# WARTHAN DERMATOLOGY CENTER

**Mandy L. Warthan, M.D.**
**5971 Virginia Parkway, Suite 100**
**McKinney, Texas 75071**

**Robert Marinaro, M.D.**
**5913 Virginia Parkway, Suite 300**
**McKinney, Texas 75071**

**Phone 972-542-4646** **Fax 972-542-0909**

**PATIENT INFORMATION**

Last Name: _____ First Name: _____ MI: _____Title:_____

Home Address: _____ Apt# :_____ City: _____State: _____Zip:_____

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____ Work phone/daytime phone: ( ) _____-_____

Driver's License #:_____ State_____ Social Security#_____-_____-_____

Email Address: _____ Date of Birth: ____/____/_____ Sex: _____ Age: _____

How would you like to be reminded about appointments? □Phone □Email ☐Text

May we send you our monthly newsletter and current promotions? □Yes □No

Pharmacy Name: _____Address:_____Pharmacy#_____

Employer's Name: _____Occupation:_____

Marital Status: _____Spouse Name: _____

Referring Physician: _____ Phone: _____

PCP: _____ Phone: _____

How did you hear about us? □ Friend _____□Family Member_____□ McKinney Magazine Ad

□ Insurance Book □ www.McKinneyDermCenter.com □ Google search □ Internet site_____

□ Living Magazine Ad □ Yellow Pages □ Newspaper_____□ Seminar_____□ Other_____

**PERSON RESPONSIBLE FOR PAYMENT (IF DIFFERENT FROM ABOVE):**

Name_____Relationship_____

Street Address: _____Apt #:_____City: _____State _____Zip:_____

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____ Work phone/daytime phone: ( ) _____-_____

Social Security #_____Date of Birth_____

**INSURANCE INFORMATION **you must present your insurance card/Medicare card, and driver's license at each visit.**

**Primary Insurance Co**: _____

Name of Insured: _____ relationship to insured: Self Spouse Parent

Member ID#_____ Group #_____

Insured Social Security #_____ Date of Birth_____

**Secondary Insurance Co**: _____

Name of Insured: _____ your relationship to insured: Self Spouse Parent

Member ID#_____ Group #_____

Insured Social Security #_____ Date of Birth_____

**EMERGENCY CONTACT INFORMATION**

Name _____Relationship to you: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

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**www.mckinneydermcenter.com**

## MEDICAL HISTORY

Patient Name (First, Middle, Last):_____ today's date: ____/_____/_____
Date of Birth: _____/_____/_____ Male ☐ Female □
Reason for today's visit: _____
Did a doctor refer you? □ Yes ☐ No If yes, please list: _____
Are you allergic to any medications? □ Yes ☐ No If yes, please list: _____

Have you ever had dental anesthesia (Novocain)? □ Yes □No any bad reaction? □ Yes □ No
List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, herbals):
_____
_____

Do you have a pacemaker or defibrillator? _____
Do you have any artificial joints (hip, knee, shoulder) or artificial heart valves (animal or cadaver)? _____
Do you have any history or infective endocarditis or congenital heart abnormalities? _____
Have you been told you need antibiotics prior to dental or surgical procedures? _____

Do you have now or have you ever had disease, condition, or procedures pertaining to: (Please check YES or NO)

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Asthma | □ | □ | Thyroid | □ | □ | Tattoo | □ | □ |
| Allergic Rhinitis | □ | □ | Kidney | □ | □ | Tuberculosis | □ | □ |
| Bronchitis | □ | □ | Dialysis | □ | □ | Phlebitis | □ | □ |
| Emphysema | □ | □ | Arthritis | □ | □ | Cataracts/Glaucoma | □ | □ |
| High Blood Pressure | □ | □ | Lupus | □ | □ | Autoimmune Disease | □ | □ |
| Heart Attack | □ | □ | Artificial Joint | □ | □ | Hives | □ | □ |
| Heart Murmur | □ | □ | Fibromyalgia | □ | □ | **For Women:** | | |
| Irregular Heartbeat | □ | □ | Epilepsy, Seizures | □ | □ | Polycystic Ovaries | □ | □ |
| Blood Clots | □ | □ | Depression | □ | □ | Hysterectomy | □ | □ |
| Artificial Heart Valve | □ | □ | Sexually Transmitted | | | Are you pregnant? | □ | □ |
| Pacemaker | □ | □ | Diseases | □ | □ | Are you trying to | | |
| Mitral Valve Prolapse | □ | □ | HIV/AIDS | □ | □ | become pregnant? | □ | □ |
| Bleeding Abnormalities | □ | □ | Hepatitis | □ | □ | Are you nursing? | □ | □ |
| Anemia | □ | □ | If yes, which type? _____ | | | | | |
| Cancer | □ | □ | | | | | | |
| Diabetes | □ | □ | Blood Transfusion | □ | □ | | | |
| GI/Stomach Problems | □ | □ | If yes, what year? _____ | | | | | |
| Bladder | □ | □ | Organ Transplant | □ | □ | | | |

List any other diseases or conditions: _____
List any surgical procedures you have had in the last 6 months: _____

Completed by :_____( please print) Date: _____ Physician Initials: _____

Patient Name (First, Middle, Last):_____

## SKIN

Have you ever had skin cancer? □Yes ☐ No If yes, what type? _____
Has anyone in your family had skin cancer? □Yes ☐ No If yes, what type? _____
Do you have a history of any specific skin diseases? □Yes ☐ No If yes, what type? _____
Do you ever have problems with healing? □Yes ☐ No
Do you develop keloids (scars) after surgery? □Yes ☐ No
Do you bleed easily? □Yes ☐ No
Have you ever had a full body skin exam? □Yes ☐ No If yes, when? _____
Number of blistering sunburns as a child: _____
Do you wear sunscreen daily? □Yes ☐ No
Do you go to the tanning bed? □Yes ☐ No
Do you develop skin rashes in reaction to: □Medications □Food □Bandages □Tape □Topical Neosporin?
□Other_____

## REVIEW OF SYSTEMS (Please mark which of the following you are <u>currently having</u>)

| | | | | | |
|---|---|---|---|---|---|
| Prone to infection | □ | Rash | □ | Penile/vaginal discharge | □ |
| Weight change | □ | Dry skin | □ | Irregular menstruation | □ |
| Fever/sweats | □ | Itchy skin | □ | Painful urination | □ |
| Chronic Cough | □ | Skin sores | □ | Frequent urination | □ |
| Shortness of Breath | □ | Hearing problems | □ | Bad scarring/keloids | □ |
| Wheezing | □ | Dizziness | □ | Nausea/vomiting when | |
| Chest Pain | □ | Fainting | □ | Taking antibiotics | □ |
| Palpitations | □ | Joint/muscle pain | □ | (Frequency/urgency) | □ |
| Easy bleeding | □ | Back pain | □ | Yeast Infection when | |
| Blood clots | □ | Headaches | □ | Taking Antibiotics | □ |
| Vision changes | □ | Stuffy Nose | □ | Moodiness | □ |
| Weakness of body part | □ | Sinus pain | □ | Anxiety | □ |
| Numbness of body part | □ | Sore throat/mouth pain | □ | Depression | □ |

## FAMILY HISTORY (Please check if someone in your family has these conditions)

| | | | | | |
|---|---|---|---|---|---|
| Basal Cell Carcinoma | □ | Psoriasis | □ | Hay fever | □ |
| Squamous Cell Carcinoma | □ | Actinic keratosis | □ | Sinus problems | □ |
| Melanoma | □ | Eczema | □ | Autoimmune disease | □ |

## SOCIAL HISTORY

Do you drink alcohol? □Yes ☐ No If Yes, _____drinks per day
Do you or have you used IV drugs? □Yes ☐ No If Yes, what? _____ how often? _____
Do you smoke? □Yes ☐ No If Yes, how many per day? _____
Do you chew tobacco? □Yes ☐ No
Have you ever been exposed to HIV/AIDS? □Yes ☐ No
What is your occupation? _____ Hobbies? _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Completed by :_____( please print) Date: _____ Physician Initials: _____

## WARTHAN DERMATOLOGY CENTER

Patient Name: _____ Date of Birth: _____/_____/_____

**AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS**

Under HIPAA requirements, we are not allowed to give any of your health information to anyone else without your consent. Please sign below if you wish to have us leave of discuss information regarding your appointment, test results, or procedures with a member of your family. Signing this form will only allow us to discuss appointment information, test results, and procedure information with the persons listed below.

I authorize Warthan Dermatology Center to release appointment information, test results, and procedure information to the following individuals:

1. _____ Relation to Patient:_____ _____Phone:

2. _____ Relation to Patient:_____ _____Phone:

3. _____ Relation to Patient:_____ _____Phone:

Patient Signature: _____ Date: _____

**AUTHORIZATION TO LEAVE A MESSAGE ON ANSWERING MACHINE**

Under HIPAA requirements, we are not allowed to give any of your health information to anyone else without your consent. Please sign below if you wish to have us leave information regarding your appointment, test results, or procedures on a voicemail or answering machine. Signing this form will only allow us to discuss appointment information, test results, and procedure information on the phone numbers listed below.

I authorize Warthan Dermatology Center to leave a message regarding appointment information, test results, or procedure information on the following answering machines/voicemails.

1. (_____)_____ 2. (_____)_____

Patient Signature: _____ Date: _____

**AUTHORIZATION TO SEND AN EMAIL MESSAGE**

Under HIPAA requirements, we are not allowed to give any of your health information to anyone else without your consent. Please sign below if you wish to have us send information regarding your appointment or procedures in an email. Please note that we cannot transmit any Protected Health or Billing Information in this manner.

I authorize Warthan Dermatology Center to send an email regarding appointment information or procedure information to the following email address:

Email: _____

Patient Signature: _____ Date: _____

## WARTHAN DERMATOLOGY CENTER

# FINANCIAL POLICY

Thank you for selecting our practice for you dermatological needs. Our goal is to provide you with the highest quality of treatment and service. Your complete understanding of your financial responsibilities is an essential element of your care.

1. **Patients are responsible for all payments including, but not limited to co-pays, co-insurance, deductibles, and past due balances at the time of service. We accept cash, check, debit cards, MasterCard, Discover, American Express, and Visa.**
2. Insurance Policies: We are contracted providers with many insurance plans and will accept assignment of benefits. As a courtesy, we will bill your primary insurance policy to the plans with which we participate. If your insurance company denies your bill, you are ultimately responsible for payment of services not covered by your insurance plan and will be held financially responsible. It is your responsibility to call and check with you insurance as to which services are covered prior to being seen and treated. We do not file on secondary insurances, other than Medicare. **If you are in a "grace period" with your insurance, you will be expected to pay the full self-pay cost of the visit at the time of service. This will be refunded to you once your premiums have been paid, and your insurance processes the claim.**
3. All health plans are not the same and do not cover the same services. In the event your insurance plan determines a service to be "not covered," or "not medically necessary", or you do not have an authorization, you will be responsible for the complete charge.
4. If you are out-of-network, payment is still due in full at the time of service. We will prepare a receipt for you at the time of service with all the necessary information needed for you to file the claim.
5. You must inform the office of all insurance changes, authorization referral requirements, and address changes at the front desk. In the event the office is not informed before care is rendered, you will be responsible for any charges that are denied.
6. In cases of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those charges on the date of the child's office visit. If the divorce decree requires the other parent to pay all or part of the costs, it is the authorizing parent's responsibility to collect from the other parent.
7. You may receive a separate bill for laboratory or pathology services from an off-site lab for any tests your physician orders. Or, you may receive a separate pathology bill from Dr. Warthan, as she is also a dermatopathologist and may read your pathology slides herself. In the case you receive a bill from an outside lab; you may discuss any bills with that lab.
8. Cosmetic services must be paid in advance of the time of your visit, and all cosmetic services and products are **non-refundable**. These services cannot be billed to your insurance. Cosmetic services include, but are not limited to: skin tag removal, benign growth removal, Botox, Restylane, Juvederm, chemical peels, CoolSculpting, and all laser treatments.
9. You must call us at least 48 hours before your appointment time if you need to reschedule, change, or cancel an appointment**. A $50 charge will be applied for any appointment that is not cancelled at least 48 hours prior to your appointment time. A deposit of $500 may be required for all surgical appointments.** If the appointment is missed and not cancelled at least 48 hours before your appointment time, the deposit will not be refunded. **A deposit equal to half of the cost of a cosmetic appointment is required and the same cancellation policy applies.** Patients with multiple missed appointments or cancellations may be discharged from Warthan Dermatology Center.
10. Request of Medical Records -We will provide this information within 15 days from receipt of request and that a fee of $25 for the FIRST 20 pages and $.50 for each additional page for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners. **Initial: _____**
11. A $40 returned check fee will be charged for all returned checks. A $50 Dispute fee will be charged to an account that disputes their credit card charges, and the dispute is ruled unfounded by Merchant Services. Refunds on credit cards incur a 10% processing fee of the refund total or $10 flat fee, whichever is greater.
12. If your account is past due, you will be assessed late fees and interest. Your account may be turned over to a collection agency, and you will be responsible for the collection fee charged to us by the agency in the amount of $50, and all attorneys' fees (including litigation, if necessary) in addition to your original outstanding balance.

**I have read and understand the financial policy of Warthan Dermatology Center, and I agree to be bound by its terms. I understand and agree that such terms may be amended in the future by the practice.**

Print Name_____ Signature_____ Date_____

# WARTHAN DERMATOLOGY CENTER

**PAYMENT OF INSURANCE DEDUCTIBLE**

If we have a contract with your insurance company, our office will file on your insurance for your office visit(s) and any surgical procedure(s) that you may have had done. Most insurance policies have a yearly deductible, the amount of which varies with each policy. After your insurance company pays its share, we request you sign an authorization with a credit card so we can bill your credit card for any outstanding balance that your insurance does not pay. We do accept Medicare, so this same policy applies to Medicare patients. This policy is similar to having a credit card on file for incidentals during a hotel stay or in the case when you are renting a car.

You hereby acknowledge receipt of the services, authorize us to bill the credit card for dermatology services, and agree to take all further actions required to pay the charges in full and to perform the obligations set forth in your agreement with the credit card issuer.

A copy of the charges and current statement will be mailed to you.

Please complete the following information:

Circle one: Visa Master card American Express Other_____

Name on Card: _____

Number on Card: _____

Expiration date: _____

PIN # (3 digits on back of card) _____

Address of cardholder: _____

City: _____ State _____ Zip _____

After Dr. Warthan files my charges with my insurance company, and after my insurance pays its maximum share, I agree to allow Dr. Warthan to file on my credit card listed above for any outstanding balance that my insurance company does not pay, and is then due by me.

Print Cardholder Name: _____

Cardholder Signature: _____ Date: _____

# *WARTHAN DERMATOLOGY CENTER*
# *SKIN & BODY ASSESSMENT*

What issues are you mainly concerned with?

____Fine lines and wrinkles
____Deep wrinkles around nose/mouth
____Double chin
____Darkness or thin skin around eyes
____Sparse or thinning lashes
____Acne Scarring
____Excess or unwanted body hair
____Face/neck sagging
____Stubborn fat or bulging areas
____Spider Veins
____Brown Age/Sun Spots
____Facial discoloration or mask-like appearance
____Dull complexion
____Skin Care Products
____Sunscreen advice

Would you like us to teach you how to care for your skin? ☐Yes ☐No

What cosmetic procedures, if any, have you had in the past?

_____

Were you pleased with the outcome? If not, why?

_____

In our office, we hold cosmetic open houses and parties to learn more about certain cosmetic procedures, specials, and promotions. Would you like an email invitation to these events? ☐Yes ☐No

What topics would be of interest to you?

_____

May we notify you by email with monthly specials, news, and events? ☐Yes ☐No
If yes, please print your email address: _____
Follow our blog at mckinneydermcenter.com!

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____

# WARTHAN DERMATOLOGY CENTER

**BENEFITS ASSIGNMENT:** I hereby authorize the assignment of benefits (payments) directly to Warthan Dermatology Associates, PA, for all my insurance claims including Medicare, private insurance and any other health/medical plan related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles, and non-covered services are due at the time of service.

Signature of responsible party: _____ Date: _____

**RECORDS RELEASE:** I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of responsible party: _____ Date: _____

**HIPAA:** Warthan Dermatology Center complies with the Health Insurance Portability and Accountability Act. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operation. This also means we may not disclose information, including medical diagnosis, test results or treatment plans to anyone other than you, for example spouse, child over the age of 18 or any other relation without your written consent._____ initials

**AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR: •N/A**

Name of Minor: _____ Date of Birth: ____/_____/_____

I, parent or guardian of the above named minor, do hereby authorize providers of Warthan Dermatology Center to administer dermatologic medical care to my child. It is my intention that this authorization be effective during my absence._____ initials

**AUTHORIZATION FOR PHOTOGRAPHY:**

I understand that photography may be taken for the purpose of diagnosis and treatment of your condition, as well as medical education and is considered part of your medical record._____ initials

**REFERRALS:**

If your insurance requires a referral from your primary care physician, it is your responsibility to obtain a referral for your visit **PRIOR** to your appointment. If we do not have the authorization on file, you will not be seen and may be charged a cancelled appointment fee. If you choose to be seen without your referral, you will be responsible for payment in full at the time of service.

**FEMALE PATIENTS OF CHILD BEARING POTENTIAL:**

I understand that if I am trying to get pregnant or I become pregnant, I will stop all oral and topical medications you have prescribed and contact this office._____ initials

Effective Date: _____

# WARTHAN DERMATOLOGY CENTER

**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PURPOSES REQUESTED BY THE PRACTICE**

By signing this authorization, I authorize Mandy Warthan, M.D. and Robert Marinaro, M.D. to use and/or disclose certain protected health information (PHI) about me. This authorization permits Mandy Warthan, M.D., and Robert Marinaro, M.D. to use and/or disclose the following individually identifiable health information about me including symptoms, test results, diagnosis, treatment and related medical information. We may disclose this information to other healthcare providers who are participating in your treatment, to pharmacists, to laboratories and to family members who are helping with your care, but to no third parties not involved in your healthcare treatment and/or payment regarding your healthcare treatment.

The information will be used or disclosed to a person or organization to which health information is necessary for your treatment to obtain payment, and for health care operations, including administrative purposes and evaluation of the care you receive. The Practice may receive payment or other remuneration from a third party, including your insurance company, in exchange for using or disclosing the PHI.

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5971 Virginia Parkway, Suite 100
McKinney, Texas 75071

Robert Marinaro, M.D.
5913 Virginia Parkway, Suite 300
McKinney, Texas 75071

Signed by: _____ _____
Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____
Patient's Name — Date

_____
Print Name of Patient or Legal Guardian

**PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION ON REQUEST.**

## WARTHAN DERMATOLOGY CENTER

## Privacy Policies

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment, and healthcare operations (TPO). To that end, our practice and its physicians and staff will:

- ✓ Adhere to the standards set forth in the Notice of Privacy Practices.

- ✓ Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.

- ✓ Use and disclose PHI to remind patients of their appointments only within their consent.

- ✓ Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its physicians and staff will implement reasonable measures to protect the integrity of all PHI maintained about patients.

- ✓ Recognize that patients have a right to privacy. Our practice and its physicians and staff respect the patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.

- ✓ Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will:
  - ➢ Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
  - ➢ Not disclose PHI data unless the patient (or his or her authorized representative) has properly consented to or authorized the release or the release is otherwise authorized by law.

- ✓ Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believe his/her information is inaccurate or incomplete. Our practice and its physicians and staff will:
  - ➢ Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.
  - ➢ Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.

- ✓ All physicians and staff of our practice will maintain a list of all disclosures of PHI for purposes other than TPO for each patient. We will provide this list to patients upon request, so long as their requests are in writing.

- ✓ All physicians and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.

- ✓ All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.

- ✓ Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.