CLEAR LAKE dermatology

Narin “Dr. Joe” Apisarnthanarax, M.D., F.A.A.D.
Prapand “Dr.A” Apisarnthanarax, M.D., F.A.C.P.
Miranda Uzoma, M.D., F.A.A.D.
David Raimer, M.D.
Stephanie Kokolis, PA-C
Hannah Stevenson, NP

Medical History

Name (First, Middle, Last):_____ DOB: _____

Preferred Name: _____ Gender: _____ Race: _____ Ethnicity: _____

Emergency Contact: _____ Relation to patient: _____ Phone: _____

Reason for your visit? _____

How did you hear about us? _____ PCP: _____

Pharmacy: _____ Phone: _____ Allergies: _____

Please list your current medications in the space provided along with the Strength/Dose/Frequency. Include all vitamins and over the counter medications. Continue on the back if needed. Write " NONE" if you are not on any medications. Write "List Attached" if you wish for us to make a copy of your personal medication list.

_____

_____

_____

Please select any of the following medical conditions that you currently have, or have had, below:

☐ Anxiety	☐ Arthritis	☐ Asthma	☐ Atrial Fibrillation	☐ Bone Marrow Transplant
☐ COPD	☐ Coronary Artery Disease	☐ Depression	☐ Diabetes	☐ End Stage Renal Disease
☐ Heartburn	☐ Hearing loss	☐ Hepatitis	☐ High Blood Pressure	☐ HIV/AIDS
☐ High Cholesterol	☐ Overactive Thyroid	☐ Low Thyroid	☐ Leukemia	☐ Lymphoma
☐ Seizures	☐ Stroke	☐ Cancer: _____	☐ Other: _____	☐ NONE

Past Surgeries:_____
Do you have a family history of Melanoma? Y / N If Yes, who: _____

Woman Section:
Are you pregnant/planning pregnancy/fertility treatment? _____
Are you breast feeding? _____

Social Activities

Do you wear sunscreen? Y / N What SPF? _____
Do you tan in a tanning salon? Y / N How often? _____

Do you drink Caffeine? Y / N
several times a day/ once a day /a few times a week/ a few times a month

Sexual activity:
not sexually active/ one partner/ more than one partner/ same sex partner

Driving habits:
drives throughout the day/ daytime only/ nighttime only / no longer drives

Do you use any form of tobacco? Y / N Smoke/Chew/Dip
How often do you use tobacco? _____

Do you drink Alcohol? Y / N
3 or more 1-2 less than 1 (per day usage) socially

Do you exercise? Y / N
once a day/ a few times a week/ a few times a month

Do you feel safe at home? Y / N

_____ _____
Patient/Guarantor Signature Date (MM/DD/YYYY)

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Notice of Privacy Practice

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

OUR LEGAL DUTY

We are required by applicable federal and state law to main the privacy of your health information. We are also required to give this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

TREATMENT: We may use or disclose your health information to a physician or other healthcare provider who is providing treatment for you.
PAYMENT: We may use and disclose your health information to obtain payment for services provided to you. We may use or disclose your medical information to any person or entity that may be reasonable for payment of charges associated with your medical care, including but not limited to insurance companies, governmental payers such as Medicare, and workers' compensation carriers.
HEALTHCARE OPERATION: We may use and disclose your health information in connection with our healthcare operation. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner or provider performance, conducting training programs, accreditation, and certification, licensing, or credentialing activities.
YOUR AUTHORIZATION: In addition to our use of your healthcare information for treatment, payment, or healthcare operation, you may give us written authorization to use your health information or to disclose to anyone you authorize for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or discuss your health care information for any reason except those described in this notice. .
REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.
ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail, postcards, or letters).

Financial Policies

This office will bill your insurance carrier, including Medicare, as a courtesy; you (the patient or guarantor) are ultimately responsible for any and all charges accrued in our office that are not covered or rejected by your insurance plan. Additionally, you will be responsible, at the time of service, for the payment of:

- Annual deductibles and/or co-payments
- Charges for non-covered and/or cosmetic services

We will verify your insurance eligibility and benefits prior to your visit; however, verification of benefits is not a guarantee of payment by your insurance. You will be billed any remaining balances if:

- Your insurance company pays less than the payment obtained on the date of service
- We obtain a denial from your insurance company
- A valid referral from your Primary Care Provider(PCP) was not obtained and is not on file at the time of service
- We have not received payment from the insurance company within 60 days of filing your claim

IF YOU HAVE NO HEALTH INSURANCE, YOU ARE ‘SELF-PAY’ AND PAYMENT IS EXPECTED IN FULL AT TIME OF SERVICE

No Show Fee: If you do not show up for a scheduled appointment; your account will be charged the **$50.00** “No Show fee.”
Same Day Cancellation Fee: If you cancel your appointment within 48 hours, your account will be charged **$50.00** “Same Day Cancellation fee”.
Returned Checks: there will be a **$50.00** service fee charged for all returned or canceled checks
Saturday Appointments: All patients seen on Saturdays are required to have a credit card on file. You will be charged **$50.00** if you “No Show” or cancel within 48 hours.
Surgical Appointments: There is a **$100.00** deposit for all excisions and Mohs . This will be applied towards your surgery. If you “No Show” or cancel within 48 hours, you forfeit your deposit.
Cosmetic Appointments: There is a **$100.00** deposit for all cosmetic appointments that will be applied towards your visit, you forfeit your deposit if you “No Show” or cancel within 48 hours.

I have read, understood, and agree to ALL fees and charges stated above.

_____ _____

Patient/Guarantor Signature Date (MM/DD/YYYY)

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HIPAA Authorization Form (Medical Information Release Form)

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies on a format other than photocopies. We will use the format you request unless we cannot practicably do so. **YOU MUST MAKE A REQUEST IN WRITING TO OBTAIN ACCESS TO YOUR INFORMATION**. You may be charged a reasonable cost-based fee for expenses such as copies, postage, and staff time. All requests can take up to 14 business days to process and review.

I _____ authorize Clear Lake Dermatology to use and disclose protected health information to the following:

[ ] Spouse _____

[ ] Child(ren)/Parent _____

[ ] Other _____

[ ] None (I do not wish to release my records to any person)

I authorize the release of the following: (check all applicable)

[ ] All health information	[ ] Chart Notes	[ ] Past/Present Medications
[ ] Diagnostic/Biopsy Reports	[ ] Lab Results	[ ] Billing Medications

[ ] You have my permission to leave a message (including medical care/appointment reminders) on the phone number on file.
[ ] You have my permission to leave a message (including medical care/appointment reminders) with the above person.
[ ] DO NOT leave messages on my phone or with any other person.

EFFECTIVE TIME PERIOD: This authorization is valid until the earlier of the occurrence of the death of the individual; the Individual reaching the age of majority; permission is revoked in writing
or the following specific date (optional) Month _____Day _____ Year _____

_____ _____
Patient/Guarantor Signature Date (MM/DD/YYYY)

Printed name of legally authorized representative (if application) _____

If representative, specify relationship to the individual [ ] Parent of minor [ ] Legal Guardian [ ] Other _____

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