



Susan E. Dozier, M.D., P.A.

8240 North MoPac Expressway, Suite 355 Austin, Texas 78759

Mohs Micrographic and Dermatologic Surgery

Patient Name: _____
Address: _____
City, State & Zip: _____

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

Email Address: _____

Date of Birth: _____ Social Security: _____

Marital Status: Single Married Other Sex: Male Female

Referring Physician: _____ Phone Number: _____
Pharmacy of Choice: _____ Phone Number: _____
Emergency Contact: _____ Phone Number: _____

May we leave laboratory test results on your voicemail? Yes No

Insurance Information

Please be prepared to provide your Insurance Card(s) and an ID or Drivers License at each visit to our office

Primary Insurance: _____ N/A
Secondary Insurance: _____ N/A
Tertiary Insurance: _____ N/A

Payment Arrangements and Collections Policy

Please initial each box to the left, signifying your understanding of the items below

Initial each box below
Anyone wishing to pay the full balance of all billed charges at the time of service is eligible to receive a 20% prompt pay discount. Discounted charges are billed at our standard fee schedule amount and are not applied to previous balances or contractually reduced fees of any kind. This discount excludes all cosmetic procedures and can not be used in conjunction with or addition to your insurance policy. Please note, all charges must be paid on the day of service.

All debts not paid in full at the end of 90 days, from the date of service and/or the date your insurance carrier has paid the claim, will be considered to be in default and may be turned over to a collections agency immediately. Note, the agency reports to all three credit bureaus.

Payment in full of all balances are due at the time of service, including but not limited to, co-pays, co-insurance, deductibles, cosmetic procedures and any self pay balances that may apply.

(OVER PLEASE)

Payment Policy

Self Pay

For self pay or patients without insurance, payment in full is expected at the time of the service unless prior arrangements have been made. Billing information will be provided upon request to expedite patient reimbursement from private insurance policies. Your signature below signifies your understanding of this policy.

Insurance

All professional services rendered are charged to the patient, with the exception of plans for which Dr. Dozier is a participating provider.

In the later case, we will bill your insurance company and only the patient portion of the visit is payable at the time of service. This includes all applicable co-pays, co-insurance and deductibles. If correct insurance information, including referrals, is not provided to our office and the insurance carrier refuses payment, you will be billed for the visit. If we are not contracted with your insurance carrier you will be billed for the visit. It is your responsibility to know what your insurance covers. Your signature below authorizes Dr. Dozier to release medical information concerning your examination and/or treatment for insurance purposes and to receive direct payment for services rendered from your insurance carrier(s) payable to Susan E. Dozier, M.D., P.A.

Tricare Prime, Extra and Standard

Dr. Dozier is not contracted with the Tricare network. We agree to see Tricare patients and to bill Tricare based on the current Medicare fee schedule. At check-in, you must provide your military I.D. Some Tricare products may require referrals. Acquiring these referrals is the patient's responsibility. We will bill Tricare and only the patient portion will be due at the time of service. If current and/or correct insurance information, including referrals, is not provided and Tricare refuses payment, you will be billed for the visit. If Tricare denies payment for the service, you will be billed for the visit. It is your responsibility to know what your insurance covers. Please note that we chose to bill Tricare based on Medicare fees due to the fact that they are similar in rate. Your signature below acknowledges that you understand and agree to the above statements.

Privacy Notice & Authorization

HIPAA and 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 complementary copy of this document upon request.

Medicare Authorization

Your signature below authorizes Susan E. Dozier, M.D., P.A. to use this document in place of the original, and request payment of medical insurance benefits to Susan E. Dozier, M.D., P.A. Regulations pertaining to Medicare assignment of benefits apply. I agree to pay any patient portions at the time of service.

Authorization of Medical Records Release

By signing below, I authorize the release of my confidential health information to Susan E. Dozier, M.D., P.A. This information may be in the form of medical or billing records, a summary or narrative of my protected health information whole or in part, pathology reports and slide requests. In turn, I authorize Susan E. Dozier, M.D., P.A. to release my confidential health information to insurance companies or other physicians in order to coordinate my care, or for billing purposes.

No Show and Appointment Cancellation Fees

Time has been specifically reserved for your appointment with Dr. Dozier. Please call our office at least 24 hours in advance of your appointment time if you must cancel or reschedule an appointment. Your early cancellation will give another person access to timely medical care. There is a **\$150 charge** if you no show or cancel with less than 24 hours notice for a scheduled surgical appointment.

My signature below signifies that I have read and acknowledge the above Payment Policy, Privacy Notice and Authorizations.

Signature:

Date:



Susan E. Dozier, M.D., P.A.

8240 North MoPac Expressway, Suite 355 Austin, Texas 78759

Patient Name: _____

Date: _____

Medical History

◆ Please describe the *main* reason for your visit/referral:

◆ Have you been previously diagnosed with, treated for or received any of the following:

| | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart disease |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | High blood pressure |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Angina or heart attack |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart rhythm disturbance or irregular heart rate |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pacemaker |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Automatic implantable defibrillator |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart murmur |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Artificial heart valve(s) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mitral valve prolapse |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Artificial joint(s) (E.g. hip, knee) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Antibiotics before undergoing dental or surgical procedures |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Breathing difficulty |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bleeding disorder or tendency |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney disease |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glaucoma |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver disease |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis or yellow jaundice |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Blood transfusions |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | HIV exposure or AIDS |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cold sores or fever blisters |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Problems with excessive scarring or keloids |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Problems with healing |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Skin cancer |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Family history of skin cancer |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ultraviolet light treatment |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation therapy |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Arsenic exposure |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dizziness or fainting |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke |

(OVER PLEASE)

Medical History Continued...

Yes No Seizures or epilepsy

Yes No Psychiatric illness or emotional problems

Yes No Skin infections including cellulitis

Yes No Other illnesses - if yes please list below

◆ Please list previous hospitalizations including year and reason:

◆ Please list previous surgery(s) including year:

◆ Do you smoke?

Yes No How much? _____ How many years? _____

◆ Do you drink alcohol?

Yes No How much? _____ How many years? _____

◆ Women are you pregnant?

Yes No Due Date? _____

Medications

◆ Are you allergic to any medications?

Yes No If yes: _____

Please list **ALL MEDICATIONS** that you are currently taking including over-the-counter medications and medications that you take only occasionally; please include topical medications, as well as vitamins and supplements. For your convenience you may also attach a separate medication list to this page.

| MEDICATION NAME | DOSE | FREQUENCY |
|-----------------|-------|-----------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

My signature below signifies that the information contained herein is true and correct to the best of my ability.

Signature: _____

Date: _____