

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

Phone 956-661-0500

McAllen, Texas 78501

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:

CIUDAD/ESTADO

CODIGO POSTAL

CITY/STATE:

ZIP CODE:

OCUPACION

TEL. NEGOCIO

OCCUPATION:

BUSINESS#:

SITIO DE TRABAJO

EMPLOYER:

DIRECCION DEL TRABAJO

EMPLOYER'S STREET ADDRESS:

CIUDAD, ESTADO Y CODIGO POSTAL

CITY, STATE AND ZIP CODE:

NOMBRE DE CONYUGE

NUMERO DE SEGURO SOCIAL ESPOSO(A)

SPOUSE'S NAME:

SPOUSE'S SSN#:

FECHA DE NACIAMLNTO 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 RESPONSIBILITY

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 seguro paga o no paga y que seré responsable del cualquier costo adicional Includo 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
FIRMA DEL PACIENTE/PADRE/APODERADO LEGAL

DATE
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

MEDICAL HISTORY RECORD / HISTORIA MEDICA

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

Occupation: _____ Primary Care Physician: _____

PERSONAL MEDICAL HISTORY / HISTORIA MEDICA PERSONAL

Asthma/Asma	Yes No _____	Injuries/Lesiones	Yes No _____
Arthritis/Artritis	Yes No _____	Kidney Disorders/Riñones	Yes No _____
Back Problems/Espalda	Yes No _____	Nervous Disorders/Nervios	Yes No _____
Cancer	Yes No _____	Osteoporosis	Yes No _____
Diabetes	Yes No _____	Paralysis	Yes No _____
Dizziness/Mareos	Yes No _____	Pneumonia/Neumonía	Yes No _____
Epilepsy/Epilepsia	Yes No _____	Rheumatism/Reumas	Yes No _____
Hear Disorder/Corazon	Yes No _____	Stomach Disorders/Estomago	Yes No _____
Hepatitis	Yes No _____	Thyroid Disorders/Tiroides	Yes No _____
Tuberculosis	Yes No _____	Ulcers/Ulceras	Yes No _____
High Blood Pressure/Alta Presión	Yes No _____		

SURGERIES / CIRUGIA

Please list any previous surgeries you have had and when. / Haga una lista de cirugía que ha tenido.

MEDICATIONS / MEDICAMENTOS

Please list ALL medications you are currently taking. / Haga una lista de medicamento que esté tomando.

ALLERGIES / ALERGIAS

Codeine/Codeína _____	Cortisone/Cortisona _____	Penicillin/Penicilina _____
Latex _____	Other/Otro _____	None/Ninguno _____

FAMILY MEDICAL HISTORY / HISTORIA MEDICA FAMILIAR

Cancer _____	Diabetes _____	Stroke/Derrame Cerebral _____
Hypertension/Alta Presión _____		Hypotension/Baja Presión _____

SOCIAL HISTORY / HISTORIA SOCIAL

Number of children / Cuantos hijos tiene: _____ Do you smoke? / Fuma? Yes No _____ How much / Cuanto? _____

Status: Single / Soltero(a) Married / Casado(a) Divorced / Divorciado(a) Widowed / Viudo(a) Separated / Separado(a)

Do you consume alcohol? / consume alcohol? Yes No _____ How many drinks per week? / Cuantas bebidas al día? _____

I hereby declare that the above answers are complete and true. / Yo declare que las respuestas están completas y verdaderas.

Patient or Guardian's Signature/Firma _____

Date/Fecha _____

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).

<input type="checkbox"/> Skin care advice	<input type="checkbox"/> Freckles	Other Concerns/Comments:
<input type="checkbox"/> Skin care products	<input type="checkbox"/> Facial redness	
<input type="checkbox"/> Botox Cosmetic	<input type="checkbox"/> Liver spots/age spots	
<input type="checkbox"/> Frown lines between the brows	<input type="checkbox"/> Fine lines and wrinkles	
<input type="checkbox"/> Lines around nose and mouth	<input type="checkbox"/> Sagging Skin	
<input type="checkbox"/> Tired looking skin	<input type="checkbox"/> Inadequate eyelashes	
<input type="checkbox"/> Acne	<input type="checkbox"/> Blotchy skin	
<input type="checkbox"/> Hyperpigmentation	<input type="checkbox"/> 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.

<i>Younger Than</i>		<i>True Age</i>		<i>Older Than</i>
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.

<i>Not Concerned</i>		<i>Somewhat Concerned</i>		<i>Very Concerned</i>
1	2	3	4	5

How did you hear about us?

- My physician
- My insurance company provider
- The yellow pages
- A friend or family member
- Internet
- Seminar
- Other

Full name:

Name:

Specify Ad:

Name:

Date /location:

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

- Yes No

<input type="checkbox"/> Approval to contact you.	<i>Best phone number to reach you:</i>
<input type="checkbox"/> Approval to send you information.	<i>Email address:</i>

Patient Signature:

Date:

	For Office Use Only	
<i>Follow-Up</i>	<i>Date</i>	<i>Completed by (name)</i>
<input type="checkbox"/> Initial Inquiry/Information Mailed		
<input type="checkbox"/> Follow-up call		
<input type="checkbox"/> Procedure scheduled		
<input type="checkbox"/> Procedure completed		

Comments:

