Adean Kingston, MD, PLLC
Cosmetic & Medical Dermatology
4514 Cole Avenue, Suite 910
Dallas, Texas 75205
P 214-420-DERM (3376) F 214-420-3630
www.DrAdeanKingston.com

DATE: _____

Name _____ Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Date of Birth _____ Age _____

Zip Code _____ DL # _____ SS # _____ Sex: M _____ F _____

E-mail Address _____ Marital Status _____

PharmacyName/Address/Telephone_____

Primary Care Physician Name and Telephone _____

Patient's Employer _____ Occupation _____

Employer's Address _____ Work Phone _____

City _____ State _____ Zip Code _____

Have other family members been treated here? ___ Yes ___ No Name _____

How did you find out about our practice? _____

RESPONSIBLE PARTY (IF UNDER 18 YEARS OF AGE)

Name of Responsible Party/Insured _____ Date of Birth _____

Address _____ Home Phone _____

DL # _____ SS # _____ Patient with our practice _____ YES _____ No

Relationship to patient: _____ Occupation _____

Employer _____ Work Phone _____

Employer's Address _____

City _____ State _____ Zip Code _____

IN CASE OF EMERGENCY CONTACT

Name _____ Relationship _____

Address _____ Phone Number _____

PRIMARY INSURANCE CARRIER

Name of Primary Insurance Company _____

Mailing Address for Insurance Claim _____

Name of Policyholder _____ Relationship to Policyholder _____

Date of Birth of Policyholder _____ Name of Employer _____

Group No. _____

Member ID _____ Effective Date of Policy _____

Phone Number for Verification _____

SECONDARY INSURANCE CARRIER

Name of Secondary Insurance Company _____

Mailing Address for Insurance Claim _____

Name of Policyholder _____ Relationship to Policyholder _____

Name of Employer _____Group No. _____

Member ID. _____ Effective Date of Policy _____

Phone Number for Verification _____

NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As outlined in our notice, the terms of our notice may change. If our notice is changed or modified, you may obtain a revised copy by requesting at the front office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you acknowledge that you have received our Notice of Privacy Practices and consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as though original.
3. I may revoke this consent at any time, except where information has already been released. This consent is valid until revoked by me in writing.

_____ _____

SIGNATURE Date

2020 PAYMENT POLICY – TERMS OF AGREEMENT

We are committed to providing you and your family with the best possible care. In order to achieve this, we want you to understand our financial policy. Below you will find the details of our policy. Please review the policy, as it may have changed since your last visit.

1. We are contracted providers for several managed care plans. As a courtesy to you, we will file claims for those plans we participate in and will require you to pay your co-pay/deductible/co-insurance **at the time of the visit.** Please be advised if you have not heard from your insurance company within **60 days, the balance will become the patients responsibility. All lesion removals are required, by law, to be sent for biopsy. If you have a biopsy or excision, your tissue will be sent to an outside laboratory for analysis which is a separate entity from our office and you will be billed separately for their services. _____INITIAL HERE**

2. **The majority of procedures done are the office are considered outpatient surgery and may have a different benefit than an office visit. For example, if the doctor performs a procedure, it is likely that the insurance company will pay their ratio portion and the patient owes the balance. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW WHAT THE TERMS OF MY INSURANCE ARE, AND AM IN COMPLIANCE WITH THOSE TERMS. _____INITIAL HERE**

3. Not all services are medically necessary. Some insurance companies arbitrarily select services they will not cover. **You are responsible for these services**. **We must emphasize that as medical care providers, our relationship is with you and NOT your health insurance company. _____INITIAL HERE**

4. **Payment for any cosmetic procedures is due at the time the service is rendered.** The doctor will inform you, to the best of her knowledge, what procedures are deemed "cosmetic" by most insurance companies, It is always a good idea to ask whether the procedure is likely deemed "cosmetic" before the procedure is performed so you better understand your financial responsibility. **Payment for cosmetic procedures is expected at the time of service. Any unpaid bills will be sent to a collections agency after three attempts to collect payment. _____INITIAL HERE**

5. **Referrals: We make every effort to help you with your referral from your primary care physician if one is required; however, it is your responsibility to confirm that we have a current valid referral, if necessary.** Physicians are only allowed to treat the conditions noted on the referral and will not see patients without valid referrals as it violates the contract we have with your insurance provider. **Full payments on patient due balances are required before seeing the physician. Any unpaid bills will be sent to a collections agency after three attempts to collect payment. ____INITIAL HERE**

6. **ALL SALES ARE FINAL FOR PRODUCTS AND/OR SERVICES. _____ INITIAL HERE**

7. We are NOT providers for Medicaid and will only accept Medicaid patients as SELF PAY. **We will not file any claims to Medicaid.**

If you have any questions regarding our financial policy, please do not hesitate to contact us. By signing this Payment Policy page, I acknowledge that I have read it and understand my own personal financial responsibility.

Signature:_____ Date:_____

PAYMENT POLICY - DESCRIPTIVE

We accept an array of in-office payment options, including cash, check, credit card as well as credit card payments over the telephone for payments on your account. We also accept online payments via our website.

Payment Options

Payment is expected at the time services are rendered for medical and cosmetic services and products. For your convenience, we accept many insurance plans and offer an array of other payment options, including cash and check, most major credit cards, and Care Credit. Checks returned for insufficient funds carry a $30 processing fee.

Most treatments for skin diseases are covered by insurance to some degree. However, cosmetic procedures are usually not covered under medical healthcare plans. And, to make it more complex, a procedure that is categorized as medial dermatology and covered under one plan, may be considered cosmetic dermatology and not covered under another, even though it is actually the same service being provided. Please refer to your individual plan for such coverage details.

Insurance

Although our practice is contracted as a provider for many major health insurance carriers, it is the patient's responsibility to know what insurance company currently provides his or her coverage and the details of that coverage – including which treatments and procedures are covered within that plan. Employers often change plans annually, so we will ask to see your insurance card/information at each visit. This step helps to ensure that our records are accurate and your claim may be filed and paid with as little inconvenience to you as possible.

Please, have the following Subscriber or Insured's information available when you schedule your appointment AND when you check in for your appointment: Name, Date of Birth, ID# or Social Security #, Policy Information, Coverage effective dates, Individual policy or employer/group policy? If it's an Employer/Company Policy, Employer/Group Name, Employer/Group Number, Health Savings Accounts (HSA's).

When checking in for an appointment, please let us know if you have a Health Savings Account (HSA) in connection with your high deductible health plan. Depending upon whether your deductible has been met, we will handle the office visit charges in one of two ways:

If you have not met your deductible, we will still bill your insurance carrier for your visit charges; however, we will collect all charges IN FULL at the time of your visit. Once we receive our Explanation of Benefits (EOB) statement from your insurance carrier, we will bill you for any remaining balance or refund you for any overpayment.

Insurance Accepted

We are not always contracted with every plan each carrier offers. During the appointment scheduling process we can confirm our participation with your specific coverage.

- Aetna
- Blue Cross Blue Shield
- Cigna/Great West (exception: We are OUT OF NETWORK for Cigna Local Plus)
- Humana
- Medicare
- United Healthcare

CANCELLATION POLICY

When you schedule an appointment with our office, we reserve that time specifically for you.
We appreciate at least 24-hour cancellation notice. Effective January 1, 2019, there is a $30 same day/no show cancelation fee for medical appointments. Laser appointment no show/same day cancelation fee is $150.

INITIAL HERE _____

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF INFORMATION

I authorize the release of medical information and records necessary to determine liability for payments or treatment, to process any claim and to obtain reimbursement.

I authorize payment of medical benefits to be made on my behalf to Adean Kingston, MD, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this form will have the same validity as the original.

_____ _____

Signature Date

CONSENT TO TREAT

I authorize medical procedures to be performed on the patient named below at the direction of Dr. Adean Kingston.
I (we), the patient or the patient's representative and Dr. Adean Kingston, including employees and agents, rendering medical care, to patient agree: (1) that all health care rendered shall be governed exclusively and only by Texas law and in no event shall the law of any other state apply to any health care rendered to patient; and (2) in the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall only be brought in a Texas Court in the county/ district where all or substantially all of the health care was provided or rendered and in no event will any lawsuit, action, or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

SIGNATURE ON FILE

I acknowledge that I have read and agree to be bound by the terms stated above. This signature shall be valid unless revoked by me in writing.

_____ _____

Signature Date

RELEASE OF INFORMATION TO SOMEONE <u>OTHER THAN MYSELF</u>

I authorize Adean Kingston, MD, PLLC to release medical, appointment, and/or financial information over the telephone and/or to release copies of my medical records to the following person(s):

Name _____ Relationship _____ Phone: _____

_____ _____

Patient Signature Date

Name _____ Relationship _____ Phone: _____

_____ _____

Patient Signature Date

HEALTH QUESTIONNAIRE

Please list the purpose of your visit: _____

_____

How long have you had this problem? Associated symptoms? Treatments you have tried?

_____

1. Medical/Surgical History

Have you ever had skin cancer (Basal Cell Carcinoma/ Squamous Cell Carcinoma/ Melanoma)? ☐ Yes ☐ No

If yes, what type(s) of skin cancer/location on body/year diagnosed and by which physician/how treated?

_____

Last Full Body Skin Exam?

_____

Do you have a history of or a present medical or skin condition(s) that you receive(d) care for? ☐ Yes ☐ No

If *yes* please list condition(s)

Condition	How Long

2. Medications

Please list any medications you take regularly. Prescription, non-prescription, vitamins, home remedies, birth control pills and herbs: ☐ None

Medication (Including strength)	How many times a day	How long taken

3. Allergies

Are you allergic to any medications? (If yes, please list below) ☐ Yes ☐ No

Allergic to: _____

4. Family History

Has any blood relative (Father/Mother/Sister/Brother/Child) ever had any significant medical condition including skin cancer (Melanoma) that we should know about to better manage your health care? ☐ Yes ☐ No

If you answered "Yes" to the above, please specify relationship and medical problem below:

Relation	Age	Medical Problems	If deceased,cause of death	Age at death

5. System Review

Please place an "X" in the appropriate box if you are currently experiencing any of the following symptoms:

Do you have any of the following:	Yes	No		Yes	No
Change in skin character/color			Shortness of Breath		
Unusual growth on skin			Cough/Wheezing		
Change in color or size of any mole			Mouth sore/ Throat pain		
Prone to infection			Weakness of body part		
Rash			Numbness		
Dry Skin			Seizures		
Itchy Skin			Hearing Problems		
Skin Sores			Dizziness		
Hair/Nail Problems			Faint		
Bad Scar/Keloid Formation			Nausea/Vomiting		
			Abdominal Pain		
Weight Change			Bowel Change		
Fever/Night Sweats			Joint/Muscle Pain		
Chest Pain/Palpitations			Back Pain		
Lymph Node Swelling			Stuffy nose/Sinus Pain		

Limb Swelling/Edema			Change/Pain in urination or any discharge		
Easy Bleeding			WOMEN ONLY:		
Blood Clots			Pregnant? Number of times pregnant:		
Eye/Vision Problems			Menstrual Irregularity		

6. Smoking/ Alcohol/ Drug Use / Tanning Bed Use

Have you ever smoked? ☐ Yes ☐ No Do you currently smoke? ☐ Yes ☐ No

If you do not currently smoke but have in the past, how long did you smoke? _____
If you currently smoke, how many packs do you smoke per day? _____

History of Alcohol or Drug Abuse? ☐ Yes ☐ No If yes, Please explain _____

History of Tanning Bed use? ☐ Yes ☐ No If yes, Please explain _____