W. EDWARD COLLINS, MD, PA JANNA K. NUNEZ-GUSSMAN, MD ASHLEY BREW, NP
DERMATOLOGY, DERMATOLOGIC SURGERY, AND MOHS SURGERY

WELCOME TO OUR OFFICE !

We would like to thank you for choosing our office for your dermatological needs. As often happens in offices, patients usually have questions regarding office policies. We would like to take this opportunity to explain them to you, so there will be no misunderstanding later ;

1. **Inactive Patients:** You are considered an "inactive patient" if we have not seen you in the last three years. This means you will need to complete a new set of paperwork, and come in at least once a year to have any prescriptions filled.
2. **Financial Information:** Our office staff will be happy to discuss our fees with you prior to seeing the doctor. We want our patients to understand our fees and feel confident that they are getting the best medical care available for their dollar. If you are not on one of the Insurances that we are in-network with, we will require payment in full for each visit before you leave. You may receive an itemization of charges on file, on your own, on any insurance that we are not in-network with. No payment arrangements will be made for new patients. We accept VISA, Mastercard, Discover as well as cash, check, and debit card. A fee of $25.00 will be charged for all insufficient funds, checks returned for this must be paid in full before you can reschedule any future appointments.
3. **Insurance:** It is your responsibility to get an insurance referral from your physician. Most referrals expire within one year; please make sure that you have a valid insurance referral or you will not be able to be seen. Your copay will be collected as you check in. If you have any procedures done and you have not met your yearly deductible, it will be collected at check out. If you have a deductible and are worried about cost, please ask the doctors before any procedures are done. Some procedures may be considered cosmetic and are not covered by insurance, billed separately, and may be very costly.
4. **Pathology/Lab Expenses:** Pathology is a separate charge, and is billed by the pathology lab. Your social security number is required for all pathology/lab work.
5. **Minor Children:** Minor Children are 18 years and younger. When you send your son or daughter to see us without parents or a guardian being present, you must sign the minor paperwork giving us permission to treat them. We require a social security number on file for all patients, even those under eighteen. Please make sure that they have payment with them on the appointment date. Just a quick note, divorce is a civil action between husband and wife. It is still your financial responsibility for the child you bring in for treatment.
6. **Adult Children:** Adult Children are eighteen to twenty-one years of age. If your child is still living at home and is a dependent and you are paying his/her bills please make sure they have payment on appointment date. We cannot speak to parents about medical care unless the patient has given us their permission directly to us on our medical information release form.
7. **Medical Records & Insurance Forms:** We charge a $25.00 processing fee for the first 20 pages and $0.50 per page thereafter. Medical record requests will be processed within 10 business days of receipt of the written request and pre-payment is obtained in our office. Affidavits are charged $25.00 to complete, with a $10.00 fee for notarization. If you require disability insurance forms or any other forms to be completed by us the charge is $25.00 per form. If they require medical records or billing records the above applies. You may print your own billing records through your patient portal to avoid this being a costly process.
8. **Appointments/ Appointment Fees:** Please call at least 24 hours in advance to cancel an appointment. Failure to call within 24 hours will result in a $25 fee. We will discharge you as a patient if you "no-show" more than three times. We do send out appointment reminders as a courtesy, but ultimately it is the patient's responsibility to remember and put it on your calendar. If you want to trade an appointment with a relative and/or friend please call us in advance.

I HAVE READ AND FULLY UNDERSTAND THE OFFICE POLICIES OF W. EDWARD COLLINS MD PA

_____ _____

Patient Signature **Date**

W. EDWARD COLLINS, MD, P.A.
JANNA K. NUNEZ-GUSSMAN, MD
ASHLEY BREW, NP
3070 College St, Suite 208
Beaumont, TX 77701

NOTICE OF OUR PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPPA provides penalties for covered entities that misuse protected health information.

As required by HIPPA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: Treatment, payment and healthcare operation

- TREATMENT means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.

- PAYMENT means such activities as obtaining reimbursement for services rendered, confirming coverage, billing or collection activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- HEALTHCARE OPERATIONS include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

W. EDWARD COLLINS, MD, P.A.
JANNA K. NUNEZ-GUSSMAN, MD
ASHLEY BREW, NP
Dermatology and Dermatologic Surgery
3070 College St, Suite 208
Beaumont, TX 77701

HIPPA ACKNOWLEDGEMENT FORM

Patient Name (please print):_____ Date of Birth:_____

I have received the Notice of Privacy Practices and have been provided the opportunity to review it. I authorize W. Edward Collins, M.D., P.A. to release information regarding my health and/or billing account (including pathology and lab reports, medical records, billing information, etc.) to the following people:

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

May we leave a message on your voicemail at the phone number provided?

YES_____ NO_____

This authorization is valid for three years. It is your responsibility to update it as needed within the three year period. W. Edward Collins, MD PA will not be able to speak to anyone regarding your medical record if their name is not listed on this sheet.

Patient Signature:_____Date:_____

W. EDWARD COLLINS, MD, PA

JANNA K. NUNEZ-GUSSMAND, MD

ASHLEY BREW, NP

3070 College St, Suite 208
Beaumont, TX 77701

DO YOU KNOW YOUR INSURANCE BENEFITS?

Did you know your insurance “copay” may only cover your office visit?

Most procedures such as skin biopsies, excisions, wart removals, and injections in our office are considered a surgery, even though they are rendered in the office.

Does your deductible apply to a procedure completed in an office setting?

Payment for surgical procedures done in the office that apply to your deductible will be collected at checkout. If you are concerned about costs, we will gladly give you an estimate on procedure prices. This is an estimate ONLY. Procedures depend on diagnosis, size, and medical necessity and can not be quoted an EXACT price.

OUR STAFF DOES VERIFY YOUR INSURANCE IN ADVANCE, HOWEVER INSURANCE INFORMATION GIVEN IS NOT A GUARANTEE OF PAYMENT FROM YOUR INSURANCE COMPANY. YOU ARE RESPONSIBLE FOR ALL SERVICES RENDERED THAT YOUR INSURANCE DOES NOT COVER IN FULL. IF YOU HAVE QUESTIONS, PLEASE ASK BEFORE SERVICES ARE PROVIDED.

We are no longer contracted with Medicaid effective 1-1-2019. If we are not contracted with your insurance and wish to be self pay, we will be happy to see you. This amount will be due in full at checkout. **By law, we can not accept patients that have medicaid as self pay.**

Patient Signature:_____ Date:_____

W. EDWARD COLLINS, MD, P.A

JANNA K. NUNEZ-GUSSMAN, MD

ASHLEY BREW, NP

3070 College St, Suite 208

Beaumont, TX 77701

Intake and History Form

Name:_____ Date:_____

Street Address:_____ City/State:_____

Zip Code:_____Date of Birth:_____SS No._____ Gender: _____

Phone number:_____ Alternate Phone:_____

Email address:_____

Emergency Contact:_____

Preferred language:_____ Race:_____ Ethnic Group:_____

Primary Insurance Company Name: _____ Policy No. _____

Group No. _____ Policy Holder: _____ Relationship: _____

Policy Holder Date of Birth: _____

Are you currently on hospice? _____ If so, list your Medicare ID No. _____

Secondary Insurance Company Name: _____ Policy No. _____

Group No. _____ Policy Holder: _____ Relationship: _____

Policy Holder Date of Birth: _____

Preferred Pharmacy:_____

Patient Signature: _____Date: _____

Medical History

Please list any medical conditions you currently have: _____

_____

_____

_____

Have you had a flu shot this flu season? _____ If you are over 65, have you had a pneumonia shot? _____

Skin Disease History

Please list any skin conditions you currently have:_____

_____

_____

_____

Do you have a family history of Melanoma?_____

If yes, which relative: _____

Past Surgical History

Please list all surgical history:_____

_____

_____

_____

_____

_____

Medications

Please list all current medications and dosage:_____

_____

_____

_____

_____

_____

Patient Signature: _____Date: _____

Allergies

Please list all allergies/reactions if known:_____
_____
_____
_____
_____

Social History

Smoking status (Please check one): ____Everyday ____Someday ____Former ____Never

Alcohol Intake (Please check one): _____None ____1 or less a day ____1-2 a day ____3 or more

Do you have an advanced directive/living will?☐ yes ☐ no

If so, who is the surrogate decision maker? _____

Patient Signature: _____Date: _____