BONNIE FURNER, MD

General, Cosmetic & Surgical Dermatology

Feel good about your skin again

PATIENT INFORMATION RECORD

(Please Print or Write Legibly)

Referred by:_____ **Family Physician:**_____

Patient's Name	Date of Birth	Age	Marital Status S M W D Sep	Sex M F

Mailing Address:	City and State	Zip Code

Preferred telephone number for confirming appointment:	Best Contact Number	Alternate Number
( )	( )	( )

Email Address:	Employer	Occupation	Work Number
			( )

Spouse/Parent Name:	Emergency Contact: Name	Phone	Relationship

Payment is requested at the time of service. I understand that I am financially responsible for all services provided. I authorize release of this information to my insurance company if necessary for reimbursement, and payment to Dr. Bonnie Furner if not already paid.

_____ **X**_____

Date **Signature of Patient/Responsible Party**

I authorize any physician, hospital, laboratory or x-ray facility to release to Bonnie Furner M.D., any and all medical information, hospital records, laboratory studies, pathology results, or x-rays that may be requested. A copy of this authorization is as binding as the original.

_____ **X**_____

Date **Signature of Patient/Responsible Party**

PATIENT RECORD OF DISCLOSURES

If it becomes necessary to contact you regarding appointments, biopsies, treatment, or general inquires please check any and all ways you authorize us to reach you.

Home telephone # (_____)_____

____ ok to leave message with detailed information on answering machine

____ ok to leave detailed message with whom ever may answer the phone at home

____ ok to leave message with call back number only

Work telephone # (_____)_____

____ ok to leave message with detailed information on voice mail

____ ok to leave message with call back number only

____ok to leave message with _____only

Cell phone # (_____)_____

____ok to leave detailed information on voice mail

____ ok to leave message with call back number only

Written Communication

____ ok to mail to home address

____ ok to mail to work/office address

____ ok to fax to #_____

____ E-Mail address_____

Confirmation of Appointment

We may communicate by one of the following:

____ text to cell

____ message to E-Mail

____ message on voicemail

_____ _____

Print name **Date**

_____ _____

Signature **Date of Birth**

NOTICE OF PRIVACY PRACTICES

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

Bonnie Furner, M.D. uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of **Bonnie Furner, M.D.**

How Bonnie Furner, M.D. May Use or Disclose Your Health Information

For Treatment. **Bonnie Furner, M.D.** may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions. **Bonnie Furner, M.D.** may use your health information when referring you to other health care professionals and facilities.

For Payment. **Bonnie Furner, M.D.** may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you, your insurance policy holder, or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. **Bonnie Furner, M.D.** may use your information to contact you about account balances.

For Health Care Operations. **Bonnie Furner, M.D.** may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

Evaluate the performance of our staff;
Assess the quality of care and outcomes in your case and similar cases;
Learn how to improve our facilities and services; and
Determine how to continually improve the quality and effectiveness of the health care we provide.

Required by Law. **Bonnie Furner, M.D.** may use and disclose information about you as required by law. For example, **Bonnie Furner, M.D.** may disclose information for the following purposes;

For judicial and administrative proceedings pursuant to legal authority;
To report information related to victims of abuse, neglect or domestic violence; and To assist law enforcement officials in their law enforcement duties.

Appointment Reminders and Treatment Calls. **Bonnie Furner, M.D.** may contact you to provide appointment reminders or information about treatment plans, medication or test results, other health-related benefits and services that may be of interest to you. When contacts are made via telephone, messages will be left on answering machines with limited information.

Notification. **Bonnie Furner, M.D.** may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Family. **Bonnie Furner, M.D.** health professionals and staff, exercising their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Miscellaneous Communications. **Bonnie Furner, M.D.** may occasionally use your information to send you greeting cards, notices or other written communications. We may also use your information to identify candidates for focus groups to improve the quality of service for our patients.

Business Associates. In some cases, **Bonnie Furner, M.D.** contracts with business associates to provide services on its behalf. An Example includes arrangements with business associates & **Bonnie Furner, M.D.** to provide Computer technician services. **Bonnie Furner, M.D.** may disclose your health information to such a business associate so that they can perform their respective job functions. To protect your health information, however, **Bonnie Furner, M.D.** requires the business associate to sign a Business Associates Contract to safeguard your information.

Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Decedants. Health Information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Food and Drug Administration (FDA) **Bonnie Furner, M.D.** may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Government Functions. Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

Workers Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.

Other Uses. Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent Bonnie Furner M.D. has taken action in reliance on such.

Your Health Information Rights

You have the right to:

- Request a restriction on certain uses and disclosures or your information; however, **Bonnie Furner, M.D** is not required to agree to a requested restriction;
- Obtain a paper copy of the notice of privacy practices upon request;
- Inspect and obtain a copy of your health record;
- Request that your health record be amended;
- Request communications of your health information by alternative means or at alternative locations; and Receive an accounting of disclosures made of your health information.

Complaints

You may complain to **Bonnie Furner, M.D.** and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Obligations of **Bonnie Furner, M.D.**

Bonnie Furner, M.D. is required to:

- Maintain the privacy of protected health information;
- Provide you with this notice of its legal duties and privacy practices with respect to your health information;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations.

Bonnie Furner, M.D. reserves the right to change its privacy practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you upon your request at your next visit to our practice.

Contact Information

If you have any questions or complaints, please contact:

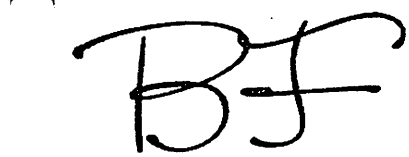
Bonnie Furner, M.D. Chief Privacy Officer 8122 Datapoint Drive, Suite 1110 San Antonio, TX 78229 Telephone (210) 616-0448

Effective: January 1, 2016

I acknowledge that I have received the Notice of Privacy Practices.

Signature of Patient or Legal Representative_____ Date_____

Printed Name of Patient or Legal Representative_____ RelationshiptoPatient_____



BONNIE FURNER, MD

General, Cosmetic & Surgical Dermatology

Feel good about your skin again

FACIAL SKIN CARE

Please describe your step-by-step skin care regimen including specific brand names.

Morning:

Cleanser/Soap: _____

Astringent/Toner: _____

Acne /Anti-aging Medicine: _____

Moisturizer/Sunscreen: _____

Makeup:

Foundation: _____

Powder: _____

Evening:

Cleanser/Soap: _____

Astringent/Toner: _____

Acne/Anti-aging/Treatment: _____

Moisturizer: _____

Do you have a Clarisonic brush?_____ If yes, how often do you use it? Please circle; **Daily, Weekly, Rarely, AM** or **PM.**

Please circle if you are interested in any of the following cosmetic procedures: **Botox, Juvederm, Medical Microdermabrasion, Intense Pulse Light PhotoRejuvenation, or Hair removal.** We will be happy to give you additional information for review.

NAME_____DATE_____

Ashford Oaks Building • 8122 Datapoint Dr., Suite 1110, San Antonio, Texas 78229 • (210) 616-0448 • Fax (210) 614-1241 • www.DrFurner.com

BF

Medical History

Patient: _____ Age: _____ Today's Date: _____

Reason for today's visit: _____

DRUG ALLERGIES
Are you allergic to any medications? ☐ No ☐ Yes Please list: _____

Circle any other **allergies**: local anesthetics, lidocaine (including dental anesthesia), rubber/latex, tape/bandages, topical antibiotics

PRESCRIPTION MEDICATIONS you are currently taking

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

GENERAL MEDICAL HISTORY
Do you have a past or present history of any of the following?

	NO	YES		NO	YES
Asthma	☐	☐	Fever Blisters/Cold Sores	☐	☐
Eczema	☐	☐	HIV	☐	☐
Seasonal Allergies	☐	☐	Hepatitis	☐	☐
Lung Disease (Emphysema/COPD)	☐	☐	Cancer-Type: _____	☐	☐
High Blood Pressure	☐	☐	Diabetes	☐	☐
High Cholesterol	☐	☐	Kidney Disease	☐	☐
Heart Attack	☐	☐	Gastrointestinal Disease	☐	☐
Irregular Heartbeat/Heart Murmur	☐	☐	Seizures	☐	☐
Pacemaker	☐	☐	Fainting	☐	☐
Artificial Joint	☐	☐	Arthritis	☐	☐
Lupus	☐	☐	Bruise or bleed easily	☐	☐

Other diseases/ conditions/ recent surgeries _____

SKIN HISTORY
When you are exposed to sun do you: ☐ Tan Only ☐ Tan and Burn ☐ Burn How many times? _____

Have you ever had skin cancer? ☐ NO ☐ YES Basal Cell, Squamous Cell or Melanoma _____

Has anyone in your family had skin cancer ☐ NO ☐ YES If yes, who & type? _____

Do you have any difficulty in wound healing or form unsightly or unusual scars? ☐ NO ☐ YES

SOCIAL HISTORY
Do you drink alcohol? _____drinks/day Do you smoke? _____packs/day for _____ yrs

Occupation: _____ Hobbies: _____

IS IT OK TO LEAVE VOICE MAIL FOR LAB RESULTS? ☐ NO ☐ YES PREFERRED MESSAGE PHONE # _____

Would you like more information on the cosmetic procedures we offer? Yes( ) No( )

( ) Fillers ( ) Microdermabrasion ( ) Intense Pulse Light Skin Rejuvenation ( ) Skin care products
( ) Botox ( ) Chemical peels ( ) Hair removal

_____ _____
Signed By Patient or Guardian Date Signed By Physician Date

AURORA DIAGNOSTICS

South Texas Dermatopathology

Aurora Diagnostics South Texas Dermatopathology
Diplomates of the American Boards of Dermatology and Pathology-Dermatology and Dermatopathology

CHARLES S. STEVENS, MD
THOMAS L. DAVIS, MD
LESTER F. LIBOW, MD
MAREN M. CHAN, MD

PLEASE PRINT CLEARLY

PLEASE PROVIDE FRONT & BACK COPIES OF PATIENT INSURANCE CARD

Patient's Name: _____

Patient's Date of Birth: _____

Patient's Social Security #: _____

Medicare #: _____

Medicaid #: _____

Primary Insurance: _____

Member ID / Group #: _____

Name of Insured: _____

Secondary Insurance: _____

Member ID / Group #: _____

Name of Insured: _____

Place of Employment: _____
(person insured)

Insurance Phone #: _____

Patient's Relationship to Insured: _____

Doctor Who Performed Biopsy: _____

Date of Biopsy: _____

☐ I authorize payment of medical benefits to Aurora Diagnostics South Texas Dermatopathology for services rendered, and I release to my insurance company any information necessary to process this claim.

Patient Signature: _____

PATIENT INFORMATION

Effective 4/1/98

You will receive a separate bill for the processing and diagnosis of your biopsy specimen. This statement will come from Aurora Diagnostics South Texas Dermatopathology. For information about our fees, please ask your physician or call our office at 210-342-6488.

INSURANCE INFORMATION

We file and accept assignment for all Medicare, Medicaid, and commercial insurances. If you have an HMO plan or require a referral for lab services, please contact your primary care physician. Please make sure that the necessary information is sent to us on our pathology request form with your specimen. Medicaid patients should provide the necessary information before the 90 day filing deadline; otherwise the patient will be responsible for this bill. For filing of private insurance, please fill out the back of this form and mail to: **Aurora Diagnostics South Texas Dermatopathology 1122 Austin Highway, San Antonio, TX 78209.** For any Assistance in filing claims, please call 210-342-6488.