***We know you have a choice when choosing dermatologic care and are pleased to welcome you here. Wallis Dermatology Associates has been serving the skin care needs of the East Texas community for over 30 years and we look forward to establishing a long-lasting relationship with you.***

Upon arrival to our office, we ask that you provide proof of insurance and your driver license to our receptionist. If you present the wrong information and your claim is denied, you will be responsible for any charges incurred and you will need to file any claims for treatment already performed.

**ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES**

 I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Signature of Patient or Legal Guardian

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Name of Patient or Legal Guardian Date

**Consent to Receive Electronic Communications**

(\_\_\_\_\_\_\_\_\_\_\_Initials here) "By initialing this line, you consent to receive text messages sent through an automatic telephone dialing system."

**\_\_\_\_\_\_\_\_\_\_\_\_\_"**Yes, I would like to receive text messages about our practice. These automated text messages can include special promotions, information about new services or team members, as well as allow me to request an appointment. I understand that I will always have the ability to opt-out if I decide that I no longer want to receive texts from this practice.”

\_\_\_\_\_\_\_\_\_\_\_\_\_”No, I do not want to receive text message reminders for my appointment date and time.”

|  |  |
| --- | --- |
| **Email address**: |  |

|  |  |
| --- | --- |
| Patient ID: |  |

|  |  |
| --- | --- |
| WHO IS YOUR PRIMARY CARE PHYSICIAN?  |  |

We will only file insurance for you if you are with a managed care plan. Otherwise, you, the patient, will be asked to pay in full and file on your own insurance.

Wallis Dermatology Associates does not accept any indemnity plans.

Please contact your insurance carrier to confirm we are in network.

If you require a referral from your primary care physician, and are unable to present it at

Check-in, we will need to reschedule your appointment.

 PLEASE LET US COPY ALL INSURANCE CARDS. FULL PAYMENT IS REQUIRED IF
INSURANCE INFORMATION IS NOT PRESENTED NOW.

To My Insurance Carriers:

1. I authorize the release of any medical information necessary to process my insurance
 claim(s).
2. I authorize and request payment of medical benefits directly to my physician.
3. I agree that this authorization will cover all medical services rendered until such authorization
 is revoked by me.
4. I agree that a photocopy of this form may be used in lieu of the original.
5. I hereby assign benefits due from my Medicare supplement policy for services rendered by
 Mark S. Wallis, M.D., Laura J. Fite, M.D., Stan Taylor, M.D., Luke S. Wallis, M.D.,

 Tammi Short RN- FNP-C, Rachel Smith, PA-C, Kim Calderon, NP, to the doctor.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Signature of Patient or Representative Date

 **ASSIGNMENT AND RELEASE**

|  |  |  |
| --- | --- | --- |
| I, |  | , the undersigned, certify that I (or my dependent) have insurance coverage |
| with: |  |

and assign directly to Dr. Mark S. Wallis all insurance benefits, if any, otherwise payable to me for
services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Responsible Party Signature Relationship Date

|  |  |
| --- | --- |
| Patient ID: |  |

**CONFIDENTIALITY NOTICE**

 It is my understanding that by initializing this statement I give Dr. Wallis’ office my consent to leave information about my medical condition and/or appointment information with individuals who may answer the phone at the phone numbers I have provided, or they may leave messages on my answering machine at the numbers I have provided until I say otherwise.

Initials:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (This applied to anyone 18 years or older)

**Permission to Release Information to the Following Individuals**

|  |  |  |
| --- | --- | --- |
| I, |  | , give my permission to speak with the individuals  |

listed below about any and all of my healthcare given by Wallis Dermatology Associates.

Name / Relationship:

|  |
| --- |
|  |
|  |
|  |
|  |
|  |

|  |  |
| --- | --- |
| Patient Signature: |  |
| Date: |   |

|  |  |
| --- | --- |
|  Patient ID: |  |

Cancellation Policy/No Show Policy

* We understand that there are times when you must miss an appointment due to emergencies or other obligations. However, when you do not call to cancel an appointment, you are likely preventing another patient from receiving much needed treatment. Conversely, the situation may arise where another patient fails to cancel

and we are unable to schedule you for a visit, due to a seemingly “full” appointment book. Due to this critical fact, if an appointment is not cancelled at least 24 hours in advance you will be charged a thirty-dollar ($30) fee; this will not be covered by your insurance company.

* We understand that delays can happen. However, we must attempt to keep the other patients and doctors on time. If a patient arrives 15 minutes past the scheduled appointment time, we reserve the right to reschedule the appointment at our discretion.
* We will require that patients with self-pay balances do pay their account balances to

 zero (0) prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask

to speak to an Office Manager with whom they can review their account and concerns. Patients with balances over $100 must make payment arrangements prior to future appointments being made.

|  |  |  |
| --- | --- | --- |
|  |  |  |

 Print Name Patient/Guardian Signature Date

E-MAIL CONSENT FORM FOR NON-SECURE E-MAIL

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MRN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient E-mail : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Wallis Dermatology Associates cannot guarantee the security and confidentiality of an e-mail transmission. Because of the many internet and e-mail factors beyond our control, we cannot be responsible for misaddressed, misdelivered, or interrupted e-mail. Your health care provider is not liable for breaches of confidentiality caused by yourself or a third party.

• All e-mails between you and your provider regarding diagnosis or treatment will be printed and made part of your permanent health information.

• Your provider may forward your e-mail to other staff members as necessary for response. However, your e-mail will not be forwarded outside the practice without your authorization.

• In order to prevent the introduction of computer viruses into our system, do not send attachments to us in your e-mail.

• You are responsible for protecting your password or other means of access to e-mail.

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Name:** |  |
| **Date:** |  |
| **Pt ID:** |  |

**Medical History Questionnaire**

Current Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History (Check all that apply)**

No pertinent past medical history \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Autoimmune Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer\_\_\_\_ Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_\_ Are you insulin dependent? \_\_\_\_\_\_\_\_\_\_\_

Heart Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis or Liver Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIV \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Memory Loss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other History \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pacemaker/Defibrillator \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Planning Future Pregnancy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pregnant \_\_ Due Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Radiation Therapy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shingles \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid Disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tuberculosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin History (Check all that apply)**

No significant skin history \_\_\_\_

Abnormal Moles \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Acne \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Actinic Keratosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Basal Cell Carcinoma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eczema/Childhood eczema \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Malignant Melanoma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Suspicious Lesion\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psoriasis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rosacea \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Squamous Cell Carcinoma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Urticaria/Hives \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History of Skin Cancer**

None \_\_

Personal History of Skin Cancer \_\_\_\_\_

Personal History of Melanoma \_\_\_\_\_\_

Family History of Skin Cancer \_\_\_\_\_\_\_

**Social History**

*Alcohol* *Recreational Drugs*

Denies alcohol use \_\_\_ Denies drug use \_\_\_\_\_\_

Alcohol use socially\_\_\_ Admits drug use \_\_\_\_\_

# Drinks per week \_\_\_\_

*High Risk Factors*

Have you ever used a tanning bed? \_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a severe sunburn? \_\_\_\_\_\_\_\_\_\_

**Family History-Afflicted Family Member**

No Relevant Family History \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Unknown \_\_\_\_ Adopted \_\_\_\_\_\_

Autoimmune Disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Colon Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Liver Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lung Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Malignant Melanoma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Skin Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Smoking Status**

Never Smoker \_\_\_\_\_\_ Current Smoker \_\_\_\_\_\_\_

Former Smoker \_\_\_\_\_ Quit date \_\_\_\_\_\_\_\_\_\_\_\_

Are you interested in any smoking cessation information?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Surgical History**

No Past Surgeries or Hospitalizations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following surgeries:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_