

Ralph A. Brooks, M.D.

Dermatology and Dermatologic Surgery

909 9th Avenue, Suite 405
Fort Worth, Texas 76104
(817) 870-9718

Dear New Patient:

As a new Patient we would like to welcome you and give you some additional information about our office.

Initial Visit: This visit usually takes approximately 20 minutes. Please verify if we have received a referral from your Primary Care Physician if this applies to your insurance. Please give us all your information regarding your health insurance. Payment is due at the time of the appointment and the amount will depend upon your insurance coverage.

Additional Visits: If further treatment is necessary Dr. Brooks will ask to see you back in the office. These additional visits will usually be for 10 minutes or if surgery is required 30 minutes to 2 hrs. Please check with our office to verify insurance coverage and referrals. Please remember to verify the referral before your visit. However, if Dr. Brooks treats you without a referral then payment becomes your responsibility. Dr. Brooks will not treat you without a current referral unless you are self-pay. Please keep in mind all referrals do expire, either by date or number of visits.

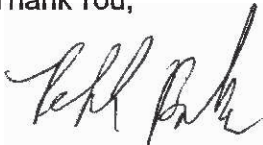
Medication: If medication is needed, Dr. Brooks will write out a prescription with the instructions. To get a refill of your medication, please call your pharmacy and have a refill request faxed to the office at 817-335-5608. All refills will take approximately 2 business days.

Cancellations: As a courtesy to you, we will try and contact you by phone to confirm your appointment. If you need to cancel your appointment, please call within 24 hours before your scheduled appointment. You can also leave a message on our answering system. **If you fail to show up for your appointment you will be charged a \$40.00 NO SHOW FEE. If you fail to cancel within 24 hours, you will be charged a \$20.00 CANCELLATION FEE.**

Insurance: We will be more than happy to file your insurance for you. For Patients with deductible. If your deductible has not been met payment is due at time of service. Patients with co-payment amount are due at the time of service.

As it is our goal to provide the best care for our Patients, we would like to help you in any way that we can. Please tell us if there is anything we can do for you.

Thank You,



Ralph A. Brooks, M.D.

Patient's Signature

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Patient Consent for the Disclosure of Information

I have read the NOTICE OF PRIVACY PRACTICES and have had any questions answered by this office. I understand that by signing this form I consent to the following:

- Sharing information for purposes of treatment: You will share my information with all members of my treatment team, both within this office and with other providers (personal and institutional) in order to provide me with quality care and the educational/wellness programs specified in my insurance plan.
- Sharing of information for purposes of payment: You will share all necessary information with my insurer(s), payor(s), governmental entities (such as Medicare, Tricare, Champus, etc.) and their representatives (including, but not limited to benefit determination and utilization review) as well as your representatives involved in the billing process (including, but not limited to) claims representatives, data warehouses, billing companies).
- Sharing of information for purposes of operations: You will share all information necessary for ongoing operations of this office, including (but not limited to) the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

Patient's Name (print)

Date

Patient's Signature or Guardian, if a minor

Witness

Date

RALPH A. BROOKS, M.D.

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PATIENT MEDICAL INFORMATION

PATIENT NAME: _____ DOB: _____

MEDICATION ALLERGIES: _____

CURRENT MEDICATIONS AND VITAMINS: _____

PAST SURGERIES: _____

Please check if you have ever had any of the following:

- Eczema
- Skin Cancer: Type _____ When _____ Dr. Name: _____
- Family history of melanoma
- Other cancers: of what origin? _____
- Keloids or excessive scarring
- Asthma or Emphyzema
- Hay Fever
- Lung Disease
- Tuberculosis
- Heart Disease, murmurs, or rheumatic fever
- High Blood Pressure
- Pacemaker
- Bleeding problems
- Anemia
- Diabetes
- Thyroid Disease
- Stomach ulcers or peptic ulcer disease
- Hepatitis
- Liver Disease
- Lupus Erythematosus
- Seizures or Epilepsy
- HIV or AIDS

Any other medical conditions: _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of Protected Health Information (PHI). The individual is also provided the right to request confidential communications.

I wish to be contacted in the following manner (check all that apply)

Home Telephone

- Okay to leave message with detailed information on answering machine
- Leave message with call-back number only

If you are not home, is there a person we may leave a detailed message with?

Name: _____ Relation: _____

Work Telephone

- Okay to leave message with detailed information
- Leave message with call-back number only

Other (other person or phone number where we may leave detailed information)

Patient Signature

Date

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PATIENT CONSENT FORM

In order for us to diagnose and treat your condition(s) it is necessary for you to give your informed consent.

I authorize Ralph A. Brooks, M.D. to diagnose and/or treat my skin condition(s).

PATIENT: _____ DATE: _____

Print

I understand that the purpose of this consent is to diagnose and /or treat my skin condition(s). The nature and effect of any procedure/biopsy to be performed based on the diagnosis of my skin condition(s), and the risks involved, as well as possible alternative methods of treatment, have been explained to me. In executing this consent, I fully understand the risks involved and that I have signed this consent on my own free will. I consent the use of local anesthesia and or regional anesthesia as Dr. Brooks may deem advisable. I agree that Dr. Brooks in performing such procedure may use assistants who will be under his direct supervision. I agree to fully cooperate with Dr. Brooks and to comply to the best of my ability with his instructions and recommendations relative to my care and treatment.

I understand that no guarantee has been given to me by Dr. Brooks as to the results of this procedure. I realize that surgery is not an exact science and therefore results can not be guaranteed. I further realize that there may be varying degrees of discomfort and variations in the period of the recovery following the procedure. I further understand that more than one procedure may be necessary to fully complete the treatment depending on the nature of the treated condition.

I have read the above consent and understand it fully and therefore authorize Dr. Brooks to diagnose and treat my condition(s).

PATIENT'S SIGNATURE

GUARDIAN'S SIGNATURE

Ralph A. Brooks, M.D.

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REGISTRATION

(PLEASE PRINT)

Date _____

Home Phone _____

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birth Date _____ Single Married Widowed Separated Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

PRIMARY INSURANCE / PRIVATE PAY

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birth Date _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents covered under this plan _____

Private Payer's Signature _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Relation to Patient _____ Birth Date _____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

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Name: _____ **Date:** _____

Phone: _____ **Email:** _____

1. Are you presently taking any type of nutritional supplements (such as vitamins, minerals, herbs, amino acids, fish oils, etc)?
yes no

2. If you are taking supplements, which of the following are you currently taking:
 Multivitamin Calcium Omega III Fish Oil Antioxidants
 Vitamin B Vitamin C Vitamin D Joint Supplement
 Minerals Flaxseed Hormone Therapy Allergy Aids
 Other (please specify) _____

3. Who recommended you take these supplements?
 family member or friend
 advertisement
 health professional
 other

4. Where did you purchase these supplements?
 mail-order healthcare provider
 nutrition or vitamin shop pharmacy
 other (please specify): _____

5. If this practice offered advanced high quality supplements, would you consider purchasing them?
 Yes No

6. If this office offered a simple genetic test to determine what supplements are best for you, based on genetics, would you consider doing it?
 Yes No

7. Would you attend a program that promotes any of the following. (Check the ones that you are Interested in.)
 Healthy eating life Style Weight Management
 Complete Beauty makeover High Quality Children's Vitamins
 Cellulite Reduction through Medical Massage Therapy

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8. Would you be interested in a monthly news letter from Dr. Brooks Office with the latest developments in "skin issues" and simple home care tips?
 Yes No

9. Please note any questions or comments: _____

