SkinMD
804 NE Mall Blvd.
Hurst, TX 76053
817-595-4500 (Office)
817-595-4505 (Fax)

750 Eureka St. STE. A
Weatherford, TX 76086
817-550-6073 (Office)
817-550-6076 (Fax)

Tracie D. Swayden, M.D.
www.SkinMDonline.com

Demographic Patient History

Name: _____ _____
(First) (Middle Initial) (Last) (Age)

Sex: □ Male □ Female **D.O.B.** _____ **Race:** _____ **Ethnicity:** _____

Address: _____
Street Name City State Zip

Please mark which phone number is best to contact you by: **Email:** _____

□Home Phone: _____ □Work:_____ □Mobile:_____

Marital Status: □ Single □Married □Divorced □Widowed **Language:** _____

Employer: _____
Position/Occupation Phone Number

Address: _____
Street Name City State Zip

Person Financially Responsible For All Charges: _____
Phone Number

Address (if different from the patient) : _____

Primary Care Physician: _____

Who May We Thank For Referring You To Our Office: _____

Insurance Plan(s) Information

Primary Insurance: _____ **Insured's Name:** _____ **D.O.B.:** _____

Insured's Address (if different from patient): _____

Relationship to patient: □ Self □ Spouse □ Parent □ Other: _____

Referral Required: □ Yes □No **S.S.:** _____

Secondary Insurance: _____ **Insured's Name:** _____ **D.O.B.:** _____

Insured's Address (if different from patient): _____

Relationship to patient: □ Self □ Spouse □ Parent □ Other: _____

Referral Required: □ Yes □No **S.S.:** _____

Notify in Case of Emergency:

_____
Name **Relationship** **Emergency Contact Number**

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my own account for any professional services rendered. I certify that the above information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information. If I am not covered by insurance, I understand that the payment is expected at time of service unless prior arrangements have been made.

Assignment of Benefits: I hereby assign all medical and surgical benefits to include major benefits to which I am entitled, including Medicare, Private insurance and any other health plans to Tracie D. Swayden, M.D. This assignment will remain in effect until revoke by me in writing. A photocopy of this assignment will be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance.

I hereby authorize assignee to release all information necessary to secure payment.

Signed: _____ **Date:** _____

All Sales and Services Are Final No Refunds, Exchanges or Returns.

SkinMD
804 NE Mall Blvd.
Hurst, TX 76053
817-595-4500 (Office)
817-595-4505 (Fax)

750 Eureka St. STE. A
Weatherford, TX 76086
817-550-6073 (Office)
817-550-6076 (Fax)

Tracie D. Swayden, M.D.
www.SkinMDonline.com

Consent and Agreement:

I am at least 18 years of age, if not I am accompanied by parent/legal guardian/responsible party. I hereby consent to and authorize an examination via the doctor and such assistant(s)/staff, as may be assigned by him/her. If appropriate, I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I understand it is my responsibility to provide current up to date insurance information prior to treatment. I also acknowledge that the filing of the insurance claim(s) is not a guarantee of payment, and that I am financially responsible for payment if the claim(s) remains unpaid. I authorize payment of medical benefits directly to the doctor for the service(s) provided to me. A copy of this authorization shall be considered as valid as the original. I authorize SkinMD, to fax my records to any physician or pharmacy for the purpose of coordinating or managing my healthcare.

In case of divorce/separation, the party responsible for the account prior or the divorce/separation remains responsible for the account. After a divorce/separation, the parent authorizing treatment for the child/children will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

For cosmetic services not covered by health insurance, I understand that charges are payable on or before the day of service is rendered. I understand that photography is at times a necessary part of planning and evaluating treatment, and hereby authorize the taking of photographs at the direction of the physician/delegate, solely for documentation purposes and recognize the pictures will be kept confidential, unless otherwise disclosed. I understand that I am ultimately responsible for payment of services rendered.

_____**Date**_____
Patient's Signature

_____**Date**_____
Patient's Printed Name

Written Acknowledgement Form

I am a patient of Dr. Tracie Swayden. I hereby acknowledge receipt of SkinMD's Notice of Privacy Practices.

Name (Please Print):_____

Signature: _____

Date:_____

OR

I am a parent or legal guardian of _____**(Patient Name).**

I hereby acknowledge receipt of SkinMD's Notice of Privacy Practices with respect to the patient.

Name(Please Print):_____

Relationship To Patient: Parent:_____ **Or Legal Guardian:**_____

Signature:_____

Date:_____

SkinMD
804 NE Mall Blvd.
Hurst, TX 76053
817-595-4500 (Office)
817-595-4505 (Fax)

750 Eureka St. STE. A
Weatherford, TX 76086
817-550-6073 (Office)
817-550-6076 (Fax)

Tracie D. Swayden, M.D.
www.SkinMDonline.com

SkinMD®
AESTHETIC AND MEDICAL SKIN CARE

Credit Card / Debit Card Authorization

As of January 1st 2015 SkinMD has implemented a financial agreement policy. You will be asked for a credit or debit card number at the time you check in and the information will be held securely until your insurance(s) have paid their portion and notified SkinMD if there is a remaining amount left as patient responsibility. At that time, any remaining balance owed by you will be charged to your credit or debit card, and a copy of the charge will be mailed to you upon request.

As of January 1st 2015 ALL COSMETIC PATIENTS will be required to provide the credit / debit card information prior to scheduling any cosmetic consultations or cosmetic procedure. Cosmetic Consultations are a $50.00 Fee that can be paid at the time of scheduling the consultation or at the time of being seen in the office. If you choose to have a procedure provided you will have the option of applying the $50.00 fee to your cosmetic procedure. ***(This Can Not Be Used Towards Cosmetic Products.)***

FOR ALL COSMETIC PATIENTS WE HAVE IMPLEMENTED A COSMETIC CANCELLATION / NO SHOW POLICY - IF YOU DO NOT CANCEL YOUR APPOINTMENT WITHIN 24 HOURS OR NO SHOW FOR YOUR APPOINTMENT, THERE WILL BE A $50.00 (NON REFUNDABLE) CHARGE.

FOR ALL *DERMATOLOGY* PATIENTS WE HAVE IMPLEMENTED A CANCELLATION / NO SHOW POLICY FOR APPOINTMENTS SET THAT ARE NOT CANCELLED WITH-IN 24 HOURS FROM THE DAY OF THE SET APPOINTMENT TIME . YOU WILL BE CHARGED A $25.00 (NON REFUNDABLE) NOSHOW FEE TO THE INFORMATION PROVIDED BELOW OR RECEIVE A STATEMENT IN THE MAIL. ALL NOSHOW BALANCES MUST BE CLEARED BEFORE NEXT APPOINTMENT CAN BE SET.

FOR ALL *MOHS SURGERY* PATIENTS WE HAVE IMPLEMENTED A CANCELLATION/NO SHOW POLICY FOR APPOINTMENTS SET AND NOT KEPT WITH-IN A 24 HOUR TIME FRAM E FROM THE SCHEDULED SURGERY DATE. THERE WILL BE A $100.00 (NON-REFUNDABLE) CHARGE TO THE INFORMATION PROVIDED BELOW IF THE APPT IS NOT CANCELLED WITH-IN 24 HOURS OR IF THE PATIENT SCHEDULED NO SHOWS FOR THE SURGERY.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us, as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.
Co-Pays, Deductibles and Coinsurance Amounts due at the time of the visit will, of course, still be due at the time of the visit.
If you have any questions about this payment method, please do not hesitate to ask.
Sincerely,
Tracie D. Swayden, M.D.

I authorize Skin MD, P.A. to charge outstanding balances on my account to the following card:
Visa Master Card Discover American Express (Circle One)

Account Number _____ Expiration Date_____

Name on Card (Please print) _____ Zip _____

Signature: _____ Date: _____

All Sales and Services Are Final No Refunds, Exchanges or Returns. **Revised 03/04/2015**

SkinMD
804 NE Mall Blvd.
Hurst, TX 76053
817-595-4500 (Office)
817-595-4505 (Fax)

750 Eureka St. STE. A
Weatherford, TX 76086
817-550-6073 (Office)
817-550-6076 (Fax)

Tracie D. Swayden, M.D.
www.SkinMDonline.com

Patient Financial Responsibility

Patient Name: _____ Date: _____

SkinMD appreciates the confidence you have shown in choosing us to provide you with your skincare needs. Any service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full for your fees. As a courtesy, we will bill your insurance carrier on your behalf. **However, you are ultimately responsible for the payment of your bill.**

If a biopsy is taken during your office visit, there are **two separate charges** for this. A provider charge for collecting the biopsy which is added to your charges the day you are seen in the office. The other charge will be from **ProPath Laboratories** for the pathologist to examine the specimen to provide the diagnosis.

Some treatments done by scissor snipping or platinum wire are often not covered by most insurance plans. This would include sebaceous hyperplasia, skin tags, and cherry angiomas. These are considered cosmetic services and the patient is responsible for these charges at the time of service.

You are responsible for payment of: any copayment at the time of service, and balance of a bill for any deductible/coinsurances as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, you will be responsible for your account balance in full. For your convenience, we accept cash, checks, and most major credit cards. Payment is expected by payment due date on your Monthly Patient Statement. Payments will be accepted at the office. Other payment options will be included on your statement, including our mailing address or by contacting our billing department.

FOR ALL COSMETIC PATIENTS WE HAVE IMPLEMENTED A COSMETIC CANCELLATION / NO SHOW POLICY - IF YOU DO NOT CANCEL YOUR APPOINTMENT WITHIN 24 HOURS OR NO SHOW FOR YOUR APPOINTMENT, THERE WILL BE A $50.00 (NON REFUNDABLE) CHARGE.

FOR ALL *DERMATOLOGY* PATIENTS WE HAVE IMPLEMENTED A CANCELLATION / NO SHOW POLICY FOR APPOINTMENTS SET THAT ARE NOT CANCELLED WITH-IN 24 HOURS FROM THE DAY OF THE SET APPOINTMENT TIME . YOU WILL BE CHARGED A $25.00 (NON REFUNDABLE) NOSHOW FEE TO THE INFORMATION PROVIDED BELOW ALL NOSHOW BALANCES MUST BE CLEARED BEFORE NEXT APPOINTMENT CAN BE SET.

FOR ALL *MOHS SURGERY* PATIENTS WE HAVE IMPLEMENTED A CANCELLATION/NO SHOW POLICY FOR APPOINTMENTS SET AND NOT KEPT WITH-IN A 24 HOUR TIME FRAM E FROM THE SCHEDULED SURGERY DATE. THERE WILL BE A $100.00 (NON-REFUNDABLE) CHARGE TO THE INFORMATION PROVIDED BELOW IF THE APPT IS NOT CANCELLED WITH-IN 24 HOURS OR IF THE PATIENT SCHEDULED NO SHOWS FOR THE SURGERY.

I have read the above policy regarding my financial responsibility to SkinMD for providing services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to SkinMD. I agree to pay SkinMD the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment made by my insurance carrier.

ALL SALES ARE FINAL, NO REFUNDS ON PRODUCTS OR COSMETIC SERVICES. ALL PACKAGES EXPIRE ONE YEARS FROM DATE OF PURCHASE.

Signature: _____ (relationship to patient: self – guardian – other: _____)

Date: _____

SkinMD
804 NE Mall Blvd.
Hurst, TX 76053
817-595-4500 (Office)
817-595-4505 (Fax)

750 Eureka St. STE. A
Weatherford, TX 76086
817-550-6073 (Office)
817-550-6076 (Fax)

Tracie D. Swayden, M.D.
www.SkinMDonline.com

DERMATOLOGY MEDICAL HISTORY

Name:_____ **DOB :**_____
Date:_____**Occupation:**_____
Reason For Visit:_____
Allergies:_____
Medications/Vitamins:_____

Skin Conditions and Social History **Location** **Year**

Have you had Skin Cancer ? **Y / N**
- Basal Cell Carcinoma? _____ _____
- Squamous Cell Carcinoma? _____ _____
- Melanoma Skin Cancer? _____ _____

Have you had abnormal / dysplastic moles? **Y / N**
Have you had Pre-Cancerous Actinic Keratoses? **Y / N**
List any other skin conditions you have: **Y / N**
Eczema, Psoriasis, Acne, Rosacea, Vitiligo, Warts, Hives
Other:_____
_____
Do you have a History of Cold Sores? **Y / N**
Do you use Sunscreen? **Y / N**
Do you use Tanning Booths? **Y / N**
Have you had blistering sunburns? **Y / N**
Do you heal with thick (Keloid) scars? **Y / N**
Do you bleed / bruise easily? **Y / N**
Do you react to numbing medications? **Y / N**
Do you react to bandages or adhesives? **Y / N**
Have you had staph infections / MRSA? **Y / N**
Do you smoke? **Y / N** Number Per Day? _____
Do you drink alcohol? **Y / N** Drinks Per Day? _____
Have you recently traveled out of the U.S?_____ **Y / N**

ROS: Circle any *Symptoms* you are having below :

General: Weight Loss Fatigue Other:_____
Immune: Fever Night Sweats Frequent Infections
Eye: Dryness Blurry Vision Irritation
Heart: Chest Pain Palpitations Other:_____
Lungs: Cough Shortness of Breath Chest Tightness
GI: Nausea Vomiting Diarrhea Stomach Pains
Joint: Stiffness Pain Swelling
Neuro: Numbness Tingling Headaches Weakness
Endocrine: Heat/Cold Intolerance Excessive Thirst Sweating
Psych: Depression Anxiety High Stress
Heme: Easy Bleeding Bruising Swollen Nodes
Skin: Itching Burning Redness Discoloration Scale Pain

Female's: Pregnant Nursing Irregular Periods
Planning Pregnancy: **Y / N**
Birth Control : _____
How Long:_____

Past Surgeries: **Year**
Pacemaker / Defibrillator **Y / N** _____
Joint Replacement **Y / N** _____
Heart Valve Replacement **Y / N** _____
Other_____
_____
_____

PMH: Circle Your medical Problems
Cancer: Breast Prostate Colon
Other:_____
Immune: HIV Allergies
Autoimmune: Lupus Scleroderma RA
Eye: Glaucoma Cataracts
Heart: High Blood Pressure Heart Attack
High Cholesterol Atrial Fibrillation Heart Valve
Lung: COPD Asthma Tuberculosis
GI: Acid Reflux Colitis IBS Crohn's
Joint: Arthritis Joint Replacement
Brain: Stroke Seizures Headaches Epilepsy
Endocrine: Thyroid Diabetes PCOS
Psych: Depression Anxiety Attention Deficit
Heme: Blood Clots Anemia
Kidney: Stones Disease:_____
Liver: Hepatitis , or C
Other:_____

Family Medical History **Relationship**
Skin Cancer?
- Melanoma **Y / N** _____
- Basal Cell **Y / N** _____
- Squamous Cell **Y / N** _____

Psoriasis? **Y / N**
Autoimmune diseases? **Y / N**
Other:_____
_____
_____

Pharmacy Information

Pharmacy:_____
Address: _____
_____
Phone: _____

SkinMD
804 NE Mall Blvd.
Hurst, TX 76053
817-595-4500 (Office)
817-595-4505 (Fax)

750 Eureka St. STE. A
Weatherford, TX 76086
817-550-6073 (Office)
817-550-6076 (Fax)

Tracie D. Swayden, M.D.
www.SkinMDonline.com

Waiver of Confidentiality:

You understand if this account is submitted to a collection agency or attorney, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment in our facility may become a matter of public record.

Disclosure of Patient Information and Patient Communication Form

A. Family and Friends. It is the office policy of SkinMD not to release confidential medical information Regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized
By the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or
Friends into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment, (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
If you anticipate that you will need or want our medical information to be provided to family members, friends, or caretakers/babysitters, please indicate below, so that we may best serve you. By signing below, you authorize the following people to receive information regarding your treatment or care: (If you wish to add names later, please confirm this in writing, or call our staff.

B. Alternative Communications: You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way. I hereby request the following means of contact only

I hereby authorize Tracie D. Swayden, M.D. and her staff/billing agency to disclose information regarding my medical condition, personal medical history, plan for treatment, laboratory/pathology results, medications, appointments, or billing to the following persons:

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Specific Information I do not want disclosed:

_____

Disclosure to Healthcare Professionals : I also give permission to the office of Tracie D. Swayden, M.D. to give verbally or by facsimile any required or requested information to other physicians, hospitals, or medical facilities serving a part in my health care needs.

*****I am fully aware that a cell phone is not a secure and private line.*****

Answering Machine:

I authorize SkinMD to leave personal information or instructions on my answering machine or voice mail at the number(s) listed below. I will not hold the staff responsible for other individuals who may hear the message. This will remain in effect until I revoke these instructions in writing to SkinMD.

Answering Machine / Voicemail #: _____

I Consent SkinMD to provide Text Message Reminders on my Cell Phone: Yes OR No

_____Date_____

Patient's Signature

_____**Date**_____

Patient's Printed Name