South Texas Skin Cancer Center

Ryan P. O'Quinn, MD

Courtney S. Aldridge, PA-C

9238 Floyd Curl, Suite 101
San Antonio, TX 78240
(210) 558-6234 - Phone
(210) 615-1840 - Fax

Medical Records Release Form

Name of Patient _____ Date of Birth _____

Street Address _____ City, State, Zip _____

I authorize:

South Texas Skin Cancer Center
Ryan P. O'Quinn, MD
Courtney S. Aldridge, PA-C
9238 Floyd Curl, Suite 101
San Antonio, TX 78240

To disclose my protected health information, as described below, to:

_____

_____

_____phone_____fax

I hereby authorize and request that you send copies of my complete medical records, including but not limited to office visits, labs/pathology, and diagnostic testing, to South Texas Skin Cancer Center.

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be redisclosed without obtaining my authorization.

I understand that I have the right to:
- **Receive a Copy of this Authorization**
- **Refuse to Sign the Authorization**, and that treatment may not be contingent on my signing this authorization.
- **Revoke this Authorization**, except to the extent that the person(s) and or organization(s) listed above have already made in reference to this authorization.

This authorization will remain in effect until the following date(s) or one year: _____

_____ _____
Signature of Patient (or Legal Representative) Date

If signed by Legal Representative:

_____
(Relationship of Patient (authority to act on patient's behalf)

SOUTH TEXAS SKIN CANCER CENTER
HOME MEDICATION LIST

☐ **See Attached Patient List**

(INCLUDES HERBALS, OVER THE COUNTER MEDS AND HOME REMEDIES)

Name of Medication	Dose	Route	Frequency	Reason/Dx Indication	Last Taken

Allergies/Reactions *(to include food)*:_____

Patient/guardian Signature:_____ Date: _____

FOR OFFICE USE ONLY – Please do not write below this line

Date Reviewed: _____ by: _____ Date Reviewed:_____by:_____

Reviewed with: ☐ patient ☐ care person Reviewed with: ☐ patient ☐ care person

SOUTH TEXAS SKIN CANCER CENTER

RYAN P. O'QUINN, M.D. / COURTNEY S. ALDRIDGE, P.A.
9238 FLOYD CURL DRIVE, SUITE 101
SAN ANTONIO, TX 78240

Attn: Elizabeth Sánchez, Administrator, HIPAA Officer
PHONE (210) 558-6234 / FAX (210) 446-5039

HIPAA NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received and read the *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

_____

_____

Patient Name: _____ DOB: _____
(Please Print Name)

Patient Signature: _____ Date: _____

Patient/Legal Representative: _____ Date: _____

If Legal Representative, relationship to Patient: _____

Name of any person, besides yourself, that we may release any information to:

_____

_____

MEDICAL INSURANCE

All **HMO** plans require a current Referral/Authorization on file.

Please present your insurance card(s) and picture I.D. to the Receptionist at every visit.

Name of Primary Insurance:	Name of Secondary Insurance:
Member ID / Policy #:	Member ID / Policy #:
Group #:	Group #:
Co-Pay: Deductible:	Co-Pay: Deductible:
Is this a Medicare Replacement Plan or HMO Plan? (please circle one): YES NO If yes, your plan may require a referral/authorization. Please discuss with the front desk staff. Failure to comply may result in the patient becoming responsible for the entire cost of the visit and/or treatment.	Is this a Medicare Replacement or HMO Plan? (please circle one): YES NO If yes, your plan may require a referral/authorization. Please discuss with the front desk staff. Failure to comply may result in the patient becoming responsible for the entire cost of the visit and/or treatment.
Primary Policy Holder: Self Spouse Parent Guardian	Primary Policy Holder: Self Spouse Parent Guardian
Name of Primary Policy Holder:	Name of Primary Policy Holder
Primary Policy Holder DOB	Primary Policy Holder DOB
Primary Policy Holder ID #	Primary Policy Holder ID #
Group #	Group #
Employer's Name	Employer's Name
Relationship of patient to Insured	Relationship of patient to Insured

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name _____ Date of birth ____/____/____

Mailing Address _____

Home Phone (____)_____ Work Phone (____)_____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients applicable co-payments and deductibles will be collected. Please be advised HMO plans are out-of-network, therefore "out-of-network deductibles" will apply. We accept payment in the form of cash, check or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you may be asked to pay any unmet deductible, non-covered services and co-payments. In the event that your account must be turned over to collections, a $25.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature _____Date ___/____/___

PATIENT INFORMATION (Please Print)

Office Use
MR# _____
Portal UN: _____
Portal PW: _____

Today's Date ____/____/____

Name _____ Sex: Male Female
Last First Middle

Mailing Address _____
Address City State/Country Zip Code

E-Mail: _____ Home Phone (____) _____

Cell Phone (____) _____ Work Phone (____) _____

***Which is the best number to reach you at?** _____ **May we leave a detailed message:** ☐ no ☐ yes

Date of birth ____/____/____ Age _____ SS# _____

Occupation: _____ Occupation Industry: _____

Emergency Contact: _____ Relationship _____ Phone (____) _____

Marital Status: S M W D Spouse Name: _____ Phone (____) _____

Referring Physician _____ Phone (____) _____

Address _____ FAX (____) _____

Primary Care Physician _____ Phone (____) _____

Address _____ FAX (____) _____

Pharmacy of choice: _____ Phone (____) _____

LANGUAGE PREFERENCE: _____

STATE REQUIREMENTS:
Against the wishes of the South Texas Skin Cancer Center, we are required by law to request this information.

Ethnicity (Please check one of the following):

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (Please check one of the following):

- ☐ American Indian/Eskimo/Aleut
- ☐ Asian or Pacific Islander
- ☐ Black
- ☐ White
- ☐ Other

Important Notice: Any person who knowingly presents false or fraudulent insurance information may be subject to fines and pay balance acquired in-full. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature _____ Date ____/____/____