HOWSDEN DERMATOLOGY
1919 S. Shiloh Rd, Suite 300, Garland, TX 75042
(972) 278-4992, (972) 271-1597 (fax)

Patient Registration

Akash A. Patel, MD
F. Lester Howsden, MD
Kevin F. Kia, MD

I. PATIENT IDENTIFICATION

Date: _____

Name: _____ (Last / First / Middle Initial) Phone #: _____

Mailing Address: _____ (Street Address / City / State / Zip Code)

Age: _____ Birthdate: _____ Sex: ☐Male ☐Female Social Security Number: _____

Occupation: _____ Employer: _____ Work phone: _____

Insured's name: _____ **Relation:** _____ **Insured Birthdate:** _____

II. EMERGENCY CONTACT

_____ (Name / Relationship / Number(s))

Not living with you: _____ (Name / Relationship / Number(s))

III. FOR PATIENTS LESS THAN 18 YEARS

Name of Parent/Guardian: _____ Employer and Work Number: _____

If I find that I am unable to accompany my above child/young adult to an appointment, I hereby grant permission to Howsden Dermatology to see and treat my child if and when he/she arrives at the office unaccompanied. _____ (Signature of Parent/Guardian)

IV. PRIMARY DOCTOR & REFERRING DOCTOR

Name of Primary Care Doctor: _____ Phone: _____

Address: _____

Did a doctor refer you to our office? Yes / No

Referring Doctor's Name _____ Phone: _____

PAST MEDICAL HISTORY, FAMILY HISTORY, & SOCIAL HISTORY

List any medications you are allergic to including dental anesthesia (Novacaine): _____

Do you require antibiotics before dental procedures/operations and why: _____

Please list all known medical problems including skin: _____

_____

_____

Please list prior surgeries: _____

Current medications: _____

_____

Any type of skin cancer in your family and relation: _____

Do you live alone: ☐Yes ☐No Do you smoke: ☐Yes ☐No Do you drink alcohol: ☐Yes ☐No

My signature below signifies that the above information is correct to the best of my knowledge and provides my consent for the necessary examination and treatment (Parent/Guardian if under 18): _____

Updated/Doctor's initials:

HOWSDEN DERMATOLOGY
AKASH A. PATEL, MD
F. LESTER HOWSDEN, MD
KEVIN F. KIA, MD

TELE: 972-278-4992 FAX: 972-271-1597

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:

Spouses and/or children frequently request the results of laboratory studies and biopsy reports, as well as patient account information. Without your authorization we cannot provide such basic information to them. Your signature below will provide the needed authorization.

PLEASE CHECK INDIVIDUALS YOU WISH TO AUTHORIZE TO RECEIVE SUCH INFORMATION:

____ Spouse
____ Parents
____ Children
____ Spouses of children
____ Other (specify) _____

LINE THROUGH ANY OF THE ABOVE THAT YOU WISH TO SPECIFICALLY EXCLUDE

I understand that information released is for the purpose of providing quality, continued patient care. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it.

May we leave information on your home answering machine if we are unable to reach you?
YES NO **(Please circle appropriate response)**

Patient name _____ Date of Birth _____

_____ _____
Signature of Patient or Legal Representative Date signed
(Parent or Legal Guardian must sign for patient under 18 years of age.)

_____ _____
(if not signed by patient, please indicate relationship to patient) Witness

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PLEASE SIGN SO WE HAVE YOUR INSURANCE AUTHORIZATION ON FILE

I understand that if any of the insurance information I have provided is incorrect or if I fail to notify the office of any insurance changes that I am responsible for all charges. I authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical benefits to which I am entitled to Howsden Dermatology, P.A. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as an original.

Patient/Guardian Signature:_____ Date:_____

HOWSDEN DERMATOLOGY

AKASH A. PATEL, MD
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1919 S. SHILOH ROAD
SUITE 300, LB42
GARLAND, TEXAS 75042

TELE: 972-278-4992 **FAX: 972-271-1597**

Financial Policy

If we are not filing insurance for your visit, you are responsible for payment in full at the time of service. If you have a deductible plan, payment in full is due at the time of service. We accept cash, checks, Mastercard, Visa, and Discover.

Patients covered by contracted insurance plans:

It may be necessary to perform minor procedures during your visit. **In addition to your office visit co-pay, covered procedures may be applied to your deductible and/or coinsurance.** It is up to you to understand the financial responsibilities required of you by your insurance policy.

We routinely freeze precancerous lesions and warts and biopsy suspicious lesions for pathology. Some of these CPT procedure codes are:

precancerous lesion destructions 17000, 17003
benign lesion destructions 17110, 17111
incision & drainage, (simple) 10060 or (complicated) 10061
excision/closure of skin cancers or cysts 11401 - 11606, 12031 - 13132
biopsies 11100, 11101
pathology 88305
skin tags 11200, 11201
intralesional injection 11900, 11901

You may wish to review these procedures with your insurance company before your visit. (This is not a complete list of procedures.)

I understand and agree to the financial responsibilities listed above.

Patient/Guardian Signature:_____Date:_____

HOWSDEN DERMATOLOGY

WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FORM

Our Notice of Privacy Practices provides information as to how we may use and disclose protected health information about you. You have been given a copy of our Notice of Privacy Practices. The terms of our Notice may change. You may obtain a revised copy of contacting our office.

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By signing this form, I acknowledge that I have received a copy of the Notice of Privacy Practices and consent to the disclosure of protected health information about me for treatment, payment, and health care operations as described in the Notice of Privacy Practices. Howsden Dermatology provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____

Signature of Patient or Patient Representative **Date**

_____

Relationship to Patient
(if signed by other than patient)

HOWSDEN DERMATOLOGY

NOTICE OF PRIVACY PRACTICES
As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information—also known as Protected Health Information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT THE PRIVACY OFFICER FOR THIS OFFICE (Name of individual available upon request.)

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:

1. Treatment. We are permitted to use and disclose your medical information to those involved in your treatment. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. This is a specialist practice and when we provide treatment we may provide your primary care physician information about your particular condition so that he or she can take this into consideration in your general health care.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may submit a claim to your insurer in order to obtain payment from your insurer or HMO. The form used will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to have in order to approve payment to us. Also, we may use your PHI to bill you directly for services and items.

3. Health Care Operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

4. Laboratory or Biopsy Information, Appointment and Patient Recall Reminders. We may use and disclose PHI to contact you as a reminder that you have an appointment for medical care with the Practice or that you are due to receive periodic care from the Practice. This contact may be by phone, in writing, e-mail, or otherwise and may involve leaving an e-mail, a message on an answering machine, or otherwise. We may use the same various means to notify you, or, with your consent[1], a family member, of laboratory results or histopathology results. In these cases, if we are unable to contact you directly, any message left on an answering machine would generally be limited to a request to contact the Practice.

5. Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives. This would generally be done by direct contact with you, or with your consent[2], a family member. For example, patients with certain skin conditions may be referred for care and the reasons for this as well as the alternatives (e.g.: names of various Mohs surgeons or plastic surgeons) may be discussed by telephone with you, your referring physician, or, with your consent, other family members.

6. Release of Information to Family/Friends. Our practice may release your PHI, with your written consent, to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a grandparent or babysitter take their child to the Practice for treatment. In this example, the grandparent or babysitter may have access to this child's medical information. When someone other than a parent or legal guardian brings a minor child to the office, the parent or legal guardian must provide written consent for the Practice to provide care to that minor patient. That written consent can be brought by the individual bringing the minor patient.

8. Disclosures Required By Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices

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[1] See "Authorization for Release of Medical Information" form.

[2] See "Authorization for Release of Medical Information" form

- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Serious Threats to Health or Safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, **you must make a written request to the Privacy Officer,** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, **you must make your request in writing to the Privacy Officer.** Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **the Privacy Officer** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **the Privacy Officer.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **the Privacy Officer.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **the Privacy Officer.**

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **the Privacy Officer.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **the Privacy Officer for further information.**