Thomas Dermatology
General, Surgical, Cosmetic

New Patient Packet

Welcome to Thomas Dermatology! Please fill out all information as accurately as possible. If you are filling this out at home, please bring all attached pages. All answers are confidential. Thank you!

Patient Information

Name: _____ Date of Birth: _____

Age: _____ Gender: _____ Marital Status: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Mobile Ph: _____ Home Ph: _____ Email: _____

Height: _____ Weight: _____ Race: _____ Ethnicity: _____ Language: _____

If Patient Is a Minor

Parent/Guardian: _____ Date of Birth: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Mobile Ph: _____ Home Ph: _____ Email: _____

Emergency Contact

Name: _____ Relationship: _____

Phone: _____ Email: _____

Primary Insurance

Name: _____ Policy #: _____ Group #: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Holder: _____ Relationship: _____ DOB: _____

Secondary Insurance

Name: _____ Policy #: _____ Group #: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Holder: _____ Relationship: _____ DOB: _____

Primary Care

Primary Provider: _____ Referring Provider: _____

Pharmacy

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Sign (Patient/Guardian): _____ **Date:** _____

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Patient History

Review of Systems

☐ Easy Bruising ☐ Easy Scarring ☐ Excessive Bleeding ☐ Joint Pain ☐ Rash ☐ Immunocompromised

Medical History

☐ Internal Cancer
Type/Yr: _____
☐ COVID-19
☐ Asthma
☐ Seasonal Allergies
☐ Food Allergies
☐ Anxiety/Depression

☐ Hepatitis B
☐ Hepatitis C
☐ Tuberculosis
☐ HIV/AIDS
☐ Diabetes
☐ COPD
☐ Arthritis

☐ Thyroid Disorder
☐ Lupus
☐ Other Autoimmune Disease
Type: _____
☐ High Blood Pressure
☐ Heart Disease
Type: _____

☐ Alzheimer's
☐ Parkinson's
☐ Multiple Sclerosis
☐ Are you pregnant?
☐ Are you nursing?
☐ Other: _____
_____

Surgical History

☐ Organ Transplant: Organ: _____ Year: _____
☐ Joint Replacement: Joint: _____ Year: _____
☐ Artificial Heart Valve: Type: _____ Year: _____
☐ Bone Marrow/Stem Cell Transplant: Year: _____

☐ Mohs Surgery or Skin Cancer Surgery
☐ Hysterectomy
☐ Pacemaker/Defibrillator
☐ Other: _____

Skin History

☐ Acne
☐ Actinic Keratosis
☐ Basal Cell Carcinoma
☐ Have you had a blistering sunburn?
☐ Have you ever used a tanning bed?

☐ Dry Skin/Eczema
☐ Hair Loss
☐ Melanoma
☐ Do you use sunscreen? Y / N
☐ Do you work: Indoors / Outdoors

☐ Abnormal Moles
☐ Psoriasis
☐ Squamous Cell Carcinoma
☐ Other: _____
_____

Family History

☐ Melanoma ☐ Basal/Squamous Cell ☐ Asthma ☐ Allergies/Hayfever ☐ Eczema ☐ Psoriasis

Medications/Supplements	Allergies to Medications/Products
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Social History

☐ Alcohol: Frequency _____ ☐ Smoker: Frequency: _____

Is this form being filled out by someone other than the patient? Yes / No Reason if Yes: _____

Sign (Patient/Guardian): _____ **Date:** _____

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Financial Policy | Assignment of Benefits

Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which you are required to read and sign prior to treatment.

- ALL FORMS MUST BE COMPLETED AND SIGNED PRIOR TO SEEING A PROVIDER.
- CURRENT INSURANCE CARD AND PHOTO ID MUST BE PRESENTED AT EVERY VISIT. PATIENTS WITHOUT PROOF OF INSURANCE ACCEPTED BY OUR CENTERS ARE REQUIRED TO PAY CASH AND WILL RECEIVE THE NECESSARY PAPERWORK TO SEND TO THEIR INSURANCE PROVIDER.
- FULL PAYMENT IS DUE AT THE TIME OF SERVICE FOR CASH PATIENTS, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.
- CO-PAYS, CO-INSURANCE, AND DEDUCTIBLE PAYMENTS ARE DUE AT TIME OF CHECK-IN.
- WE ACCEPT CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER.
- ANY BALANCE OWED FROM PRIOR VISITS MUST BE PAID PRIOR TO ANY SUBSEQUENT VISIT.
- ALL ACCOUNTS 90 DAYS PAST DUE WILL BE AUTOMATICALLY ASSIGNED TO A COLLECTION AGENCY UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.
- PATIENT AGREES TO PAY ALL EXPENSES OUR PRACTICE MAY INCUR TO COLLECT AN OUTSTANDING DEBT. COLLECTION FEES ARE BETWEEN 40% AND 50% OF THE BALANCE OWED, AND IN ADDITION TO THE DELINQUENT BALANCE.
- APPOINTMENTS HAVE A 20-MINUTE GRACE PERIOD. BEYOND THAT TIME, YOU MAY BE REQUIRED TO RESCHEDULE.
- ALL ACCOUNTS 90 DAYS PAST DUE WILL BE SUBJECT TO INTEREST AT THE RATE OF 2% PER MONTH.
- **PATIENT ACKNOWLEDGES THEY WILL BE CHARGED A $50 FEE IF THEY FAIL TO SHOW UP WITHOUT CALLING TO CANCEL AT LEAST 24 HOURS IN ADVANCE.**
- **COSMETIC PATIENTS WHO FAIL TO SHOW UP WITHOUT CANCELLING AT LEAST 24 HOURS IN ADVANCE, WILL LOSE THEIR DEPOSIT.**
- PLEASE KNOW THAT WAIVING DEDUCTIBLE AND CO-PAYMENT CHARGES IS ILLEGAL, AND A BREACH OF CONTRACT WITH THE INSURANCE COMPANIES.

Insurance Coverage

It is your responsibility to obtain any necessary referral or prior authorization information from your primary care physician prior to your appointment and bring a copy with you to your visit. If you do not have a referral or authorization number and your insurance company requires it, your appointment will be cancelled.

You hereby assign or otherwise authorize payment of medical benefits to us for the Services provided to you or your Covered Family Member. You authorize the release of any medical or other information necessary to process any claims for the Services provided. You further understand and accept your financial responsibility for any portion of the bill not covered by your health insurer or health plan. Submission of charges does not waive our right to seek payment directly from you.

I, the undersigned, do hereby authorize my insurance carrier(s) to pay directly to Thomas Dermatology the insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for any charges not covered by said insurance carrier(s), including copay and/or deductible amounts. I, the undersigned, do hereby also give my permission to Thomas Dermatology to furnish my insurance carrier(s) any and all information pertaining to my medical records.

I have read the Financial Policy, Assignment of Benefits, and Insurance Coverage described above, and understand and agree to all provisions.

Sign (Patient/Guardian): _____ **Date:** _____

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HIPAA Notice of Privacy Practices

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

Introduction

At Thomas Dermatology, we are committed to treating and using protected health information about you responsibly. This notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective, and applies to all protected health information as defined by federal regulations.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer, Mary Ann Lopez at 702-430-5333 Ext. 121. If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Building, Washington, D.C. 20201.

Acknowledgment of Receipt of Privacy Notice

At my request, I will be presented with a copy of Thomas Dermatology's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

I have read the HIPAA Notice of Privacy Practices described above, and understand and agree to all of its provisions.

Sign (Patient/Guardian): _____ **Date:** _____

Please allow access to my Protected Health Information (PHI) to my:
Spouse / Child / Parent / Guardian / Other
Name: _____

Sign (Patient/Guardian): _____ **Date:** _____

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Terms of Services

Please initial and sign:

____ I authorize Thomas Dermatology to receive, mail, fax and/or email my medical records to another physician or medical facility during the course of my diagnosis and treatment.

____ I authorize Thomas Dermatology to access my pharmaceutical records and history.

____ I understand that it is my responsibility to notify Thomas Dermatology of any changes to my information including mailing address, phone numbers, insurance policies, or any other information needed to contact me, collect payments, or carry out my treatment. All information presented today is accurate and current.

____ I authorize Thomas Dermatology to contact me by any method that I provide contact information for. I understand that if I do not want Thomas Dermatology to contact me using a specific method, I will not provide that applicable method.

____ I authorize Thomas Dermatology to send any specimen obtained through the course of my treatment to an outside laboratory. These lab's services are separate from those received from Thomas Dermatology and will be billed separately by that lab. Thomas Dermatology will make every effort to send the specimen to a lab within the insurance network, but it is my responsibility to inform Thomas Dermatology of a lab that is contracted with my insurance.

Print Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

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Medical Records Release

PLEASE ONLY FILL OUT THE HIGHLIGHTED AREA

Please initial and sign:

____ I, the undersigned, do hereby give permission to my physician's office identified below to furnish Thomas Dermatology with any and all information pertaining to my medical records.

____ I, the undersigned, do hereby give permission to Thomas Dermatology to furnish my physician's office identified below with any and all information pertaining to my medical records.

Physician Name: _____

Office: _____

Attn:_____

Address: _____

Phone: _____

Fax: _____

Requested Records: _____

____ I, the undersigned, do hereby request a copy of my protected health information from Thomas Dermatology. I understand that according to NRS 629.061, a copy of my medical records will be furnished within 30 days after the date or receipt of this request and that there may be a fee of $0.60 per page. I also understand that I may be required to pay the fee in full before a copy of my records will be released.

Please address any medical records requests to:

Phone: 702.430.5333 x258

Fax: 702.430.5335

9097 W Post Rd, Ste 100

Las Vegas, NV 89148

WARNING: THIS EMAIL TRANSMISSION MAY CONTAIN CONFIDENTIAL MEDICAL INFORMATION

IT IS UNLAWFUL FOR UNAUTHORIZED PERSONS TO REVIEW, COPY, DISCLOSE, OR DISSEMINATE CONFIDENTIAL MEDICAL INFORMATION. IF THE READER OF THIS WARNING IS NOT THE INTENDED RECIPIENT OR THEIR AGENT, YOU ARE HEREBY NOTIFIED THAT YOU HAVE RECEIVED THIS TRANSMISSION IN ERROR; PLEASE NOTIFY US IMMEDIATELY AT THE TELEPHONE NUMBER LISTED BELOW. THANK YOU.

Print Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____