Farhad Niroomand, M.D., P.A.
Dermatology and Dermatological Surgery
4144 N Central Expy
Suite 855
Dallas, Texas 75204
Phone (214) 303-1102 Fax (469) 341-0333

Patient Authorization for Disclosure **of Protected Health Information** via **TEXT, E-MAIL, TELEPHONE AND FACSIMILE**

Print Patient Name: _____
Last 4 digits of Social security: _____ **Date of Birth:** ____/____/____

I authorize the Practice to disclose or provide Protected Health Information (as directed below) directly to me at the contact Information listed below. I understand that it is **MY RESPONSIBILITY** to notify the practice of any change in this information. Any disclosure left on **E-MAIL, VOICE MAIL** or **TEXT** indicated by me, is subject to the **RE-DISCLOSURE** statement

E-Mail Address: _____

Please list phone in order of priority and specify whether number is home, mobile or work.

Telephone: _____

Telephone: _____

Name of person or persons we are AUTHORIZED to speak with about your Health Care Information including Results _____ **Relationship to you**_____

Please fill in this important information below.

Name and phone number to your Primary Care Physician
Name: _____ Phone: _____

Pharmacy Name: _____ City: _____ Phone: _____

I authorize Farhad Niroomand, M.D., P.A. to disclose the **following protected health information about me** to the **E-MAIL ADDRESS** and **PHONE NUMBERS** I have indicated .These include **appointment reminders, laboratory results, biopsy results, procedures to be scheduled and other information as necessary for my care.** I am authorizing the disclosure of my Protected Health Information to the specified e-mail, telephone numbers and fax number as a means of enhancing communication with my health care provider. **This authorization will expire one year from the date of my signature below**, unless you specify an earlier termination date. **You must submit a NEW AUTHORIZATION** after the expiration date. **You have the right to terminate this Authorization at any time. You must notify our privacy manager in writing, if you decide to terminate the authorization prior to the normal expiration date (ONE YEAR).**
Please enter earlier expiration date if less than a year: _____

As stated in the practice's Notice of Privacy, I have the right to revoke or terminate this authorization by submitting a written request to the practice's Privacy manager. This can be done in person or by mailing a request to **Attn: Privacy manager.**

RE-DISCLOSURE- I UNDERSTAND THIS OFFICE HAS NO CONTROL OVER WHOM I MAY HAVE GIVEN ACCESS (OUTSIDE OF THIS OFFICE) TO MY E-MAIL ADDRESS, TELEPHONE NUMBERS and FACSIMILE NUMBERS that I have listed to receive my protected health information. If access has been given by me, I know the information disclosed will no longer be protect by the requirements of the Privacy Rule and Future discloser is not the responsibility of Farhad Niroomand, MD, PA

_____ ____/____/____
Patient Signature Date

PATIENT INFORMATION FORM

Please Print

Date: _____ Social Security #: _____ Date of Birth: _____

Name: _____ Age: _____ Sex: M F
Last Name First Name Middle Name

Home Address: _____
Street/PO Box Apt. # City State Zip Code

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

Employer: _____ Work Address: _____ Work Phone: _____-_____

Occupation: _____ Drivers License #: _____ State: _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Responsible Party Information

Name: _____ Social Security #: _____
Last Name First Name Middle Name

Home Address: _____
Street/PO Box Apt. # City State Zip Code

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

Relationship to Patient: _____ Date of Birth: _____

Insurance Information – Please present your insurance and/or Medicare card and Driver License to receptionist so we may photocopy for our records.

_____ I have no insurance coverage

Medicare, Primary # _____ A / B

Primary Insurance:

1). Name of Insurance Company: __COPIED/ON FILE_____ ID#: _____ Group #: _____

Address and /or Phone #: _____

{Name of Insured: _____ Insured's relationship to Patient _____ Insured's DOB: _____}

Employer of Insured: _____ Address: _____ Phone: _____-_____

Secondary Insurance:

2). Name of Insurance Company: _____ ID#: _____ Group #: _____

Address and /or Phone #: _____

Name of Insured: _____ Insured's relationship to Patient _____ Insured's DOB: _____

Employer of Insured: _____ Address: _____ Phone: _____-_____

Referred by: _____ **Phone #:** _____-_____

I consent to treatment necessary for the care of patient indicated on this form

X_____ X_____

Patient Signature **Date**

FOR ALL MANAGED CARE PATIENTS

I hereby assign all medical benefits, including major medical benefits, to which I am entitled to be paid directly to Dr. Farhad Niroomand, M.D., P. A.

Since Dr. Niroomand is a contracted physician with managed care insurance plans, we have agreed to file with your insurance plan for reimbursement and to honor your insurance company's fee schedule. However, it is important that you understand that any services NOT COVERED by your insurance company will be billed to you. It is ultimately your responsibility to insure that any services rendered to you are covered by your particular policy. **Too often we hear, "all I pay is my co-payment and I'm not responsible for anything else." This is false! Some services may not be covered by your plan and some may be subject to a deductible.** You will be responsible for the payment of such services and/or the associated deductible. A few examples of services that may not be covered are: cosmetic procedures (such as non-irritated skin tags, some benign lesions, facial peels, etc...). Feel free to inquire about the cost of any procedure that may not be covered, or subject to a deductible.

If you have any questions regarding coverage, deductibles, etc., please contact the director of benefits at your company or your insurance carrier directly for assistance. If time allows, we will make every effort to verify your insurance coverage on your first visit.

If you are a member of a plan in which you must choose a "Primary Care Physician", it is your responsibility to select such a physician prior to your first visit with us. If you have not done so, your visit may not be covered and you may be responsible for payment in full.

I understand that my insurance company may not cover certain services that I will be receiving from Dr. Niroomand. I also understand that I will be responsible for paying for such services as well as any deductibles and co-payments.

We are currently noticing an increase in all forms of deductibles. Your insurance company may have separate medical, surgical, and laboratory deductibles. If you have a procedure such as a biopsy or removal of a lesion, you may be responsible for the procedure fee in addition to your copayment for the visit. Additionally, you may receive a separate bill from the laboratory, where the specimen is sent for testing. Likewise, if we order blood tests, you may get a separate bill from the facility that draw the sample and run the test(s). Please be advised the bills you receive from the laboratories are separate from invoices issued by our office and must be paid to the company.

X_____ X___/___/___

Patient/Legal Guardian Signature Date

_____

Patient/Legal Guardian Print

_____ ___/___/___

Witness Date

Farhad Niroomand, M.D., P.A.
Dermatology and Dermatological Surgery
4144 N. Central Expy, Suite 855
Dallas, TX 75204

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have read this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosure that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially prohibited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a Complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an account of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

Name: _____ DOB: _____

MEDICAL HISTORY: (Use C if current, P if past – check all that apply)

__anemia	__colon intestinal disorder	__heart problems	__neurological problems
__arthritis	__convulsions/seizures	__high blood pressure	__rheumatic fever
__asthma	__depression	__HIV disease	__STD/venereal disease
__bleeding, excessive	__diabetes	__infection, chronic	__stroke
__blood clots	__epilepsy	__kidney disease	__thyroid disease
__breathing disorder	__fainting spells	__liver disease	__tuberculosis
__bruise easily	__glaucoma	__lupus	__ulcers
__cancer	__hepatitis	__lung disease	
__cataracts	__headaches, chronic	__mitral valve prolapsed	

Other Conditions (describe): _____

FAMILY HISTORY OF ABOVE (please list): _____

SURGICAL HISTORY (list type, reason for surgery, date, surgeon): _____

SKIN HISTORY (Use C if current, P if past – check all that apply)

__blistering sunburns __herpes simplex (cold sores) __wound healing difficulty

__dry skin __scar/keloids

Do you wear sunscreen? Yes No If yes what SPF? _____ Do you tan in a tanning salon? Yes No

Skin Cancer History:

Melanoma: _____ (site) Basal Cell Carcinoma: _____ (site) Squamous Cell Carcinoma: _____ (site)

Do you have a family history of Melanoma? Yes No If yes, which relative? _____

ALERT HISTORY: (Use C if current, P if past – check all that apply)

__allergy to adhesive	__artificial heart valve	__defibrillator	__pregnant or planning
__allergy to lidocaine	__artificial joints within 2 years	__MRSA	__wound healing difficulty
__allergy to antibiotic ointment	__blood thinners	__pacemaker	

Current Medications: List type, dosage and duration: _____

OTC Medications/Supplements: _____

Current Prescriptions Skin Medications: _____

Non-Prescription Skin Products: _____

Drug Allergies: (list type of reaction): _____

FEMALES: __ currently taking oral contraceptives __ pregnant or planning Date of last period: _____

SOCIAL HISTORY Occupation: _____ Tobacco products? _____ Alcohol intake: _____

Chief Complaint: Describe symptom(s) or condition(s) for which you are seeing the doctor

_____

_____

Treatment used for your skin condition: _____

_____

Pre-Medication Required Prior to Surgery □ NO □ YES -- list drug, dosage and duration: _____

I have completed this form to the best of my ability.

_____ ___/___/____

PATIENT / LEGAL GUARDIAN SIGNATURE DATE

MEDICAL RELEASE: I hereby authorize the release of any medical information required by my insurance carrier for services rendered to me in order to process claims on my behalf. I request that payments of Authorized Medical Benefits be made to: Farhad Niroomand, M.D., P.A.

_____ _____

Signature Date

I have reviewed this patient information form.

_____ _____

Physician's Signature Date

Farhad Niroomand, M.D., P.A.
UPTOWN DERMATOLOGY
4144 N. Central Expy, Suite 855
Dallas TX 75204
Office 214.303.1102 Fax 469.341.0333

NO SHOW POLICY

Patients who **do not show** for their appointed time and have not given **24hour notice,** will be billed $25.00.

Patients, who **do not show** for their appointed time that are **scheduled for a procedure** and have not given **48hour notice**, will be billed $50.00 to $100.00 depending on amount of time that was allotted for the procedure.

Patient Signature
X_____

Date
X_____

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Cosmetic Procedures

Date: _____ / _____ / _____

Print Name: _____ Date of Birth: ____/_____/_____

Phone Number: ( ) _____-_____

As we strive to take of your total skin care needs, please let us know if you are Interested in any one of the following procedures:

____ Botox and Disport for wrinkles of the upper face and mouth

____ Fillers: Artefill/ Sculptra / Juvederm / Silicon

____ Microdermabrasion / LED / chemical peels for skin rejuvenation

____ Intense Pulse Light (IPL / Photofacial) to treat brown/red spots and veins

____ Varilite Laser for facial spider veins and leg veins

____ Sclerotherapy for larger veins

____ Laser Hair reduction

____ BBL/Pro-Fractional Laser/ Skin Tightening

Comments:_____
_____
_____
_____