No _____	Tuberculosis	Yes No _____
High Blood Pressure	Yes No _____	Ulcers	Yes No _____

SURGERIES

Please list any previous surgeries you have had and when. _____

_____

_____

MEDICATIONS

Please list ALL medications you are currently taking. _____

_____

_____

_____

ALLERGIES

Codeine _____ Cortisone _____ Latex _____ Penicillin _____ Other _____ None _____

FAMILY MEDICAL HISTORY

Cancer _____ Diabetes _____ Hypertension _____

Hypotension _____ Stroke _____

Other _____

SOCIAL HISTORY

Number of Children: _____ Marital Status: Single Married Divorced Widowed Separated

Do you consume alcohol? Yes No How many drinks per week? _____

Do you smoke? Yes No How much? _____

Do you have or have you ever had a drug dependence? Yes No Drug _____

I hereby declare that the above answers are complete and true.

_____

Patient/Parent/Guardian Signature **Date**

The Dermatology Institute of South Texas
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Phone 956-661-0500 *Fax 956-661-0510*

Advisement

Please be advised that all Pathology is sent to South Texas Dermatology.

All Lab work is sent to Lab Corp.

If you prefer to have it sent elsewhere please inform any Medical Assistant.

If you are unsure as to whether these labs are covered by your insurance company please contact them directly.

If you have any questions please notify any Medical Assistant.

Please sign and date where indicated.

_____ _____

Signature Date

Thank you,

Management

The Dermatology Institute of South Texas
Cosmetic Interest Questionnaire

Patient Name:	Date:

General appearance or products of interest to you (please check all that apply).

☐ Skin care advice	☐ Freckles	Other Concerns/Comments:
☐ Skin care products	☐ Facial redness	
☐ Botox Cosmetic	☐ Liver spots/age spots	
☐ Frown lines between the brows	☐ Fine lines and wrinkles	
☐ Lines around nose and mouth	☐ Sagging Skin	
☐ Tired looking skin	☐ Inadequate eyelashes	
☐ Acne	☐ Blotchy skin	
☐ Hyperpigmentation	☐ Rough skin texture	

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		*True Age*		*Older Than*
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

How did you hear about us?

☐ My physician	*Full name:*
☐ My insurance company provider	*Name:*
☐ The yellow pages	*Specify Ad:*
☐ A friend or family member	*Name:*
☐ Internet	
☐ Seminar	*Date /location:*
☐ Other	

Are you interested in a Personal Treatment Plan designed to meet your cosmetic needs:

☐ Yes ☐ No

☐ Approval to contact you.	*Best phone number to reach you:*
☐ Approval to send you information.	*Email address:*

Patient Signature: _____ *Date:* _____

	For Office Use Only	
Follow-Up	*Date*	*Completed by (name)*
☐ Initial Inquiry/Information Mailed		
☐ Follow-up call		
☐ Procedure scheduled		
☐ Procedure completed		

Comments: