

Leo A. Conger Jr., MD, PA
1809 SW H K Dodgen Loop Suite 100
Temple, TX 76502

PATIENT INFORMATION

(Please Print)

Today's Date ___/___/___

Name _____
Last First Middle Initial

Complete Mailing Address _____
City State Zip Code

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____ SS# _____

Date of Birth ___/___/___ Age _____ Gender _____ Marital Status _____

Parent or Responsible Party (if patient is under age 18)

Name _____
Last First Middle Initial

Complete Mailing Address _____
City State Zip Code

Home Phone _____ Work Phone _____ SS# _____

Date of Birth ___/___/___ Gender _____

INSURANCE INFORMATION (Please present insurance card at time of check-in.)

Primary Insurance Name _____

Policy Holder's Name _____

Policy Holder's DOB ___/___/___

Policy# _____

Group # _____

Relationship to Policy Holder _____

Secondary Insurance Name _____

Policy Holder's Name _____

Policy Holder's DOB ___/___/___

Policy# _____

Group # _____

Relationship to Policy Holder _____

Emergency contact: _____

Primary Care Physician: _____

Phone Number: _____

Phone Number: _____

How did you hear about us? _____

Were you referred by a friend or relative? **Yes / No** Name: _____

Were you referred by a Physician? **Yes / No** Name: _____

To keep you up to date with important information, special offers, and appointment reminders, please provide us with your e-mail address. We promise not to share this information with anyone.

E-mail: _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to Leo A. Conger, MD. I understand that there will be a \$25.00 charge for any returned check and I understand that if my account should go to collections there will be an additional \$9.90 charge for processing.

A photocopy of these assignments shall be valid as the original.

Patient or Responsible Party Signature _____ Date ___/___/___

Dermatology Associates of Central Texas
Leo A Conger Jr. MD

Name: _____ Age: _____ Gender: M/ F Race: _____

To receive the service you deserve from our office your medical history is Essential.

Are you allergic to any medications, local anesthetic, latex, etc. ? YES NO

If so, what? _____

Family History: (Check all that apply.)

Bleeding disorder
Cancer
Depression
Diabetes
Heart Disease

Kidney Problems
Melanoma
Migraine Headaches
Thyroid or Goiter Disease
Tuberculosis

List of current medications:

Personal History: (Check all that apply.)

Anemia
Asthma
Bleeding disorder
Cancer
Diabetes
Hypertension

Kidney Problems
Liver Problems
Skin Cancer
Seasonal Allergies
Thyroid or Goiter Disease
Tuberculosis

List other history if not found above: _____

List of surgical procedures:

Social History: (Circle)

Do you smoke? **Yes / No**

Do you drink alcoholic beverages? **Yes / No**

If female, are you or could you be pregnant? **Yes / No**

Do you have a history of depression? **Yes / No**

Do you have significant fears or phobias? **Yes / No**

Would you be interested in discussing Aesthetic/ Cosmetic products, treatments, procedures or services? **Yes / No**

OFFICE POLICIES AND PROCEDURES

1. **As a courtesy**, we will make an attempt to call and remind you of your upcoming appointment. **If you are unable to keep your appointment, please call within 24 hours to cancel. Failing to do so may result in a \$25.00 charge.**
2. We allow a certain amount of time for each patient in order to give them the proper care and attention they deserve. Failing to call and cancel an appointment more than once will result in dismissal from our practice.
3. Cosmetic procedures and Elective procedures (those that are not medically necessary) will not be covered by your insurance plan. Therefore payment for these services will be due in full at the time you check out.
4. There is a 24-48 hour turn around period for all prescriptions to be picked up or called into your pharmacy of choice.
5. If applicable, payment is due at the time of service.
6. Any returned check to our office will result in a \$25.00 charge. A cash only payment will be accepted for future appointments.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES AND PROCEDURES FOR THE OFFICE OF LEO A. CONGER JR., M.D.

Printed name of patient

Signature and date
(If patient is a minor, parent must sign)

(CONTINUED ON BACK SIDE)

Dermatology Associates of Central Texas

Leo A. Conger, Jr., MD, PA
1809 SW HK Dodgen Loop, Suite 100
Temple, Texas 76502

CONSENT TO RELEASE TEST RESULTS

Date: ____/____/____

I authorize Dr. Leo A. Conger's office to release my lab or pathology results to the following people in my absence when calling my residence.

Name:

Relationship:

1. _____

2. _____

3. _____

4. _____

Patient's Printed Name _____

Patient's Signature _____

Patient's Date of Birth ____/____/____

HIPAA Notice of Privacy Practices

Dermatology Associates of Central Texas
Leo A. Conger Jr., M.D.
1809 SW HK Dodgen Loop Suite 100 – Temple, TX 76502
254-778-5400 or 1-866-778-DERM

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers’ Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

(CONTINUED ON BACK SIDE)

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

Signature: _____ **Date:** _____