MEDICAL HISTORY

Patient: DOB: Height: Date:

Referring Physician: Telephone:

Primary Physician: Telephone:
(if different from above)

Pharmacy Name: Pharmacy Cross Streets:
Pharmacy Telephone:

Have you ever had reactions to local anesthetics? [ ] Yes -- Please explain: [ ] No

Do you have DRUG allergies? If so, please list:

Allergy to eggs [ ]yes [ ] no **Allergy to influenza vaccine [ ]yes [ ] no**

Medications/non-prescription medications that you **currently take including prescriptions from this office**

Medication	Dosage	Instructions

Do you have a PERSONAL HISTORY of, or are currently under treatment for, the following conditions?
(if any are "yes", please explain the lines below):

[ ] yes	[ ] no	Heart Problems	[ ]yes	[ ] no	Hepatitis	[ ] yes	[ ] no	Organ Transplant
[ ] yes	[ ] no	High Blood Pressure	[ ]yes	[ ] no	Diabetes	[ ] yes	[ ] no	X-ray Therapy
[ ] yes	[ ] no	Pacemaker	[ ]yes	[ ] no	PUVA/UVB	[ ] yes	[ ] no	Kidney Problems
[ ] yes	[ ] no	Stroke	[ ]yes	[ ] no	Arthritis	[ ] yes	[ ] no	Mitral Valve Prolapse
[ ] yes	[ ] no	Blood Clots	[ ]yes	[ ] no	Epilepsy	[ ] yes	[ ] no	Accutane past 6 months?
[ ] yes	[ ] no	Bleeding Problems	[ ]yes	[ ] no	Glaucoma	[ ] yes	[ ] no	Currently Pregnant/Nursing
[ ] yes	[ ] no	Lung Problems	[ ]yes	[ ] no	Keloid scars	[ ] yes	[ ] no	Rheumatic Fever
[ ] yes	[ ] no	HIV	[ ]yes	[ ] no	Cancer	[ ] yes	[ ] no	Artificial Joint/Valve
[ ] yes	[ ] no	Psychiatric Conditions	[ ]yes	[ ] no	Skin Cancer	[ ] yes	[ ] no	Other

[ ] yes [ ] no Previous Surgery? If yes, explain type of surgery and give dates (mo/yr) of each:

[ ] yes [ ] no Family History of Malignant Melanoma? If yes, who?

[ ] yes [ ] no Alcohol Use: How much and how often?

[ ] yes [ ] no Tobacco Use: Types and amounts used:

Have you ever had a mammogram? [ ]yes [ ] no If yes, date of last screening:

Have you ever had a colorectal screening? [ ]yes [ ] no If yes, date of last screening:

Do you have any history of MRSA infections? [ ]yes [ ] no

Have you received a pneumonia vaccination in the past year? [ ]yes [ ] no

Have you received an influenza vaccination in the past year? [ ]yes [ ] no Where (PCP, hospital, etc)?

Signature of Patient Date

Signature of Physician Date Date/Initial Date/Initial Date/Initial Date/Initial

Snyder Dermatology and Breast & Body Center of Austin
1510 W 34th Street, Suite 100 Austin Texas 78703
P: 512.533.9900 F: 512.533.9901

Patient's Last Name:	Patient's First Name & Middle Initial:		Date:
Street Address and Apt #:	City & State:	Zip Code:	Patient's Sex: F ( ) M ( )

Race (please check one):

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Caucasian
- ☐ Hispanic

Ethnicity (please check one):

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Preferred Method of Contact:	Patient's Home Phone #: ( )	Patient's Work Phone & ext : ( )	Patient's Cell Phone #: ( )
Preferred language:	Patient's Date of Birth / Age:	Patient SSN:	Texas Drivers License #:
Parent's Name(s) If Patient is a minor child:		E-mail Address: May we email you if unable to contact by telephone? Y or N	
Who referred you to our office?		Who to call in case of an Emergency? Name & Relationship: Phone: ( )	
Employer name and phone number:		Occupation:	

Primary Insurance Company:	Primary Insured's Name and DOB:	
Member or ID # (if not listed on card, then SS # of primary insured):	Group #:	Primary insured relationship to patient:
Secondary Insurance Company:	Secondary Insured's Name and DOB:	Secondary Insured's relation to patient:
Secondary Insurance Member or ID# (if not listed on card, then SSN of primary insured):	Group #:	

RELEASE & ASSIGNMENT OF BENEFITS: I hereby authorize the release of any and all medical information to my insurance carrier(s) or it's/their representative, for purposes necessary in the adjudication or processing of any and all insurance claim(s) filed on my behalf and for which I am financially responsible. I further authorize all insurance benefits be paid to the provider rendering services on behalf or Renee Snyder, M.D., P.A. or Ned Snyder IV, M.D., P.A.

AIDS/HIV TESTING IN CASES OF ACCIDENTAL EXPOSURE: I understand that if a healthcare worker is accidentally exposed to my blood or bodily fluids in such a fashion that the worker may be at risk for contracting Hepatitis B, Hepatitis C or AIDS. I will be required to have my blood tested, pursuant to Texas law and office protocols, to determine the present of Hepatitis B or Hepatitis C surface antigens and/or Human Immunodeficiency Virus Antibodies. Test results will be kept confidential to the extent allowed by law and any information concerning my identity, in connection with such testing, will be destroyed after testing and notification of the healthcare worker who was exposed.

CONSENT TO TREAT: I hereby consent to treatment by my dermatologist or plastic surgeon to include examination and treatment, prescribing medication and skin preparations.

ACKNOWLEDGEMENT OF RECEIPTS OF NOTICE OF PRIVACY PRACTICES: I have been given the opportunity to read a copy of this office's Notice of Privacy Practices. I also understand that I have the right to request a copy of the Notice of Privacy Practices for my records.

_____ _____

Patient's Signature (Parent if Patient is a minor child) **Date**

Snyder Dermatology and Plastic Surgery

FINANCIAL POLICY

Today's Date _____

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of your treatment and care. Please initial each of the following items in acknowledgement that you have read and understand:

1. _____If we participate with your managed care plan or you have a commercial insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans. You will be responsible at the time of service for the payment of:
   - Annual Deductible
   - Co-payments
   - Charges for non-covered or cosmetic services

   In the event that we are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.

   Please be advised that anything you choose to have medically/cosmetically removed or biopsied may not be covered under your office co-pay and is subject to your deductible. We will make every effort to contact your insurance to verify your benefits, but in the event we are unable to reach them, you will be responsible for your co-payment as well as payment for any procedures performed. Such procedures include but are not limited to: biopsies, removal of warts, moles, pre-cancerous lesions, or other skin lesions. Methods of removal may include but are not limited to: cutting, freezing, burning, or application of a blistering agent. Any tissue removed from the body will be sent to lab for analyzing.

2. _____ Any tissue removed from the body for medically necessary or cosmetic reasons may not be covered under your office visit co-pay and is subject to your deductible. If you are receiving care as a self-pay patient, you are responsible for any fees determined by the lab. Upon receiving a biopsy we may ask to hold a credit card on file. The card on file may be charged with at least 24 hour notice with approval once the final pathology charges are complete. You may receive a separate bill from the lab, if you do receive a bill from the lab, any questions you have will need to be addressed with the lab directly.

3. _____We are Medicare participating providers, therefore we will bill Medicare directly. You will be responsible at the time of service for payment of:
   - The annual deductibles
   - Co-payments
   - Charges for non-covered or cosmetic services

   You may be asked to sign a Waiver of Liability Form in the event that a service is provided, which we know is not covered by Medicare.

4._____ If you have no health insurance, payment is expected in full at the time of service.

5. _____In the event we receive a returned check due to insufficient funds, a fee of $35.00 will be charged to your account and payment is due upon receipt of your statement.

6. _____If you purchase skin-care products or supplies from our office, please understand that these products/supplies are a non-refundable item. In the event that the product is defective, we will gladly replace the item(s).

7. _____We request that you give 24 hours notice if you are unable to keep your appointment. Failure to give 24 hours notice will result in a $35.00 missed appointment fee up to $100 for a missed procedure fee. This fee is not covered by your insurance plan.

8. _____Plastic surgery consultation fees are $150 to reserve your appointment. Aesthetic or other cosmetic services may require a deposit prior to scheduling. This fee is taken at the time of booking and is non-refundable if the appointment is missed. This fee will be applied to any cosmetic procedure that is scheduled.

9. _____ Any packages or specials purchased are non-refundable and non transferrable. Packages and specials are valid for 1 year from purchase date.

10. _____ I understand there is a 3.5% convenience fee for all credit cards used for medical visits. This is non-negotiable and non-refundable. For your convenience we accept cash, check, MasterCard, Visa, American Express, Discover, and Care Credit. This fee does not apply to cash, check or debit card transactions.

If you have any questions, please do not hesitate to ask us. We are here to assist you any way possible.

_____
Signature

_____
Name

_____
Date of Birth

Permission to Verbally Discuss Protected Health Information

Note: Completion of this form is **optional. To be valid, this form must be filled out **COMPLETELY**, including what information you are giving us permission to share.*

Patient Name: _____ Date of Birth: _____

I give permission to Snyder Dermatology/Breast & Body Center of Austin to VERBALLY discuss the following medical and billing information about me (check all boxes that apply):

☐ Scheduling/appointment information

☐ Medical information, including my symptoms, diagnosis, medications, and treatment plan.
This may also include information about sexually transmitted disease (STD) testing and treatment, HIV/AIDs testing and treatment, pregnancy testing, prenatal care, birth control and family planning.

☐ Behavioral health information, including my symptoms, diagnosis, medications, and treatment plan

☐ Chemical dependency information, including my symptoms, diagnosis, medications, and treatment plan

☐ Lab/test results

☐ Billing and payment information

☐ Other:_____

Snyder Dermatology/Breast & Body Center of Austin has my permission to discuss the above information with:

NAME:	PHONE:	RELATION TO PATIENT:
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that I may cancel this permission at any time (by writing to Snyder Dermatology /Breast & Body Center of Austin), but that cancelling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider or my clinic to share my information with someone.

This authorization expires:

☐ When I cancel it in writing ☐ _____ *(specify date)*

If no expiration date is specified, this authorization will remain in effect until Snyder Dermatology /Breast & Body Center of Austin Records receives written notice to cancel it.

☐ I decline permission to verbally discuss medical information.

_____	_____	_____
Signature of patient/guardian	Date	Relationship to patient
_____	_____	
Witness	Date	

If authorized representative, please sign and attach copies of supporting legal documentation.

****Note: A minor patient's signature is REQUIRED (for ages 13 and above) for us to share information about care for (1) conditions relating to the minors sexuality including, but not limited to: family planning and sexually transmitted diseases (2) alcoholism and/or drug abuse; and (3) mental health conditions.***

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I hereby authorize Snyder Dermatology, Breast and Body Center of Austin, and/or representative(s) of the practice, to take photographs, slides or videotapes of me or parts of my body for and/or during the following procedure(s) and for medical purposes to be used for my care, medical presentations and/or articles.

I understand that:

1. Such photographs, slides or videotapes may be published by Snyder Dermatology and Breast and Body Center of Austin in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about dermatology and plastic surgery methods. I understand that such uses may also include marketing on behalf of Snyder Dermatology and the Breast and Body Center of Austin, for which its providers may receive direct or indirect remuneration.

2. I will not be identified by name in any of the media described above; however, I also understand that it is possible that in some circumstances the photographs, slides, or videotapes may display features that identify me.

3. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to **Office Manager** at 1510 W. 34th St. #100 Austin, Tx. 78703. A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization.

4. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Snyder Dermatology or Breast and Body Center of Austin.

5. The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by applicable federal and/or state confidentiality rules.

6. A copy of this Authorization is valid as the original. I may receive a copy of this Authorization on request. I may inspect or copy information to be used or disclosed under this Authorization, as provided by federal and/or state law.

7. **I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Dermatology and The American Board of Plastic Surgery, Inc.**

I release and discharge Snyder Dermatology and Breast and Body Center of Austin and its providers from all liability, including liability for negligence that in any way arises out of:

any and all rights that I may have or may have had in the photographs, slides or videotapes of me that I have authorized to be used and disclosed in this Authorization; and

any claim that I may have or may have had relating to such use and disclosure of those photographs, slides or videotapes of me, including any claim for payment in connection with any distribution or publication of them in any medium.

This Authorization is made as a voluntary contribution in the interest of public education, and I certify that I have read this Authorization and Release carefully and fully understand its terms.

If I have questions about the use or disclosure of my medical record, I can contact **Office Manager** at **(512)533-9900.**

Signature _____ Date _____

Witness _____

Snyder Dermatology and Plastic Surgery

Media Release Form

I grant permission to Snyder Dermatology and Snyder Plastic Surgery or representatives of the practice to take photos, slides, videos of me, parts of my body, or my voice for media purposes.

I understand,

1. that I will not be identified by name however may be identifiable through photos, videos or other means of social media.
2. Snyder Dermatology and Plastic Surgery or other representatives do not need to submit marketing propaganda, photos, videos or other social media material to me for further approval.
3. I may refuse to sign this authorization without it affecting my medical treatment.
4. I have the right to revoke this authorization without such refusal affecting my medical treatment.
5. I have the right to revoke approval and must do so in writing to the practice manager at Snyder Dermatology and Plastic Surgery at 1510 W. 34th st. Austin Tx 78703.
6. I release Snyder Dermatology and Plastic Surgery including it's employees, contractors or representatives from all claims resulting from the use of, editing or publishing to social media.
7. I release and discharge Snyder Dermatology and Plastic Surgery including all its providers from all liability, including liability for negligence.

This form is valid from date signed until permission is revoked.

If you have questions the Practice Manager can be reached at 512-533-9900.

Patient/Representative Signature: _____ Date: _____

Witness Signature: _____ Date: _____