

Fred E. Ghali, MD
Pediatric Dermatology of North Texas, PA

PATIENT NAME: _____ AGE: _____ DATE: _____

ALLERGIES: _____

CURRENT MEDICATIONS: _____

CHIEF COMPLAINT (REASON FOR TODAY'S VISIT): _____

CURRENT OR PAST PROBLEMS WITH:	YES	NO	EXPLAIN YES ANSWERS
General Health	___	___	_____
Eyes	___	___	_____
Ears/Nose/Throat	___	___	_____
Heart	___	___	_____
Lungs	___	___	_____
Stomach/bowels	___	___	_____
Kidneys	___	___	_____
Arthritis/muscles/joints	___	___	_____
Skin	___	___	_____
Headaches/seizures	___	___	_____
Psychological disorder	___	___	_____
Thyroid/diabetes	___	___	_____
Blood/bleeding disorder	___	___	_____
Allergic/immunologic	___	___	_____

FAMILY HISTORY OF THE PATIENT TODAY: (Past family & Social History)

Please check one: MOTHER: living ___ deceased ___ age ___ FATHER: living ___ deceased ___ age ___

Please check all that apply below:

DISEASE	MOTHER	FATHER	BLOOD RELATIVE
Allergies	!!	!!	!!
Arthritis	!!	!!	!!
Asthma	!!	!!	!!
Cancer	!!	!!	!!
Diabetes	!!	!!	!!
Eczema	!!	!!	!!
Hay fever	!!	!!	!!
High Blood Pressure	!!	!!	!!
Lung Disease	!!	!!	!!
Malignant Melanoma	!!	!!	!!
Psoriasis	!!	!!	!!
Skin Cancer	!!	!!	!!
Tuberculosis	!!	!!	!!

SOCIAL HISTORY:

How many live in the same household? _____ Relationship: _____

Currently enrolled in school? _____ Grade: _____ # of siblings in school: _____

REVIEWED BY: _____ DATE: _____ UPDATE: _____
(M.D. SIGNATURE)

REVIEWED BY: _____ DATE: _____ UPDATE: _____
(M.D. SIGNATURE)

REVIEWED BY: _____ DATE: _____ UPDATE: _____
(M.D. SIGNATURE)

REVIEWED BY: _____ DATE: _____ UPDATE: _____
(M.D. SIGNATURE)

Patient Registration Form

Child's Name: _____ **Date of Birth:** ____/____/____ M or F
First Middle Last Month Day Year

Referring Doctor: _____ **Office Number:** _____

Mother's Name: _____ **Date of Birth:** ____/____/____
First Middle Last Month Day Year

Father's Name: _____ **Date of Birth:** ____/____/____
First Middle Last Month Day Year

Address: _____
Street# Street Name Apt#

_____ City State Zip

Home Phone: _____ **Preferred Contact by:** home ___ or cell _____ (check one)

Mother's Cell Phone: _____ **Father's Cell Phone:** _____

****IT IS THE POLICY OF THIS OFFICE THAT THE ADULT WITH THE CHILD TODAY IS RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE****

****Name of Insured Adult:** _____ **Relation to patient:** _____

Address if different from Above: _____
Street# Street Name City State Zip

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Insurance Company: _____ **ID#** _____ **Group#** _____

Address: _____ **Phone#** _____

Employer: _____
Name Address Phone

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. **PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA, MASTERCARD AND DISCOVER FOR YOUR CONVENIENCE.** Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the Doctor to release such medical information necessary to process your insurance claims (if any), and for treatment provided to your child. You herein authorize payment of medical benefits to the Doctor when an assigned claim is filed.

Please present insurance cards and photo ID to the receptionist so copies may be made. INSURANCE CARDS WILL BE COPIED AT EVERY VISIT.

Do we have your permission for the following:

Leave a message on your answering machine at home? YES NO

Leave a message at your place of employment? YES NO

Discuss your medical condition with any member of your household? YES NO
(Office staff will not be able to speak with anyone not listed below)

If yes, whom: _____ Relationship _____

_____ Relationship _____

EMERGENCY CONTACT: _____ **NUMBER:** _____

Parent / Legal Guardian Signature

Date

WELCOME TO PEDIATRIC DERMATOLOGY OF NORTH TEXAS, P.A.

OFFICE POLICY

We want to make your experience at Pediatric Dermatology of North Texas a positive one. In order to accomplish this, we work together as a team to provide quality care in a supportive environment. We want and need you, the parent, to be a part of the team. This allows your child to receive the best and most immediate services. Below is a summary of our office policies, which we hope will allow you access to the information you need in making important health care decisions for your child.

APPOINTMENTS: ***PATIENTS WHO HAVE NOT ARRIVED WITHIN 15 MINUTES OF THEIR SCHEDULED APPOINTMENT TIME WILL BE RESCHEDULED.**

New Patients: We value information provided by the caretakers of the children we serve. It helps us to accurately understand the problems at hand and arrive at a correct diagnosis. Therefore, we ask that the parent or guardian complete all questionnaires and forms in their entirety.

Follow-up Appointments: Your follow-up appointment, if needed, will be offered at the completion of your visit and will be scheduled with either Dr. Ghali or the Pediatric Nurse Practitioner.

Urgent Appointments: We make every attempt to see patients at their scheduled appointment time. If your child needs an urgent appointment, it must be scheduled through the nurse. Leave your message with the nurse or the front desk and the nurse will return your call. We will make every effort to accommodate *true* emergency patients; however, we do not have the capacity to see walk-in patients. Please call ahead so that we can accommodate you appropriately.

Cancellations: We understand that there are times when it will be necessary for you to cancel or reschedule your appointment. In order to accommodate all patients, we ask that you provide the office with at least a 24-hour notice of any necessary changes. There will be a charge of \$35.00 for missed appointments without prior cancellation. You may leave a message after office hours.

INSURANCE:

Our goal is to help you in every way possible to utilize the insurance benefits you have for your child. To accomplish this, we must verify all insurance coverage prior to your child being seen by our providers. We will ask that you present complete and accurate insurance information at the time of your initial visit and present the insurance card at each follow-up visit thereafter. We will make a copy of your card for our records at each visit as well. Please ask to speak with the Practice Manager if you have questions or concerns about your coverage that the insurance company has not been able to explain or provide.

Benefits: You may be given a summary of benefits at your initial visit, please ask about anything you may not understand. **Some visits (procedures/surgeries) with our office may NOT fall under your normal copay and may be applied to your deductible or percentage of payment.** Always be sure and request the office to give you a new summary of benefits if your insurance plan changes.

Changes in insurance benefits: You must contact our office at least 48 hours before your next scheduled appointment to update us with your new information. This allows us to verify coverage and provide you with a summary of benefits at the time of your appointment. Due to time issues, we cannot verify new insurance coverage at the time of your appointment. **If you present new insurance information at the time of your appointment you will be asked to reschedule your appointment** to allow us time for insurance verification (and to notify you of needed referrals for HMO plans). If you choose not to reschedule and to have your child seen without verification of benefits, you will be required to pay in full for the visit.

Referrals: It is the responsibility of the patient and their primary care physician to make sure that a referral to see the specialist (pediatric dermatology) has been requested, processed and sent. The process of obtaining a referral usually takes 7-10 working days by your Primary Care Physician. We ask that you arrange this with your PCP and have the referral in our office no later than 48 hours prior to your appointment. If we do not have the referral, we will ask that you reschedule your appointment and obtain the referral before the next appointment.

Billing: This office mails statements every month. Payment is expected at the time of service for all patients. Refunds can only be made once we receive a written request.

DATE: _____

PATIENT NAME: _____

NURSING SUPPORT:

The clinical staff supports the doctor with patient care. This includes patient phone calls, prescription requests, etc. They make every effort to handle patient calls within 24 hours. If you have an urgent matter that needs immediate attention, please call our front office and ask them to notify the nurse.

All **prescription refill** requests require 24-hour notice to our office staff. *We ask that you contact your pharmacy and they will fax a refill request to our office.* These will be reviewed and faxed back with the necessary authorization. Following the 24 hour processing time, you should contact your pharmacy to see if the prescription is ready to be picked up.

OFFICE STAFF:

We have an excellent office staff to assist you with appointments, phone calls, medical records and insurance questions. We want your experience to be seamless and pleasant; therefore, we need your help in always notifying us of any changes in your address, phone numbers or insurance.

If you call after hours please leave your message with the following information: the patient’s name, date of birth, your name, a number to return the call the next business day, and a detailed message.

MEDICAL RECORDS:

All medical record requests require a written release of information with a signature from the legal guardian or parent. We will require 10 to 14 days for processing from the day we receive the request. There will be a charge for copies released to family members, attorneys and insurance companies. No charge will be applied if the records are transferred to another treating physician. No medical records will be faxed from this office.

EMERGENCIES: For after hour emergencies please call the office and follow the instructions on the recording. The numbers are below. The physician will return your call. We ask that you **do not call after hours for any refill requests or any calls about IPledge issues**, as the physician will not have your child’s records.

IMPORTANT NUMBERS:

OFFICE: 817.421.DERM (3376)
METRO: 817.481.3379
FAX LINE: 817.416.4269
Web site: www.pediatricderm.com

PLEASE SIGN AND RETURN TO THE FRONT DESK FOR YOUR RECORDS. THANK YOU FOR YOUR TIME!

OFFICE ADDRESS: 1325 WEST NORTHWEST HIGHWAY
GRAPEVINE, TEXAS 76051

I have received and read a copy of the Office Policy for Pediatric Dermatology of North Texas, P.A.

Today’s Date: _____

Patient’s name

Patient’s date of birth

Signature of Responsible Party/Parent or Guardian

PLEASE READ!!

IMPORTANT NOTICE TO ALL PARENTS OF OUR PATIENTS

DUE TO PROBLEMS WITHIN THE INSURANCE INDUSTRY AND WITH EMPLOYERS PLANS FOR THEIR EMPLOYEES WE WILL REQUIRE THE FOLLOWING ON EACH VISIT – **NO EXCEPTIONS.**

PLEASE READ:

1. We will require you to pay all co-pays, deductibles and/or coinsurance at the time of service with this office according to the benefits our office has been given for your appointment.
2. **Treatment for molluscum contagiosum and/or warts may fall under your deductible as an office procedure/surgery; make sure you understand that you will be responsible for the deductible and/or coinsurance at the time of service and PRIOR to treatment.**
3. If you are on an HMO, we must have a current referral in this office from your PCP before being seen. If we do not have your referral you will be required to reschedule your appointment. You cannot file with your insurance if you are seen without a referral.
4. If your child comes to his/her appointment alone or with a grandparent, a copy of the insurance card will be required or appointment will be rescheduled. Payment will be expected at the time of service, please make arrangements. There must also be a consent on file.
5. Our office will require a current copy of your insurance card at each and every visit, regardless of your last appointment in the office.
6. Our office will file only primary insurance on any patient.
7. Our office does not handle cash in the office for change; **payment in cash must be for the exact amount only.**

Thank you for your cooperation.

Today's Date: _____

Patient's Name

Patient's Date of Birth

Signature of Responsible Party/Parent or Guardian

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our 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 shall honor that agreement.

By signing this form, you 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, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: _____
Printed Name

Relationship to Patient (if other than patient): _____

PATIENT NAME: _____

_____/_____/_____
Parent Signature Date