MEDICAL HISTORY

Patient: **DOB**: **Date** ______________________________

Purpose of Visit: ______________________ Physician Seen Today ______________________

Referring Physician: ______________________ Telephone: ______________________

Primary Physician: ______________________ Telephone: ______________________
(if different from above)

Pharmacy Name: ______________________ Pharmacy Cross Streets: ______________________
Pharmacy Telephone: ______________________

Have you ever had reactions to local anesthetics? [ ] Yes -- Please explain: ______________ [ ] No

Do you have DRUG allergies? If so, please list: ______________________________

Medications/non-prescription medications that you **currently take including prescriptions from this office**

Medication	Dosage	Instructions

Do you have a PERSONAL HISTORY of, or are currently under treatment for, the following conditions?
(if any are "yes", please explain the lines below):

[ ] yes [ ] no Heart Problems
[ ] yes [ ] no High Blood Pressure
[ ] yes [ ] no Pacemaker
[ ] yes [ ] no Stroke
[ ] yes [ ] no Blood Clots
[ ] yes [ ] no Bleeding Problems
[ ] yes [ ] no Lung Problems
[ ] yes [ ] no HIV
[ ] yes [ ] no Psychiatric Conditions

[ ]yes [ ] no Hepatitis
[ ]yes [ ] no Diabetes
[ ]yes [ ] no PUVA/UVB
[ ]yes [ ] no Arthritis
[ ]yes [ ] no Epilepsy
[ ]yes [ ] no Glaucoma
[ ]yes [ ] no Keloid scars
[ ]yes [ ] no Cancer
[ ]yes [ ] no Skin Cancer

[ ] yes [ ] no Organ Transplant
[ ] yes [ ] no X-ray Therapy
[ ] yes [ ] no Kidney Problems
[ ] yes [ ] no Mitral Valve Prolapse
[ ] yes [ ] no Accutane past 6 months?
[ ] yes [ ] no Currently Pregnant/Nursing
[ ] yes [ ] no Rheumatic Fever
[ ] yes [ ] no Artificial Joint/Valve
[ ] yes [ ] no Other

[ ] yes [ ] no Previous Surgery? If yes, explain type of surgery and give dates (mo/yr) of each:

____

____

[ ] yes [ ] no Family History of Malignant Melanoma? If yes, who? ______________________

[ ] yes [ ] no Alcohol Use: How much and how often? ______________________

[ ] yes [ ] no Tobacco Use: Types and amounts used: ______________________

Have you ever had a mammogram? [ ]yes [ ] no If yes, date of last screening: ______________________

Have you ever had a colorectal screening? [ ]yes [ ] no If yes, date of last screening: ______________________

Have you received a pneumonia vaccination in the past year? [ ]yes [ ] no
Have you received an influenza vaccination in the past year? [ ]yes [ ] no

______________________ ______________________
Signature of Patient Date

______________________ ________ ________ ________ ________ ________
Signature of Physician Date Date/Initial Date/Initial Date/Initial Date/Initial

SnyDerma Dermatology & Breast and Body Center of Austin

1510 W 34th Street,Suite 100 Austin Texas 78703

P: 512.533.9900 F: 512.533.9901

Patient's Last Name:	Patient's First Name & Middle Initial:	Date:

Street Address and Apt #:	City & State: Zip Code:	Patient's Sex: F ( ) M ( )

Race (please check one): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Caucasian	Ethnicity (please check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Preferred Method of Contact:	Patient's Home Phone #: ( )	Patient's Work Phone & ext : ( )	Patient's Cell Phone #: ( )

Preferred language:	Patient's Date of Birth	Age:	Patient SSN:	Texas Drivers License #:

Parent's Name(s) If Patient is a minor child:	E-mail Address: May we email you if unable to contact by telephone? Y or N
Who referred you to our office?	Who to call in case of an Emergency? Name & Relationship: Phone: ( )
Employer name and phone number:	Occupation:

Primary Insurance Company:	Primary Insured's Name and DOB:

Member or ID # (if not listed on card, then SS # of primary insured):	Group #:	Primary insured relationship to patient:

Secondary Insurance Company:	Secondary Insured's Name and DOB:	Secondary Insured's relation to patient:

Secondary Insurance Member or ID# (if not listed on card, then SSN of primary insured):	Group #:

RELEASE & ASSIGNMENT OF BENEFITS: I hereby authorize the release of any and all medical information to my insurance carrier(s) or it's/their representative, for purposes necessary in the adjudication or processing of any and all insurance claim(s) filed on my behalf and for which I am financially responsible. I further authorize all insurance benefits be paid to the provider rendering services on behalf or Renee Snyder, M.D., P.A. or Ned Snyder IV, M.D., P.A.

AIDS/HIV TESTING IN CASES OF ACCIDENTAL EXPOSURE: I understand that if a healthcare worker is accidentally exposed to my blood or bodily fluids in such a fashion that the worker may be at risk for contracting Hepatitis B, Hepatitis C or AIDS. I will be required to have my blood tested, pursuant to Texas law and office protocols, to determine the present of Hepatitis B or Hepatitis C surface antigens and/or Human Immunodeficiency Virus Antibodies. Test results will be kept confidential to the extent allowed by law and any information concerning my identity, in connection with such testing, will be destroyed after testing and notification of the healthcare worker who was exposed.

CONSENT TO TREAT: I hereby consent to treatment by my dermatologist or plastic surgeon to include examination and treatment, prescribing medication and skin preparations.

ACKNOWLEDGEMENT OF RECEIPTS OF NOTICE OF PRIVACY PRACTICES: I have been given the opportunity to read a copy of this office's Notice of Privacy Practices. I also understand that I have the right to request a copy of the Notice of Privacy Practices for my records.

____ ________________________

Patient's Signature (Parent if Patient is a minor child) **Date**

SnyDerma Dermatology & Breast and Body Center of Austin
1510 W 34th Street Suite 100 Austin Texas 78703
P: 512.533.9900 F: 512.533.9901

FINANCIAL POLICY

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. Please initial each of the following numbered items:

1. _____If we participate with your managed care plan or you have a commercial insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans. You will be responsible at the time of service for the payment of:
   - Annual Deductible
   - Co-payments
   - Charges for non-covered or cosmetic services

   In the event that we are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.

   Please be advised that anything you choose to have removed or biopsied may not be covered under your office co-pay and is subject to your deductible. We will make every effort to contact your insurance to verify your benefits, but in the event we are unable to reach them, you will be responsible for your co-payment as well as payment for any procedures performed. Such procedures include but are not limited to: biopsies, removal of warts, moles, pre-cancerous lesions, or other skin lesions. Methods of removal may include but are not limited to: cutting, freezing, burning, or application of a blistering agent.

2. _____We are Medicare participating providers, therefore we will bill Medicare directly. You will be responsible at the time of service for payment of:
   - The annual deductibles
   - Co-payments
   - Charges for non-covered or cosmetic services

   You will be asked to sign a Waiver of Liability Form in the event that a service is provided, which we know is not covered by Medicare.

3. _____ If you have no health insurance, payment is expected in full at the time of service.

4. _____In the event we receive a returned check due to insufficient funds, a fee of $35.00 will be charged to your account and payment is due upon receipt of your statement.

5. _____If you purchase skin-care products or supplies from our office, please understand that these products/supplies are a non-refundable item. In the event that the product is defective, we will gladly replace the item(s).

6. _____We request that you give 24 hours notice if you are unable to keep your appointment. Failure to give 24 hours notice will result in a $35.00 missed appointment fee. This fee is not covered by your insurance plan

7. _____Cosmetic consultation fees are $150 to reserve your appointment. This fee is taken at the time of booking and is non-refundable if the appointment is missed. This fee will be applied to any cosmetic procedure that is scheduled.

For your convenience we accept cash, check, MasterCard, Visa, American Express, Discover, and Care Credit.

If you have any questions, please do not hesitate to ask us. We are here to assist you any way possible.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

______________________________ ______________________________

Patient/Guardian Signature Date

Notice of Privacy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WHO WILL FOLLOW THIS NOTICE?
Physicians affiliated with: Renee Snyder M.D., P.A.
Physicians affiliated with: Ned Snyder M.D., P.A.
All Employees

We understand that medical information about you and your health is personal and we are committed to protecting this information. When you receive care at our facility, a record of the care and services you receive is made. Typically, this record contains your treatment plan, history and physical, test results, and billing record.
This record serves as a:
 Basis for planning your treatment and services;
 Means of communication among the physicians and other health care providers involved in your care;
 Means by which you or a third-party payor can verify that services billed were actually
 Source of information for public health officials; and
 Tool for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as “medical information”). It also describes your rights and our obligations regarding the use and disclosure of medical information.

OUR RESPONSIBILITIES.
We shall:
- Make every effort to maintain the privacy of your medical information;
- Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction; and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- We will notify you, and the Department of Health & Human Services, of any unauthorized acquisition, access, use or disclosure of your unsecured medical information that presents a significant risk of financial, reputational or other harm to you, to the extent required by law. Unsecured medical information means medical information not secured by technology that renders the information unusable, unreadable, or indecipherable as required by law.

THE METHODS IN WHICH WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.
The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.
- **For Treatment.** We will use and disclose your medical information to provide, coordinate, or manage your health care and any related service. For example, we may share your information with your primary care physician or other specialists to whom you are referred for follow-up care.
- **For Payment.** We will use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to disclose your medical information to a health plan in order for the health plan to pay for the services rendered to you.
- **For Health Care Operations.** We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run our facility in an efficient manner and provide that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing.
- **Appointment Reminders.** We may use and disclose medical information in order to remind you of an appointment. For example, our facility may provide a written or telephone reminder that your next appointment is coming up.
- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the surgical outcome of all patients for whom one type of procedure is used to those for whom another procedure is used for the same condition. All research projects, however, are subject to a special approval process. Prior to using or disclosing any medical information, the project must be approved through this research approval process. We will ask for your specific authorization if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.
- **As Required by Law.** We will disclose medical information about you when required to do so by federal or Texas laws or regulations.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you to medical or law enforcement personnel when necessary to prevent a serious threat to your health and safety or the health and safety of another person.
- **Sale of Practice.** We may use and disclose medical information about you to another health care facility or group of physicians in the sale, transfer, merger, or consolidation of our practice.

SPECIAL SITUATIONS.

- **Organ and Tissue Donation.** If you have formally indicated your desire to be an organ donor, we may release medical information to organizations that handle procurement of organ, eye, or tissue transplantations.
- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Qualified Personnel.** We may disclose medical information for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the audit or evaluation, or otherwise disclose your identity in any manner.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following activities:
  - To prevent or control disease, injury, or disability;
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using;
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
  - To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence. All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.
- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.
- **Lawsuits and Disputes.** If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
  - In response to a court order or subpoena; or
  - If our facility determines there is a probability of imminent physical injury to you or another person, or immediate mental or emotional injury to you.
- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner when authorized by law (*e.g.,* to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.
- **Inmates.** If you are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide you treatment.
- **Other Uses or Disclosures.** Any other use or disclosure of PHI will be made only upon your individual written authorization. You may revoke an authorization at any time provided that it is in writing and we have not already relied on the authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information collected and maintained about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Medical Records Department. If you request a copy of the information, we may charge a fee established by the Texas Medical Board for the costs of copying, mailing, or summarizing your records. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by our facility will review your request and denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Right to Amend.** If you feel that medical information maintained about you is incorrect or incomplete, you may ask our facility to amend the information. You have the right to request an amendment for as long as the information is kept by our facility. To request an amendment, your request must be made in writing and submitted to our facility. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
  - Was not created by our facility, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by our facility;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations. To request this list you must submit your request in writing to our facility. Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists within the 12- month period, you may be charged for the

cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information our facility uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information our facility discloses about you to someone who is involved in your care or the payment for your care. We are not required to agree to your request, unless the request pertains solely to a healthcare item or service for which our facility has been paid out of pocket in full. Should we agree to your request, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions you must make your request in writing to our facility. In your request, you may indicate: (1) what information you want to limit;
  (2) whether you want to limit our facilities use and/or disclosure; and
  (3) to whom you want the limits to apply.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that our facility contact you only at work or by mail. To request that our facility communicate in a certain manner, you must make your request in writing to the Medical Records Department. You do not have to state a reason for your request. Our facility will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

CHANGES TO THIS NOTICE.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting the Medical Records Department.

COMPLAINTS.

If you believe your privacy rights have been violated, you may file a complaint with our facility or with the Office for Civil Rights, U.S. Department of Health and Human Services.

To file a complaint with our facility, contact the Practice Manager at (512)533-9900. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred.

The address for the Office of Civil Rights is:
Secretary of Health & Human Services
Region VI, Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202
All complaints should be submitted in writing.
You will NOT be penalized for filing a complaint.