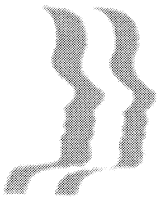


Childs Dermatology Clinic

James N. Childs, M.D., P.A.

Maria V. Childs, M.D.

New Patient Registration Form

Today's Date: _____ Referred By: _____

Patient Information:

Name: _____ Date of Birth: _____
FIRST MIDDLE LAST

Sex: Male or Female Social Security #: _____-_____-_____ Marital Status: _____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Mobile: _____ E-mail: _____

Employer: _____ Address: _____ Phone: _____

Spouse Information:

Name: _____

Date of Birth: _____ Sex: Male or Female Social Security #: _____-_____-_____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Mobile: _____ E-mail: _____

Employer: _____ Address: _____ Phone: _____

Parent/Guardian Information:

Name: _____ Relationship: _____

Date of Birth: _____ Sex: Male or Female Social Security #: _____-_____-_____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____
(If different from above)

Home Phone: _____ Mobile: _____ E-mail: _____

Employer: _____ Address: _____ Phone: _____

Insurance Information:

Insured's Name: _____ Relationship: _____ Date of Birth: _____

Insured's Name: _____ Relationship: _____ Date of Birth: _____

Patient/ Parent/ Guardian Signature:

I authorize the provider or insurance company to release any information required for this claim. I authorize my insurance benefits to be paid directly to James N. Childs, M.D.,P.A.. I understand that even though I have assigned benefits to be paid directly to James N. Childs, M.D.,P.A., I am still responsible for the entire bill.

Authorized Signature: _____ Date: _____

TO BE COMPLETED BY PATIENT - PLEASE PRINT

HEALTH QUESTIONNAIRE

Formedic

REASON FOR VISIT

FAMILY HISTORY

	ALIVE & WELL	DECEASED	FOLLOW THE LINES ACROSS THE PAGE AND MARK THE APPROPRIATE BOX CAUSE OF DEATH (AGE)	HIGH BLOOD PRESSURE	HEART DISEASE	EPILEPSY	DIABETES	CANCER	ASTHMA	HAYFEVER	ARTHRITIS	KIDNEY DISEASE	GLAUCOMA	STROKE	MIGRAINE	MENTAL ILLNESS	ALCOHOLISM	BLEEDS EASILY	ANEMIA	PSORIASIS	ECZEMA
FATHER																					
MOTHER																					
BROS / SIS																					
BROS / SIS																					
BROS / SIS																					
BROS / SIS																					
MOTHER'S RELATIVES																					
FATHER'S RELATIVES																					

HOSPITAL ADMISSIONS

Indicate the year you were admitted to hospital and the reason. Do not include normal pregnancies.

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

MEDICATIONS

List all medications that you are now taking. Include over the counter Rx

NAME	STRENGTH	HOW OFTEN	NAME	STRENGTH	HOW OFTEN
			DRUG ALLERGIES		

MEDICAL HISTORY

Mark (c) for current problems. Check (✓) box and indicate age when you had any of the following symptoms or diseases.

- ☐ HEARING PROBLEMS
- ☐ GLAUCOMA ☐ CATARACTS
- ☐ NOSE BLEEDS ☐ SINUS TROUBLE
- ☐ HOARSENESS ☐ HAY FEVER
- ☐ ASTHMA ☐ HYPERTENSION
- ☐ CORONARY HEART DISEASE
- ☐ HEART MURMUR
- ☐ PALPITATIONS ☐ IRREG. PULSE
- ☐ VARICOSE VEINS ☐ PHLEBITIS
- ☐ DIFFICULTY SWALLOWING ☐ HEARTBURN
- ☐ PEPTIC ULCER DISEASE ☐ COLITIS
- ☐ JAUNDICE ☐ HEPATITIS
- ☐ KIDNEY STONES ☐ PROSTATE PROB.
- ☐ VENEREAL DISEASE ☐ HERPES
- ☐ CHLAMYDIA ☐ GONORRHEA
- ☐ RECENT WEIGHT LOSS
- ☐ ANEMIA ☐ BRUISE EASILY
- ☐ CANCER
- ☐ DIABETES ☐ THYROID DISEASE
- ☐ SEIZURES ☐ STROKE
- ☐ MIGRAINE HEADACHES
- ☐ ARTHRITIS ☐ GOUT
- ☐ DEPRESSION ☐ MENTAL ILLNESS
- ☐ TUBERCULOSIS
- ☐ ALLERGIES (NON DRUG)

ALCOHOL – OZ / WK _____

SMOKING – CIG / DAY _____ #YEARS _____

COFFEE / TEA – CUPS / DAY _____

FEMALES

REGULAR MENSTRUAL PERIODS ☐ YES ☐ NO

No. OF PREGNANCIES _____

No. OF LIVE BIRTHS _____

No. OF MISCARRIAGES _____

BIRTH CONTROL METHOD _____

B.C. PILL(BRAND) _____

MENOPAUSAL SYMPTOMS ☐ YES ☐ NO

SKIN PROBLEMS

- ☐ ECZEMA ☐ PSORIASIS ☐ RASH
- ☐ ABNORMAL MOLES ☐ HIVES
- ☐ FREQUENT SUN EXPOSURES
- ☐ EXCESSIVE SCARRING
- ☐ SKIN CANCER
- ☐ RECENT OR PROGRESSIVE HAIR LOSS

NOTICE TO THE VALUED PATIENTS OF CHILDS DERMATOLOGY

Childs Dermatology will charge a fee to patients who No-Show or fail to cancel appointments at least 24 hours prior to the scheduled appointment..

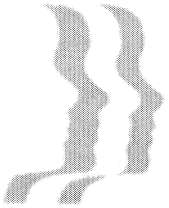
The fees are as follows:

* **$75.00** for scheduled surgical and cosmetic appointments
* **$35.00** for scheduled office visits and any other type of scheduled appointments

Childs Dermatology regrets this charge is necessary however; we are experiencing a huge demand for appointments. Our physician's time is very valuable to patients who must be seen.

Childs Dermatology looks forward to continuing to serve you!

Patient Name (Print): _____
Patient Signature: _____
Date:_____



Childs Dermatology Office
James N. Childs, M.D., P.A. | Maria V. Childs, M.D.
1605 Rock Prairie Road, Suite 312
College Station, Texas 77845
Office: (979) 696-4444 | **Fax:** (979) 764-9772

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/ FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Childs Dermatology to release my medical and/or billing information to the following individual(s):

1._____ Relation to Patient:_____

2._____ Relation to Patient:_____

3._____ Relation to Patient:_____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re disclosure by the above recipient.

You have the right to revoke this consent in writing.

Patient Name (Print) _____ Date of Birth: _____

Signature: _____ Date: _____

Childs Dermatology Office
James N. Childs, M.D., P.A. | Maria V. Childs, M.D.
1605 Rock Prairie Road, Suite 312
College Station, Texas 77845
Office: (979) 696-4444 | **Fax:** (979) 764-9772

CONSENT TO SEE A MINOR

Minor/Patient Name: _____ DOB: _____
I, _____, Mother, Father, Guardian (circle one) give my consent for the above minor to be seen and treated by the physicians and staff of Childs Dermatology Clinic and perform necessary services for my child which are deemed advisable by the physician, whether or not I am present at the actual appointment.

Anything I specifically do not give my consent for, without being in attendance, is listed below:

_____

_____

Below is a list of individuals who have my permission to bring my child in for treatment:

_____

_____

_____

_____

_____

_____

Select one of the options below:

___ Consent good for this appointment only.
___ Consent is good for all appointments.

_____
Printed Name of Mother, Father, or Guardian

_____ _____
Signature of Mother, Father, or Guardian Date

_____
Phone number (where you can be reached the day of the appointment)

CHILDS DERMATOLOGY CLINIC

Dermatology and Dermatologic Surgery
James N. Childs, M.D.
Maria V. Childs, M.D.

MUTUAL AGREEMENT

Dr. James N. Childs and/or Dr. Maria V. Childs of Childs Dermatology (collectively labeled "*Physician*") agree to provide treatment to: _____ ("*Patient*"). The Physician takes pride in being able to extend a greater degree of privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are almost always forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Even after recent Congressional attempts to tighten this restriction, however, there are still loopholes that some medical practices can use to profit from marketing activities. For example, there are exceptions for drugs currently prescribed to the patient and for recommending items or services covered by the patient's health plan. More importantly, there is no prohibition against a physician putting his patient on the spot and asking for permission to allow third parties access to information to market to patients, which could authorize essentially unlimited unwanted marketing information. Even to the extent still allowed, Physician agrees not allow others access to use Patient's medical information for the purpose of marketing directly to Patient. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient's permission for a third party to market directly to Patient.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Physician has invested significant financial and marketing resources in developing the practice. Nothing in this Agreement prevents a patient from posting commentary about the Physician - his practice, expertise, and/or treatment - on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if Patient prepares such commentary for publication on web pages, blogs, and/or mass correspondence about Physician, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Physician for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary. Importantly, Physician agrees to abide by a Code of Internet Ethics. What that means: Physician agrees to enforce no rights enabled by the assignment if Patient's commentary conforms to typical Internet Rating Sites' Terms of Use (such as Google Maps –see http://www.google.com/help/terms_maps_earth.html). Such terms include, as examples, no obscenity, no personal attacks, and the like. To be clear, constructive commentary, even if negative, helps us build a better practice. The Code of Internet Ethics encourages posting of all constructive commentary, good, neutral, and even, negative.

This Agreement shall be in force and enforceable for a period of five years from Physician's last date of service to Patient. As a matter of office policy, Physician is requiring all patients in its practice sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Physician's patients. Further, this Agreement will survive for a minimum of three years beyond any termination of the Physician-Patient relationship.

Patient and Physician acknowledge that breach of this Agreement may result in serious, irreparable harm. Patient and Physician agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

SO AGREED THIS _____ DAY OF _____, 20____. _____

(PATIENT SIGNATURE)

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.