

Ned Snyder IV, M.D. & Renee R. Snyder, M.D.
901 West 38th Street, Suite 410, Austin, Texas 78705
P: 512.533.9900 F: 512.533.9901

Patient's Last Name:		Patient's First Name & Middle Initial			Date:
Street Address and Apt #:		City & State:			Zip Code:
Patient's Home Phone #: ()		Patient's Work Phone & ext #: ()			Patient's Cell Phone #: ()
Patient's Sex: F () M ()	Patient's Date of Birth	Age:	Patient's Social Security Number:	Texas Drivers License #	
Parent's Name(s) If Patient is a minor child:			E-mail Address: May we email you if unable to contact by telephone? Y or N		
Briefly state reason for today's visit:			Would you like to receive our quarterly newsletter?		
Which Doctor Referred you to us?			Who to call in case of an Emergency? Name & Relationship: Phone: ()		
Primary Insurance:					
Name and Address of Primary Insured's Employer: (If student, name of College)				Primary Insured's Name:	
In the event that additional information is required to process your claim, may we have your authorization to verify that you are enrolled at this college?					
Member or ID #: (usually SS # of person insured)					
Primary Insured's relation to patient:		Primary Insured's DOB:		Primary Insured's Social Security #	
Primary Ins Co Name and full mailing address: (mail claims to)		Primary Ins Co Group #:		Primary Ins Co. Phone #: (claims or benefits)	
Secondary Insurance:					
Name and Address of Secondary Insured's Employer: (If student, name of College)				Secondary Insured's Name:	
Member or ID #: (usually SS # of person insured)					
Secondary Insured's relation to patient:		Secondary Insured's DOB:		Secondary Insured's Social Security #:	
Secondary Ins Co Name and full mailing address: (mail claims to)		Secondary Ins Co Group #:		Secondary Ins Co Phone #: (claims or benefits)	
<p>RELEASE & ASSIGNMENT OF BENEFITS: I hereby authorize the release of any and all medical information to my insurance carrier(s) or it's/their representative, for purposes necessary in the adjudication or processing of any and all insurance claim(s) filed on my behalf and for which I am financially responsible. I further authorize all insurance benefits be paid to the provider rendering services on behalf of Renee Snyder, M.D., P.A. or Ned Snyder IV, M.D., P.A.</p> <p>AIDS/HIV TESTING IN CASES OF ACCIDENTAL EXPOSURE: I understand that if a healthcare worker is accidentally exposed to my blood or bodily fluids in such a fashion that the worker may be at risk for contracting Hepatitis B, Hepatitis C or AIDS. I will be required to have my blood tested, pursuant to Texas law and office protocols, to determine the present of Hepatitis B or Hepatitis C surface antigens and/or Human Immunodeficiency Virus Antibodies. Test results will be kept confidential to the extent allowed by law and any information concerning my identity, in connection with such testing, will be destroyed after testing and notification of the healthcare worker who was exposed.</p> <p>CONSENT TO TREAT: I hereby consent to treatment by my dermatologist or plastic surgeon to include examination and treatment, prescribing medication and skin preparations.</p>					
Patient's Signature (Parent if Patient is a minor child)				Date	

MEDICAL HISTORY

[] **Ned Snyder, IV, MD**
[] **Renee R. Snyder, MD**

Patient:

Purpose of Visit:

Date of Visit:

Referring Physician: _____ Physician Address: _____

Telephone: _____

Primary Physician: _____ Physician Address: _____

(if different from above)

Telephone: _____

Do you have **DRUG** allergies: _____ If so, please list: _____

Have you ever had reactions to local anesthetics? [] Yes [] No

If yes, please explain:

Medications and non-prescription medications that you currently take, please list:

Do you have a **PERSONAL HISTORY** of, or are currently under treatment for, the following conditions? (if any are "yes", please explain the lines below):

- | | | |
|---------------------------------------|-----------------------------|---|
| [] yes [] no Heart Problems | [] yes [] no Hepatitis | [] yes [] no Organ Transplant |
| [] yes [] no High Blood Pressure | [] yes [] no Diabetes | [] yes [] no X-ray Therapy |
| [] yes [] no Pacemaker | [] yes [] no PUVA/UVB | [] yes [] no Kidney Problems |
| [] yes [] no Stroke | [] yes [] no Arthritis | [] yes [] no Mitral Valve Prolapse |
| [] yes [] no Blood Clots | [] yes [] no Epilepsy | [] yes [] no Accutane past 6 months? |
| [] yes [] no Bleeding Problems | [] yes [] no Glaucoma | [] yes [] no Currently Pregnant/Nursing |
| [] yes [] no Lung Problems | [] yes [] no Keloid scars | [] yes [] no Rheumatic Fever |
| [] yes [] no HIV | [] yes [] no Cancer | [] yes [] no Artificial Joint/Valve |
| [] yes [] no Psychiatric Conditions | [] yes [] no Skin Cancer | [] yes [] no Other |

[] yes [] no Previous Surgery? If yes, explain type of surgery and give dates (mo/yr) of each:

[] yes [] no Family History of Malignant Melanoma? If yes, who? _____

[] yes [] no Alcohol Use: _____ How much and how often? _____

[] yes [] no Tobacco Use: _____ Types and amounts used: _____

Signature of Patient (responsible party if patient is a minor)

Date

Signature of Physician

Date

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FINANCIAL POLICY

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. Please initial each of the following numbered items:

1. ____ If we participate with your managed care plan or you have a commercial insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans. You will be responsible at the time of service for the payment of:
- Annual Deductible
 - Co-payments
 - Charges for non-covered or cosmetic services

In the event that we are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.

Please be advised that anything you choose to have removed or biopsied may not be covered under your office co-pay and is subject to your deductible. We will make every effort to contact your insurance to verify your benefits, but in the event we are unable to reach them, you will be responsible for your co-payment as well as payment for any procedures performed. Such procedures include but are not limited to: biopsies, removal of warts, moles, pre-cancerous lesions, or other skin lesions. Methods of removal may include but are not limited to: cutting, freezing, burning, or application of a blistering agent.

2. ____ We are Medicare participating providers, therefore we will bill Medicare directly. You will be responsible at the time of service for payment of:
- The annual deductibles
 - Co-payments
 - Charges for non-covered or cosmetic services

You will be asked to sign a Waiver of Liability Form in the event that a service is provided, which we know is not covered by Medicare.

3. ____ If you have no health insurance, payment is expected in full at the time of service.
4. ____ In the event we receive a returned check due to insufficient funds, a fee of \$35.00 will be charged to your account and payment is due upon receipt of your statement.
5. ____ If you purchase skin-care products or supplies from our office, please understand that these products/supplies are a non-refundable item. In the event that the product is defective, we will gladly replace the item(s).
6. ____ We request that you give 48 hours notice if you are unable to keep your appointment. Failure to give 48 hours notice will result in a \$35.00 missed appointment fee. This fee is not covered by your insurance plan
7. ____ Cosmetic consultation fees are \$150 to reserve your appointment. This fee is taken at the time of booking and is non-refundable if the appointment is missed. This fee will be applied to any cosmetic procedure that is scheduled.

For your convenience we accept cash, check, MasterCard, Visa, American Express, Discover, and Care Credit.

If you have any questions, please do not hesitate to ask us. We are here to assist you any way possible.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

Patient/Guardian Signature

Date

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ACKNOWLEDGEMENT OF RECEIPTS OF NOTICE OF PRIVACY PRACTICES

****You have the right to refuse to sign this Acknowledgement****

I, _____, have been given the opportunity to read a copy of this office's
Notice of Privacy Practices. I also understand, that I have the right to request a copy of the Notice of Privacy
Practices for my records.

Patient or Guardian if minor

Date

Please print name

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
acknowledgement could not be obtained due to the following:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

Other: _____

Practice Representative

Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

**PLEASE REVIEW CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US**

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 2007, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by the applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we make the changes. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities reviewing the competence or qualifications of healthcare professionals, evaluating practitioner or provider performance, conducting training programs, accreditation, and certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure performed by your authorization while it was in effect. Unless you give us written authorization, we cannot use or discuss your health information for any reason except those described in this Notice.

To Your Family and Friends: With your authorization we can disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying and locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies or other similar forms of health information.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having custody of protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders such as voicemail messages, postcards, or letters.

Marketing: We may use your name and address in order to mail you a copy of our quarterly newsletter which contains information about upcoming seminars, new and improved treatment options, specials, as well as general medical and Cosmetic Dermatology & Plastic Surgery information for our patients.

Laboratory/Pathology/Culture Results: All patients are attempted to be notified of their results by telephone. It is your ultimate responsibility to call our office for your results if we are unable to reach you.

PATIENT RIGHTS

Access: You have the right to inspect and obtain a copy of your health information, with limited exceptions. You must make a request in writing to obtain access to your healthcare information. You may obtain a form to request access by using the contact information listed at the end of this Notice. There is a \$35 fee for medical records. If your records are transferred to another physician there is no fee.

Disclosure Accounting: You have the right to receive a list of instances in which our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before November 1, 2005. If you request this accounting no more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

Restriction: You have the right to request that we place additional restrictions on our use and disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in emergency situations. You may obtain a form to request restricted disclosure by using the contact information listed at the end of this Notice.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to an alternative location. You must make your request in writing. Your request must specify the alternative means or action and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendments: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written format.

Email: Email is to be used for initial contact, generalized information on procedures, or scheduling appointments. Email cannot substitute for a physical physician visit. Do not send urgent emails or requests for immediate medical attention. Please call our office if in need of immediate assistance (512-533-9900) or dial 911 in an emergency.

QUESTIONS OR COMPLAINTS

If you want more information about our privacy practices or have questions or concerns please contact us.

If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice please contact Ginna Quintanilla at (512) 533-9900. All complaints must be submitted in writing.