# MICHAEL A. SORACE, MD MOHS MICROGRAPHIC & SKIN SURGERY, PLLC

745 W San Antonio Ave
Suite 100
Boerne, TX 78006

14530 NW Military Hwy
Suite 100
San Antonio, TX 78231

457 Landa St
Suite E
New Braunfels, TX 78130

## REGISTRATION/CONSENT FORM

(Please Print)

Today's date: PCP:

### PATIENT INFORMATION

Patient's last name: First: Middle: ❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Language: ❑ Yes ❑ No Race: Email address: Birth date: / / Age: Sex: ❑ M ❑ F

Street address: Social Security no.: Home phone no.: ( ) Cell phone no.: ( )

P.O. Box: City: State: ZIP Code:

Occupation: Employer: Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

Primary Care Physician: Phone No. ( )

Referring Physician: Phone No. ( )

Pharmacy: Phone No. ( )

Spouse's last name: First: Birth date: / /

Social Security no: Phone No. ( )

Employer: Employer's Phone No. ( )

### INSURANCE INFORMATION

**Please give your insurance card and photo ID to the receptionist. You must notify us if this is an accident or work related visit.**

## IN CASE OF EMERGENCY

| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( ) |
|---|---|---|---|
| | | | |

**AUTHORIZATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION:**
ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT, NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. ALL SERVICES PROVIDED TO YOU AS A PATIENT OF MICHAEL A. SORACE, MD MOHS MICROGRAPHIC & SKIN SURGERY, PLLC ARE PAYABLE AT TIME OF SERVICE AND ARE THE SOLE RESPONSIBILITY OF YOU "THE PATIENT" AND/OR GUARANTOR OF "YOUR CHILDREN". I HERBY AUTHORIZE MICHAEL A. SORACE, MD MOHS MICROGRAPHIC & SKIN SURGERY, PLLC TO FURNISH INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONERNING MY (MY DEPENDENTS) ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO MICHAEL A. SORACE, MD MOHS MICROGRAPHIC & SKIN SURGERY, PLLC ALL PAYMENTS FOR MEDICAL SERVICES RENDERED BY MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I HEREBY AUTHORIZE AND RELEASE THE DOCTOR AND WHOMEVER HE/SHE MAY DESIGNATE AS HIS/HER ASSISTANT TO ADMINISTER TREATMENT, PHYSICAL EXAM, X-RAY STUDIOS, LABORATORY PROCEDURES, MEDICAL CARE OR ANY CLINICAL SERVICE THAT HE/SHE DEEMS NECESSARY IN MY CASE, AND I FURTHER AUTHORIZE HIM/HER TO DISCLOSE ALL OR PART OF MY (PATIENTS) RECORD TO ANY PERSON OR CORPORATION WHICH IS OR MAY BE LIABLE UNDER CONTRACT TO THE CLINIC OR TO THE PATIENT OR TO A FAMILY MEMBER OR EMPLOYER OF THE PATIENT FOR ALL OR PART OF THE CLINIC CHARGE, INCLUDING BUT NOT LIMITED TO HOSPITAL OR MEDICAL SERVICES COMPANY, INSURANCE COMPANY, WORKERS COMPENSATION CARRIERS, WELFARE FUNDS, OR THE PATIENTS EMPLOYER.

**PATIENT INFORMATION CONSENT:**

I UNDERSTAND THAT MICHAEL A. SORACE, MD MOHS MICROGRAPHIC & SKIN SURGERY, PLLC. MAY NEED TO USE AND DISCLOSE INFORMATION ABOUT MY HEALTH OR MEDICAL PROBLEMS FOR THE PURPOSE OF ARRANGING, CONDUCTING, OR REFERRING MY TREATMENT; FOR OBTAINING PAYMENT FOR SERVICES, AND FOR THE PURPOSE OF OPERATING THE PRACTICE. I CONSENT TO THE USE OF MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

I UNDERSTAND THAT MY CONSENT IS NOT NEEDED IF THE LAW REQUIRES LIVING MICHAEL A. SORACE, MD MOHS MICROGRAPHIC & SKIN SURGERY, PLLC TO REPORT SOME ASPECT OF MY PROTECTED HEALTH INFORMATION TO A GOVERNMENT AGENCY (FOR EXAMPLE, SUSPECTED ABUSE, COMMUNICABLE DISEASE AND POTENTIAL BODILY HARM TO MYSELF OR OTHERS).

I UNDERSTAND THAT I HAVE THE RIGHT TO REVIEW MICHAEL A. SORACE, MD MOHS MICROGRAPHIC & SKIN SURGERY, PLLC PRIVACY NOTICE, TO REQUEST RESTRICTIONS BE PUT ON THE USE OF MY INFORMATION, AND TO REVOKE MY CONSENT AT A LATER DATE.

I UNDERSTAND THAT IF I WITHHOLD CONSENT FOR THE USE OF MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT OR OPERATIONS, MICHAEL A. SORACE, MD MOHS MICROGRAPHIC & SKIN SURGERY, PLLC MAY REFUSE TO UNDERTAKE MY CARE.

I, THE UNDERSIGNED, HEREBY CONSENT TO THE FOLLOWING TREATMENT: ADMINISTRATION AND PERFORMANCE OF ALL TREATMENTS ADMINISTRATION OF ANY NEEDED ANESTHETICS, PERFORMANCE OF SUCH PROCEDURES AS MAY BE DEEMED NECESSARY OR ADVISABLE IN THE TREATMENT OF THIS PATIENT,USE OF PRESCRIBED MEDICATION,PERFORMANCE OF DIAGNOSTIC PROCEDURES/TESTS, CULTURES, BIOPSIES AND SURGERY,PERFORMANCE OF OTHER MEDICALLY ACCEPTED LABORATORY TESTS THAT MAY BE CONSIDERED MEDICALLY NECESSARY OR ADVISABLE BASED ON THE JUDGMENT OF THE ATTENDING PHYSICIAN OR THEIR ASSIGNED DESIGNEES. I FULLY UNDERSTAND THAT THIS IS GIVEN IN ADVANCE OF ANY SPECIFIC DIAGNOSIS OR TREATMENT. I INTEND THIS CONSENT TO BE CONTINUING IN NATURE EVEN AFTER A SPECIFIC DIAGNOSIS HAS BEEN MADE AND TREATMENT RECOMMENDED. THE CONSENT WILL REMAIN IN FULL FORCE UNTIL REVOKED IN WRITING. I UNDERSTAND THAT MICHAEL A. SORACE, MD MOHS MICROGRAPHIC & SKIN SURGERY, PLLC MAY INCLUDE CONSENT AT SATELLITE OFFICES UNDER COMMON OWNERSHIP.

**MEDICARE PATIENTS:** I AUTHORIZE TO RELEASE MEDICAL INFORMATION ABOUT ME TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES FOR MY MEDICARE CLAIMS. I ASSIGN THE BENEFITS PAYABLE FOR SERVICES TO MICHAEL A. SORACE, MD MOHS MICROGRAPHIC & SKIN SURGERY, PLLC.

**HIPPA ACKNOWLEDGEMENT:**

I HAVE RECEIVED AND HAVE READ MICHAEL A. SORACE, MD MOHS MICROGRAPHIC & SKIN SURGERY, PLLC NOTICE OF PRICACY PRACTICES.

IN MY ABSENCE OR FOR THE BENEFIT OF GAINING MEDICAL ADVICE ON MY BEHALF, I AUTHORIZE THE FOLLOWING PERSON TO GAIN PAITENT HEALTH INFORAMTION FOR OR WITH ME: _____

(Please list authorized Representative (s) or mark N/A)

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNTARILY TO ITS CONTENT. ALSO THAT ALL INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT TO MY KNOWLEDGE.

*Patient/Guardian signature* *Date*

## MICHAEL A. SORACE, MD MOHS MICROGRAPIC & SKIN SURGERY, PLLC

**745 W San Antonio Ave**
**Suite 100**
**Boerne, TX 78006**

**14530 NW Military Hwy**
**Suite 100**
**San Antonio, TX 78231**

**457 Landa St**
**Suite E**
**New Braunfels, TX 78130**

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE**
**AND CONSENT TO USE HEALTH INFORMATION**
**Read before signing the Acknowledgement and Consent**

This acknowledgement of notice and consent authorizes **MICHAEL A. SORACE, MD MOHS MICROGRAPHIC & SKIN SURGERY, PLLC** to use health information about you for treatment, payment, and health care operations purposes.

**NOTICE OF PRIVACY PRACTICES: MICHAEL A. SORACE, MD MOHS MICROGRAPHIC & SKIN SURGERY, PLLC** has a Notice of Privacy Practices which describes how we may use your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgment and consent.

**AMENDMENTS:** We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

**How to contact our Privacy Officer**

**Mail:** **MICHAEL A. SORACE, MD MOHS MICROGRAPHIC & SKIN SURGERY, PLLC** **PH: 830-331-9900**
745 W San Antonio Ave
Suite 100
BOERNE, TX 78006

**Acknowledgement and Consent**

I have received the Notice of Privacy Practices for **MICHAEL A. SORACE, MD MOHS MICROGRAPHIC & SKIN SURGERY, PLLC** is authorized to use health information about (please print patient's name) _____ for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____ _____
Signature of Patient Date Account #

Personal representative information (if applicable):

_____ _____
Name of Personal Representative Relationship to Patient

**IDENTITY OF RECIPENTS:** Provide the name or other specific identification of the person(s) or class of persons to whom the covered entity may disclose the covered information:

Permission to Leave Message: YES_____ NO_____

____Daytime Phone@#_____

____On My Home Answering Machine Phone@#_____

____On My Voicemail@#_____

____With My Designated and Authorized Person(s) Named Below:

_____

Michael A. Sorace, M.D.

MOHS MICROGRAPHIC & SKIN SURGERY, PLLC

# PATIENT HEALTH HISTORY INFORMATION

Please Print

NAME:( MR. MRS. MS. DR.) _____ DOB:_____

PHARMACY NAME/ LOCATION:_____ PHONE:_____

DO YOU HAVE ALLERGIC REATION TO ANY MEDICATIONS?

MEDICATION: TYPE OF REACTION:

_____ _____

_____ _____

CHECK EITHER THE YES BOX OR NO BOX TO ALL APPLICABLE PRESENT OR PAST CONDITIONS:

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| O | O | AIDS virus infection/ HIV | O | O | Heart Attack |
| O | O | Aneurysm | O | O | Heart Murmur |
| O | O | Asthma | O | O | High Blood Pressure |
| O | O | Prolonged Bleeding | O | O | Irregular Heart Beats |
| O | O | Chest Pains | O | O | Lupus/ Autoimmune Disease |
| O | O | Other Skin Cancers | O | O | Rheumatic Fever |
| O | O | Other Cancers (non- skin) | O | O | Diabetes |
| O | O | Seizures | O | O | Hepatitis |
| O | O | Emphysema | O | O | MRSA |
| O | O | Fever Blister/ Herpes | O | O | Other Conditions:_____ |
| O | O | Are you currently pregnant? If yes, how many wks _____ | | | |
| O | O | Have you experienced chest pain in the last month? | | | |
| O | O | Do you smoke, If yes for how long and how many packs per day _____ | | | |

PAST SURGERIES:

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| O | O | ARTIFICIAL HEART VALVES | O | O | PROSTHESIS |
| O | O | Artificial Joints | O | O | Tranplant |
| O | O | Bypass | O | O | Vascular |
| O | O | Pacemaker | | | |

LIST ANY PREVIOUS SURGERIES BELOW: DATE:

_____ _____

_____ _____

PLEASE LIST ALL MEDICATIONS, DRUGS AND VITAMINS YOU ARE TAKING AT THE PRESENT

TIME:MEDICATION & DOSAGE: ( attach list if needed) HOW OFTEN:

_____ _____

_____ _____

## Michael A. Sorace, MD Mohs Micrographic & Skin Surgery, PLLC

### Patient Consent for Medical Photography

Patient Name: _____ Date: _____

☐ Check here if minor or unable to provide consent.

I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals as I have designated below. By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact: _____

By signing this form below I confirm that this consent form has been explained to me in terms which I understand. **(please choose one)**

1) I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

_____ _____
SIGNATURE WITNESS

2) I agree for my image to be shown for teaching purposes **AND** to be used for my medical record but **NOT FOR** medical publication:

_____ _____
SIGNATURE WITNESS

3) I agree to use of my image for medical records **ONLY**:

_____ _____
SIGNATURE WITNESS

For patients between ages 7 and 18 years, a signature below indicates that the information in this consent form has been explained to me, and I assent to use of my images as outlines above:

_____ _____
SIGNATURE WITNESS

*Michael A. Sorace, MD Mohs Micrographic & Skin Surgery, PLLC*


*745 W San Antonio Ave #100*
*Ph: 830-331-9900*
*Fax: 830-331-9908*

*14530 NW Military Hwy #100*
*Ph: 210-236-9372*
*Fax: 210-251-3237*

*457 Landa Street Ste E*
*Ph: 830-331-9900*
*Fax: 830-331-9908*


**Patient Agreement**

Patient's Name _____ Account #_____

_____ I understand that I owe 100% of my bill and that I am responsible. I agree to pay balance in full.

_____ I understand that this is a biological procedure and by law cannot be guaranteed.

_____ I have been advised that if my insurance coverage should terminate during care, I will be financially responsible for services rendered to me after that date.

_____ I agree that I will bring in any payment received from the insurance company for services received at **Michael A. Sorace, MD Mohs Micrographic & Skin Surgery, PLLC**

Patient's Signature _____

Date _____

Witness's Signature _____

Date _____

# Michael A. Sorace, M.D.

MOHS MICROGRAPHIC & SKIN SURGERY PLLC

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they required if for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about e to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

---------- ----------

**Signature as it appears on Medicare Card** **Date**

If you have a supplemental policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized supplemental benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above supplemental carrier any information needed to determine these benefits or the benefits payable for related services.

---------- ----------

**Signature as it appears on Supplemental Card** **Date**

Please present your insurance cards and your photo identification to the receptionist.

The receptionist will make a copy and return them to you promptly.

14530 NW Military Hwy
Suite 100
San Antonio, Tx 78231
Phone: (210)236-9372
Fax: (210)251-3237

457 Landa Street
Suite E
New Braunfels, Tx 78130

745 W San Antonio Ave
Suite 100
Boerne, Tx 78006
Phone: (830)331-9900
Fax: (830)331-9908

WWW.MOHSSKINSURGERY.COM

# Michael A. Sorace, M.D.

MOHS MICROGRAPHIC & SKIN SURGERY, PLLC

Do you suffer from any of the following?

□ Leg pain or throbbing

□ Leg tiredness or fatigue

□ Leg swelling

□ Leg cramping

□ Itchy lower legs

□ Skin rash on your legs

□ Dark areas on your legs

□ Spider veins or varicose veins

14530 NW Military Hwy
Suite 100
San Antonio, Tx 78231
Phone: (210)236-9372
Fax: (210)251-3237

457 Landa Street
Suite E
New Braunfels, Tx 78130

745 W San Antonio Ave
Suite 100
Boerne, Tx 78006
Phone: (830)331-9900
Fax: (830)331-9908

WWW.MOHSSKINSURGERY.COM