MACIAS DERMATOLOGY
MEDICAL · SURGICAL · COSMETIC

PATIENT INFORMATION

Patient First & Last Name:_____ Sex: (circle) M / F

Address: _____ City: _____ State: _____ ZIP: _____

Social Security Number (optional): _____- _____- _____ Date of Birth: ____ / ____ / _____ Marital Status: (circle) S M D W

Phone Number: (circle preferred) Home: _____ Cell: _____

E-Mail: _____

Who to notify in case of **emergency**? _____ Relationship: _____

Daytime Phone Number: _____ Alternate Phone Number: _____

Race: (circle) American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / White / Other Race / Declined to State

Ethnic Group: (circle) Hispanic or Latino / Not Hispanic or Latino / Declined to State / Other: _____

GUARANTOR / RESPONSIBLE PARTY INFORMATION

Complete this section if the patient is a minor (under 18) or if someone other than the patient is financially responsible.

Patient's Relationship to Guarantor: (circle) Self / Parent / Spouse / Legal Guardian / Other: _____

GUARANTOR #1

First Name: _____ Last Name: _____ Date of Birth: ____ / ____ / _____

Social Security Number (optional): _____- _____- _____ Phone: _____

Address: (circle) Same as Patient / Other: _____ City: _____

State: _____ ZIP: _____

GUARANTOR #2 (if applicable — second parent or guardian)

First Name: _____ Last Name: _____ Date of Birth: ____ / ____ / _____

Social Security Number (optional): _____- _____- _____ Phone: _____

Address: (circle) Same as Patient / Other: _____ City: _____

State: _____ ZIP: _____

INSURANCE INFORMATION

Primary: _____ / Secondary: _____

Primary Responsible Party's Name: _____ Date of Birth: ____ / ____ / ____

If applicable:

Secondary Responsible Party's Name: _____ Date of Birth: ____ / ____ / ____

Patient's Relationship to Insured: (circle) Spouse / Child / Other: _____

REFERRAL INFORMATION

How were you referred to our practice? (circle): Friend _____ / Physician / Insurance / Facebook / Instagram / Website / Search Engine

If applicable:

Primary Care Physician: _____ Referring Physician: _____

I hereby authorize the above information is correct.

Patient/Responsible Party Signature: _____

MACIAS DERMATOLOGY

PATIENT REGISTRATION FORM – DISCLOSURES & CONSENTS

Insurance Benefits:
I authorize direct payment of my insurance benefits to Macias Dermatology for services provided. I understand it's my responsibility to know my insurance coverage, and I agree to pay any co-pays or balances not covered by my insurance.

Release of Information:
I have received and read the Privacy Policy. I authorize the release of my or my dependent's medical information as needed for treatment or insurance processing.

Lab/X-Ray/Diagnostics:
I understand I may receive a separate bill for lab, x-ray, or diagnostic services and am responsible for any co-pays or balances not covered by insurance.

Consent to Treatment:
I consent to medical evaluation, testing, and treatment, including biopsies and minor procedures, after discussing risks and complications. I understand that results are not guaranteed.

Acknowledgment:
By signing below, I confirm that I have read and understand these disclosures and consents.

Patient Name: _____
Date: _____
Signature: _____

MACIAS DERMATOLOGY

E-PRESCRIBING CONSENT FORM

E-Prescribing allows physicians to electronically send accurate and understandable prescriptions directly to a pharmacy, reducing medication errors and enhancing patient safety and convenience. The Medicare Modernization Act (MMA) of 2003 established E-Prescribing standards to improve patient care quality.

E-Prescribing includes:

- **Formulary and Benefit Transactions:** Provides prescribers with information on drugs covered by the patient's insurance plan.
- **Medication History Transactions:** Offers physicians access to a patient's current medications to prevent adverse drug interactions.
- **Fill Status Notification:** Notifies the prescriber if a prescription has been picked up, not picked up, partially filled, or needs a refill.

By signing below, I consent to Macias Dermatology electronically transmitting my prescriptions to my pharmacy. I understand that consenting also allows access to my prescription history from other healthcare providers and insurance companies for treatment purposes only.

I acknowledge that E-Prescribing is optional, and I may decline this service.

Patient Name: _____
Date: _____
Signature: _____

MACIAS DERMATOLOGY

PATIENT FINANCIAL POLICY

Insurance

- **Copays** are due at the time of visit; full payment is required if a referral is missing.
- **Medicare (Part B):** Patients are responsible for the deductible and 20% of the service cost.
- **Self-Pay & Out-of-Network Patients:** Full payment is required at the time of service.
- **Non-Covered Services:** Patients are responsible for all costs not covered by insurance.

Lab Work

- Any required lab work is billed separately by the laboratory.

No-Show & Cancellation Fees

- **Office Visits: Medical, Surgeries, and All Cosmetic Appointments:** $75 cancellation fee. if not canceled at least 24 hours in advance.
- **Cancellations require at least 24-hour notice from your appointment time (excluding weekends) to avoid fees.**

Cosmetic Appointments & Deposits

- A **$150 deposit** is required for all cosmetic treatments scheduled for **one hour or longer**.
- Deposits are **non-refundable** if the appointment is canceled **within 24 business hours** of the scheduled time.
- **Prepaid services** are valid for **one calendar year** from the date of purchase.

Returns & Refunds

- **Retail Products:** No refunds. Store credit is available within **14 days** for unopened, unused products with a receipt.
- **Cosmetic Services:** No refunds on pre-paid cosmetic services.

Patient Acknowledgment

I have read and understand the **Patient Financial Policy** of Macias Dermatology.

Patient Name: _____
Date: _____
Signature: _____

MACIAS DERMATOLOGY

Acknowledgment of Receipt of the Notice of Privacy Practices

Patient Name: _____
Date of Birth: _____
Address: _____
Phone Number: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of Macias Dermatology and understand my rights regarding the use and disclosure of my personal health information. I also understand that I may contact the Medical Director if I have any questions or concerns.

Patient Signature: _____
Date: _____

Macias Dermatology

HIPAA Right of Access Form for Family Member/Friend

I, _____, authorize the release of my health information to:

Name: _____
Relationship: _____

Contact Information:

Health Information to be disclosed (Check one):
❑ A. Complete health record (including diagnosis, lab tests, prognosis, treatment, and billing)
❑ B. Health record, excluding the following:
Other (please specify): _____

This authorization is effective until (Check one):
❑ All past, present, and future periods
❑ Specific date/event: _____

This authorization may be revoked at any time by notifying your health care providers in writing.

Name of Individual Giving Authorization: _____
Date of Birth: _____
Signature: _____
Date: _____

(Note: HIPAA Authority for Right of Access: 45 C.F.R.)

Review of Systems

Patient: _____ DOB: _____ Date: _____

Instructions: Check any symptoms you are currently experiencing or have experienced recently. If you have **none** for a section, check **None**.

General ☐ None

☐ Fever ☐ Chills ☐ Weight change ☐ Fatigue

Diet ☐ None

☐ Appetite change ☐ Dietary restrictions ☐ Vitamins ☐ Supplements

Skin, Hair & Nails ☐ None

☐ Rash ☐ Itching ☐ Easy bruising ☐ Skin color changes
☐ Hair loss/change ☐ Nail changes

Head & Neck ☐ None

☐ Headache ☐ Dizziness ☐ Head injury ☐ Fainting

Eyes ☐ None

☐ Vision changes ☐ Eye pain ☐ Eye injury ☐ Eye disease

Ears ☐ None

☐ Hearing loss ☐ Ringing (tinnitus) ☐ Ear pain ☐ Vertigo

Nose ☐ None

☐ Congestion ☐ Nosebleeds ☐ Postnasal drip

Mouth & Throat ☐ None

☐ Sore throat ☐ Hoarseness ☐ Mouth sores
☐ Dental problems ☐ Bleeding gums

Respiratory ☐ None

☐ Cough ☐ Shortness of breath
☐ Wheezing ☐ Shortness of breath with activity
☐ Night sweats

Cardiovascular ☐ None

☐ Chest pain ☐ Palpitations
☐ Leg swelling ☐ Leg pain with walking

Gastrointestinal □ None

□ Heartburn □ Indigestion □ Nausea
□ Vomiting □ Abdominal pain
□ Constipation □ Diarrhea
□ Blood in stool □ Bloating

Genitourinary □ None

□ Painful urination
□ Frequent urination
□ Urgency
□ Blood in urine
□ Flank pain
□ Discharge

Endocrine □ None

□ Heat intolerance
□ Cold intolerance
□ Excessive thirst
□ Frequent urination
□ Weight change
□ Hair changes
□ Increased hat/glove/shoe size

Musculoskeletal □ None

□ Joint pain
□ Joint swelling
□ Joint warmth
□ Muscle pain
□ Back pain

Neurologic □ None

□ Weakness
□ Numbness/tingling
□ Poor coordination
□ Memory loss
□ Fainting

Psychiatric □ None

□ Anxiety
□ Depression
□ Mood changes
□ Difficulty concentrating
□ Sleep problems

☐ Eating changes
☐ Suicidal thoughts

Additional symptoms or comments:

Patient Signature: _____ Date: _____