SKIN CANCER CONSULTANTS

elevate
MEDICAL SPA AND COSMETIC SURGERY

DALLAS SURGI CENTER

Patient Information:

Name:	Date of Birth:
Cell#:	Home#:
Address:	City, State, Zip:
SSN:	Sex: M [ ] F [ ]
Marital Status:	Employer:
Occupation:	Email:
Referring Dr:	Primary Dr:
Dermatologist:	Emergency Contact: (Name, Relation, Phone #)

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Name: _____ Age: _____ Weight: _____ Height:_____

Reason for visit: Please place a checkmark by the choices below that apply:

□ Skin Cancer/ Mohs Surgery_____
□ Skin Check/ Mole Check_____
□ Cosmetic Surgery_____
□ Cosmetic Non-Surgical (skin care, laser, botox, fillers) _____
□ Cyst/ Lipoma/ Wart_____
□ Other (Please specify) _____

Unfortunately, skin cancer sometimes occurs in areas where the sun does not shine. We would like to give you the most thorough exam possible. If there are any areas **you do not** want examined please indicate below:

□ Back, Chest, Abdomen
□ Breast
□ Genitalia
□ Legs

Additional comments or questions:

_____
_____
_____

Skin Disease History

Have you ever had any of the following skin conditions?

□ Acne
□ Actinic Keratosis
□ Basal Cell Skin Cancer (Year(s):_____)
□ Blistering Sunburns
□ Dry Skin
□ Other: _____
□ Eczema
□ Melanoma (Year(s):_____)
□ Precancerous Moles
□ Psoriasis
□ Squamous Cell Skin Cancer (Year(s):_____)
□ None

Do you wear sunscreen?

□ Yes
□ No

If yes, what SPF?

_____

Do you tan in a tanning salon?

□ Yes
□ No

Do you have a Family history of Melanoma?

□ Yes **If yes, which relative?** _____
□ No

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Name: _____

Past Medical History:

Do you have any of the following medical conditions?

- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Atrial Fibrillation (Irregular Heartbeat)
- □ Benign prostatic hyperplasia
- □ Bone Marrow Transplantation
- □ Breast Cancer
- □ Colon Cancer
- □ COPD
- □ Coronary Artery Disease
- □ Depression
- □ Diabetes
- □ Hearing Loss
- □ Hepatitis
- □ Hypertension
- □ Kidney: Kidney Biopsy
- □ HIV / AIDS
- □ Hypercholesterolemia
- □ Hyperthyroidism
- □ Hypothyroidism
- □ Leukemia
- □ Lung Cancer
- □ Lymphoma
- □ Prostate Cancer
- □ Radiation Treatment
- □ Seizures
- □ Stroke
- □ None

Past Surgeries:

Have you had any surgeries?

- □ Appendix (Appendectomy)
- □ Bladder (Cystectomy)
- □ Breast: Mastectomy (Right Breast)
- □ Breast: Mastectomy (Left Breast)
- □ Breast: Mastectomy (Both Breasts) □
- □ Breast: Lumpectomy (Right Breast)
- □ Breast: Lumpectomy (Left Breast)
- □ Breast: Lumpectomy (Both Breasts)
- □ Breast: Breast Biopsy
- □ Breast: Breast Reduction
- □ Breast: Breast Implants
- □ Colon (Colectomy): Colon Cancer Resection
- □ Colon (Colectomy): Diverticulitis
- □ Colon (Colectomy): Inflammatory Bowel Disease
- □ Gallbladder (Cholecystectomy)
- □ Heart: Stent
- □ Heart: Mechanical Valve Replacement
- □ Heart: Biological Valve Replacement
- □ Heart: Heart Transplant
- □ Joint Replacement: Knee (Both)
- □ Joint Replacement: Hip (Right)
- □ Joint Replacement: Hip (Left)
- □ Joint Replacement: Knee (Left)
- □ Joint Replacement: Hip (Both)
- □ Joint Replacement: Knee (Right)
- □ Kidney: Kidney Transplant
- □ Kidney: Nephrectomy
- □ Ovaries (Oophorectomy): Endometriosis
- □ Ovaries (Oophorectomy): Ovarian Cyst
- □ Ovaries (Oophorectomy): Ovarian Cancer
- □ Prostate (Prostatectomy): Prostate Cancer
- □ Prostate (Prostatectomy): Prostate Biopsy
- □ Prostate (Prostatectomy): TURP
- □ Skin: Skin Biopsy
- □ Skin: Basal Cell Carcinoma
- □ Skin: Squamous Cell Carcinoma
- □ Skin: Melanoma
- □ Spleen (Splenectomy)
- □ Testicles (Orchiectomy)
- □ Uterus (Hysterectomy): Fibroids
- □ Uterus (Hysterectomy): Uterine Cancer
- □ Other _____
- □ None
- □ **Cosmetic Surgery:** _____ □

Cosmetic Procedures:

- □ Botox
- □ Fillers: _____
- □ Lasers: _____
- □ Facials/Peels: _____

□ Other: _____

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Name: _____

Are you experiencing any of the following today?

- □ Chest pain
- □ Difficulty breathing
- □ Abdominal pain
- □ Bloody stool
- □ Bloody urine
- □ Immunosuppression
- □ Autoimmune suppression
- □ Problems with scarring (hypertrophic or keloid)
- □ Changing mole
- □ Cold sores
- □ Dentures
- □ Fever or chills
- □ Unintentional weight loss
- □ Headaches
- □ Seizures
- □ Blurry Vision
- □ Glasses or contact lenses
- □ Anxiety
- □ Depression
- □ Require walker or wheelchair
- □ None

Please check if any of the following apply to you:

- □ Pacemaker
- □ Defibrillator
- □ Artificial joints within past two years
- □ Artificial heart valve
- □ Premedication prior to procedures
- □ Allergy to adhesive
- □ Allergy to topical antibiotic ointments
- □ Allergy to lidocaine
- □ Rapid heartbeat with epinephrine
- □ GI upset with antibiotics
- □ Blood thinners
- □ Problems with bleeding
- □ Pregnant or planning a pregnancy
- □ West Africa: Travel or contact in last 21 days
- □ Fever > 100.4 degrees (F)
- □ Traveled to country with wide spread Ebola in 21 days
- □ Contact with Ebola patient in last 21 days
- □ Flu-like symptoms in last 21 days
- □ None

Smoking Status (check one)

- □ Current every day smoker
- □ Current some day smoker
- □ Former smoker
- □ Never

Alcohol Status (check one)

- □ Less than 1 drink per day
- □ 1-2 drinks per day
- □ 3 or More drinks per day
- □ None

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Name: _____

List all medications you are currently taking (including over-the-counter).
If none, please write none. Please print:

_____
_____
_____
_____
_____

Please list any drug allergies and your reaction.
If none, please write none. Please print:

_____
_____
_____
_____
_____

Other Allergies (Iodine?/ Latex?)_____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

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CONDITIONS OF ADMISSION

For your convenience, we have consolidated our new patient paperwork into this single document to cover the three affiliated covered entities ("**ACE**") under HIPAA which comprise our practice: Thornwell H. Parker, III, MD, PA (d/b/a Skin Cancer Consultants), Elevate Medical Spa and Cosmetic Surgery, and the Dallas Surgi Center, Inc. (collectively "**The Practice**")

Patient Financial Responsibility

Although patients are ultimately responsible for all charges, as a courtesy, assignment is accepted for most insurance carriers. Applicable estimated copays and deductibles are to be paid at the time of service, as well as uncovered or cosmetic procedures. Some operations/procedures may incur charges for any professional services rendered in The Practice.

Assignment of insurance Benefits and Financial Agreement:

The below signed irrevocably assigns and transfers to the center the Contract Rights, and orders and directs such insurer(s) specified on the registration to pay all monies due or to become due hereunder directly to The Practice. The Practice has irrevocably constituted power, to collect and settle any claim under the Contract Rights as insured without further notice or approval of insured and to endorse in the name of insured any check or other instrument for payment of monies hereunder. If the insured receives monies direct from the insurer, same shall be held in trust for and immediately transferred to The Practice for amount due. This assignment is irrevocable until full and complete payment of all monies due The Practice from this event of admission or otherwise. Money received by The Practice from insurer(s) or other third party sources, less the expense in procuring same, shall be deducted from the principal amount due for services rendered Patient. It is the policy of The Practice to comply with all Federal, State, and Department of Insurance regulations related to collection of co-pays and deductibles. You may be responsible for higher co-pays and deductibles. The Practice may or may not be in-network for your insurance. If your insurance company does not pay the amount within 90 days, you will be responsible for the payment in full. We do not determine payment of a claim, the insurance company does. Please contact your insurance company for any questions regarding your claims. Any deviation from this standard procedure must have arrangements made in advance.

Medicare Assignment:

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Professional Services Agreement:

To the extent that fees for professional services rendered to the patient are payable, the undersigned hereby assigns to said physicians and authorizes payment directly to said physicians all insurance benefits, including major medical, for professional services rendered to the patient.

Patient Rights/Responsibilities:

I acknowledge that I have been given a copy of the Patient Rights and Responsibilities at time of admission.

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Name: _____

Personal Valuables:

The Practice will make its best effort to protect Patient valuables but will not be responsible for any loss.

Physician Disclosure of Ownership:

Pursuant to Texas Law please note that Dr. Thornwell H. Parker III, M.D. has financial agreements with Dallas Surgi Center, Inc., one of the ACE. If you are referred to this entity, Dr. Thornwell H. Parker III, M.D. will receive direct remuneration. If you have any questions regarding this paragraph, please discuss it with Dr. Thornwell H. Parker III, M.D. directly.

Authorization for Release of Information:

The Practice is authorized to furnish from the patient's record requested information or excerpts to the referring physician, primary care physician and to any insurance company or third party payer for the purpose of obtaining payment of the account of The Practice or any physician for services provided to the patient. The Practice is authorized to release information from my medical record to any health care facility to which I may be transferred.

Verification of Third Party Benefits:

The below signed authorizes the verification of third party benefits, any item referenced herein, statements and other data obtained from Patient and/or below signed and all other persons pertaining to the respective credit and financial responsibilities, understanding that an investigative consumer report may be made whereby information is obtained through personal interviews with third parties. The Practice or its contractor is authorized to investigate all information given by the below signed verbally and other such areas as reasonable connected with The Practice efforts in collection, now or in the future. Below signed hereby releases from liability, indemnifies from loss and specifically authorizes any requesting entity to make such disclosure to The Practice or its agents as they deem necessary in considering and verifying any application for credit. Below signed acknowledges that a complete and accurate disclosure of the nature and scope of the investigation will be given upon written request and herby declares that all information furnished hereon and subsequently is and shall be true.

_____

Patient's Signature **Date**

_____

Witness **Date**

_____ **OR**

Guardian Signature | Relationship | Date

Name: _____

Newsletter and Specials
Would you like to receive periodic emails from The Practice?

Skin Cancer Consultants

- ☐ Yes, I give permission to email me specials/info
- ☐ No, I do not give permission to email me specials/info

Elevate Medical Spa & Cosmetic Surgery

- ☐ Yes, I give permission to email me specials/info
- ☐ No, I do not give permission to email me specials/info

Email: _____

Note: appointment reminders may be emailed as a normal course of business.

_____
Patient's Signature **Date**

_____
Witness **Date**

_____ **OR**

Guardian Signature | Relationship | Date

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Consent for Photography

Patient Name: _____ **Date of Birth:** _____

Social Security Number: _____

I, as the patient identified above or the legal representative of such patient ("**Patient**"), consent to have photographs, videotapes, digital or audio recordings, and/or images of the Patient, and any other method to reproduce or edit such Patient's likeness or image now known or hereafter developed (collectively, "**Photography**"), taken by any of the HIPAA Affiliated Covered Entities ("**ACE**") owned by Thornwell H. Parker, III, including Thornwell H. Parker, III, MD, PA (d/b/a Skin Cancer Consultants), Elevate Medical Spa and Cosmetic Surgery, and the Dallas Surgi Center, Inc. (collectively "**The Practice**") and its staff. I understand that such Photography will be recorded to document and assist with the Patient's care and to assist with The Practice health care operations.

I understand the Photography will become part of the Patient's medical record and therefore protected, used and/or disclosed in accordance with The Practice's Notice of Privacy Practices. I understand that The Practice will own the Photography and I will not receive any payment for such Photography, but that I will be allowed to access or view them or to obtain copies of them as part of the Patient's medical record.

I have read this consent in its entirety and agree to be bound by all of its terms and conditions as described above. I acknowledge and agree that I have been given the opportunity to ask any questions and had all my questions answered to my satisfaction.

_____ _____

Patient Signature (or Legal Representative) **Date**

_____

Printed Name

_____

Legal Representative's Authority (if applicable)

_____ _____

Witness Signature (The Practice) **Date**

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Optional Release to Disclose Photographs for Patient Education

Patient Name: _____ **Date of Birth:** _____

Social Security Number: _____

I, as the patient identified above or the legal representative of such patient ("**Patient**"), have consented to the taking of photographs, videotapes, digital or audio recordings, and/or images of Patient, and any other method to reproduce or edit such Patient's likeness or image now known or hereafter developed (collectively, "**Photography**"), by any of the HIPAA Affiliated Covered Entities ("**ACE**") owned by Thornwell H. Parker, including Thornwell H. Parker, III, MD, PA (d/b/a Skin Cancer Consultants), Elevate Medical Spa and Cosmetic Surgery, and the Dallas Surgi Center, Inc. (collectively "**The Practice**") and its staff which will be part of my medical record. I also understand that the Photography that identify Patient can be released and/or used outside The Practice only upon written authorization from me.

The Practice desires to utilize the Photography for purposes of professional publications, training, education or clinical evaluation. The Practice IS NOT receiving direct or indirect remuneration from a third party in connection with the use/disclosure of the protected health information described in this authorization.

I authorize The Practice to use Patient's Photography for purposes of patient education. In addition, I understand that the Photography may incidentally disclose additional protected health information related to Patient's treatment, condition, procedure, or other protected health information associated with the Photography, and I authorize such disclosure.

This authorization is valid until the earlier of the occurrence of the death of Patient; Patient reaching the age of majority; or permission is withdrawn.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to The Practice's Privacy Officer. I understand that a revocation is not effective to the extent that The Practice has relied on the use or disclosure of the protected health information. I understand that, except as otherwise provided in this authorization, The Practice may use or disclose my protected health information in accordance with The Practice's Notice of Privacy Practices. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or other applicable laws or regulations. I release and hold harmless The Practice, its officers, staff and employees from any and all claims or causes of action that I may have of any nature whatsoever, which may in any manner result from the use of the Photography. I understand that The Practice will not condition my treatment, payment or eligibility for benefits on whether I provide authorization for the requested use.

_____ _____

Patient Signature (or Legal Representative) **Date**

_____

Printed Name, Legal Representative's Authority (if applicable)

_____ _____

Witness Signature (The Practice) **Date**

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Optional Release to Disclose Photographs for Marketing

Patient Name: _____ **Date of Birth:** _____

Social Security Number: _____

I, as the patient identified above or the legal representative of such patient ("**Patient**"), have consented to the taking of photographs, videotapes, digital or audio recordings, and/or images of Patient, and any other method to reproduce or edit such Patient's likeness or image now known or hereafter developed (collectively, "**Photography**"), by any of the HIPAA Affiliated Covered Entities ("**ACE**") owned by Thornwell H. Parker, including Thornwell H. Parker, III, MD, PA (d/b/a Skin Cancer Consultants), Elevate Medical Spa and Cosmetic Surgery, and the Dallas Surgi Center, Inc. (collectively "**The Practice**") and its staff which will be part of my medical record. I also understand that the Photography that identify Patient can be released and/or used outside The Practice only upon written authorization from me.

The Practice desires to utilize the Photography for purposes of print and email marketing both of which will result in the publication and distribution of protected health information to the general public. The Practice IS NOT receiving direct or indirect remuneration from a third party in connection with the use/disclosure of the protected health information described in this authorization.

I authorize The Practice to use Patient's Photography in its print and digital marketing. I understand that the Photography may incidentally disclose additional protected health information related to Patient's treatment, condition, procedure, surgery or other protected health information associated with the Photography, and I authorize such disclosure.

This authorization is valid until the earlier of the occurrence of the death of Patient; Patient reaching the age of majority; or permission is withdrawn.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to The Practice's Privacy Officer. I understand that a revocation is not effective to the extent that The Practice has relied on the use or disclosure of the protected health information. I understand that, except as otherwise provided in this authorization, The Practice may use or disclose my protected health information in accordance with The Practice's Notice of Privacy Practices. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or other applicable laws or regulations. I release and hold harmless The Practice, its officers, staff and employees from any and all claims or causes of action that I may have of any nature whatsoever, which may in any manner result from the use of the Photography. I understand that The Practice will not condition my treatment, payment or eligibility for benefits on whether I provide authorization for the requested use.

_____ _____

Patient Signature (or Legal Representative) **Date**

_____

Printed Name, Legal Representative's Authority (if applicable)

_____ _____

Witness Signature (The Practice) **Date**

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Notice of Privacy Practices Acknowledgement

I understand that, under the **Health Insurance Portability & Accountability Act of 1996** (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have been provided the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I acknowledge that my medical information/records will be released to The Practice. I further acknowledge that my medical information/records will be released from The Practice to my primary care provider, referring/consulting providers, and to my insurance company to process insurance claims.

I also allow release of my medical information to the following individuals: (i.e. family, caregivers, etc.)

Name: _____ **Relationship:** _____

_____ _____

Patient Name _____

_____ _____

Patient's Signature **Date** **Witness** **Date**

_____

OR Guardian Signature **Relationship** **Date**

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Patient Questionnaire

For Patients 65 years of age and older

Name: _____ Date: _____

Have you received a pneumonia vaccination?

○ Yes ○ No

Do you have a healthcare proxy in the event you are unable to make your own medical decisions?

○ Yes ○ No

Do you have a living will?

○ Yes. ○ No

Which statement best reflects your wishes or advanced care recommendations?

○ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

○ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to start by heart, even if it's necessary to save my life.

○ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

_____ _____

Patient's Signature **Date** **Witness** **Date**

_____

OR Guardian Signature **Relationship** **Date**