SHERRIE G. WILLIAMSON DO, PLLC

DERMATOLOGY

Save Form

Today's Date: _____

Clear Form

Please fill out this registration completely. Also, please provide your Insurance ID cards and Drivers License to the receptionist.

First Name _____ Middle Initial _____ Last Name _____

Date of Birth _____ Gender _____ Social Security # _____ Marital Status _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Work/Day Phone _____

Whom May We Thank For Referring You? _____ Patient Physician _____

Patient Employer _____ Occupation_____

Spouse First Name _____ Spouse Last Name _____

Spouse Employer _____

Person Responsible for Bill (If other than above)

First Name _____ Last Name _____

Relation to Patient _____ Date of Birth _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Work/Day Phone _____

Employer _____ Payment Method ☐Cash ☐Check ☐Visa/MC ☐Insurance

Nearest relative to Notify in an emergency

First Name _____ Last Name _____

Relation to Patient _____ Cell Phone _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Insurance Information

Name of Primary Insurance Company _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Insured's First Name _____ Last Name _____ Date of Birth _____

Relation to Patient _____ Social Security # _____ Group # _____ Policy # _____

Co-Payment $_____ Deductible $_____ Effective Date: _____ Exp Date: _____

Second Insurance (if applicable)

Name of Secondary Insurance Company _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Insured's First Name _____ Last Name _____ Date of Birth _____

Relation to Patient _____ Social Security # _____ Group # _____ Policy # _____

Co-Payment $_____ Deductible $_____ Effective Date: _____ Exp Date: _____

Your Preferred Pharmacy

Pharmacy Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

☐ Check to Acknowledge

Signature on File: I authorize use of this form on all my insurance submissions. I authorize release of information to all my insurance companies & emergency contact. I understand I am ultimately responsible for my bill. I authorize payment direct to my doctor and I permit a copy of this authorization to be used in place of the original. I hereby acknowledge I have read the Notice of Privacy Practices provided by Dr. Williamson's Office.

Signature _____

Print name _____

Print Form

DERMATOLOGY MEDICAL HISTORY FORM

Name_____ Age_____ Prefer to be called_____

Height_____ Weight_____ **Did a doctor recommend that you see a dermatologist?** No Yes, Dr._____

General Medical History: Do you have or have you ever had any of the following?

Y N Pacemaker or defibrillator*
Y N Asthma
Y N Hayfever, seasonal allergies
Y N Eczema
Y N Psoriasis
Y N Diabetes, controlled with (circle): diet, medication, insulin
Y N High cholesterol
Y N High blood pressure
Y N Stroke
Y N Heart attack
Y N Angina/Coronary artery disease
Y N Congestive heart failure
Y N Heart murmur or heart valve problem
Y N Have you been told to take antibiotics before dental procedures due to a heart murmur, heart valve, or artificial joint?

Y N Acne &/or Rosacea (circle)
Y N Scleroderma
Y N Overgrown scars or keloids
Y N Kidney problems (what type?)
Y N Epilepsy or seizures
Y N Crohn's disease or ulcerative colitis
Y N Arthritis (if yes, osteoarthritis, rheumatoid, or psoriatic?)
Y N Thyroid problem (what type?)
Y N Osteoporosis
Y N Organ transplant (what type?)
Y N Fibromyalgia
Y N Reflux/GERD/Heartburn or peptic ulcers
Y N Emphysema or COPD
Y N Melanoma year_____ location_____
Y N Basal cell or squamous cell skin cancer year_____ location_____

Y N Sarcoid
Y N HIV or AIDS
Y N Hepatitis (what type?) A B C
Y N Multiple sclerosis
Y N Lupus-(circle) Systemic or Discoid
Y N Liver cirrhosis or other liver problems
Y N Herpes-(circle) genital or mouth
Y N Genital warts
Y N Blistering sunburns
Y N Tuberculosis
Y N Blood clots in legs (DVT)
Y N Anemia-(circle) Iron or Folate
Y N Blood transfusion (when) _____
Y N Bleeding disorder, type _____
Y N Anxiety
Y N Depression or other psychological condition, type_____
Y N Cancer (what type, how treated, and when?)

Surgeries:

Y N Abnormal moles proven on biopsy
Y N Heart valve replacement

Y N Artificial joint *
(If yes, which one & when?)

Y N Gallbladder removed
Y N Heart bypass surgery

Female Patients:

Y N Are you pregnant or breastfeeding?
If not, method of birth control _____

Y N Are you planning to get pregnant?
If yes, when:_____
Y N Hysterectomy (if yes, uterus only or uterus and ovaries?)

Y N Prone to yeast infections with antibiotics
Y N Tubal ligation (tubes tied)

Other Medical Problems or Surgeries:_____

_____

_____

***Allergies to medications** and type of allergic reaction (example: hives, difficulty breathing, swelling) _____

_____

_____

Medications (Prescription, Non-Prescription, Vitamins, Herbs):_____

_____

_____

Skin Type: If 1st exposed to the sun in the summer without sunscreen, would you: 1. always burn, never tan 2. always burn, sometimes tan 3. sometimes burn, always tan gradually 4. burn minimally, always tan well 5. rarely burn, tan profusely 6. Never burn, deeply pigmented

Social History: Do you smoke or use tobacco Y N Do you drink alcohol? Y N Number per day_____ per week_____ per year_____
Marital status:_____ # of Children:_____ Hobbies:_____ Occupation/School:_____

Family History: Circle any conditions affecting a blood relative. Specify who is affected below the circle.

Melanoma Basal cell or squamous cell skin cancer Breast Cancer Psoriasis Eczema

Hayfever or allergies Asthma Acne Lupus Sarcoid

Signature of person filling out this form_____ **Today's date**_____
Updated_____

Sherrie G. Williamson DO, PLLC

General Dermatology and Dermatologic Surgery

Cancellation and No Show Policy

Dear Patient:

We strive to render excellent medical care to you and the rest of our patients. In order to do so we have had to implement an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

Schedule Appointments
For a scheduled appointment, please call our office at 405-701-1010 and our staff will try their best to schedule your appointment at the most convenient time possible. As a courtesy, we contact you two (2) business days prior to your appointment to remind you. If we leave you a message, please confirm your appointment by calling our office.

Cancellation/Rescheduling of an Appointment
In order to be respectful of the medical needs of the community, please be courteous and call our office promptly if you are unable to attend an appointment. We require at least 24 hours' notice, so that your appointment time can be reallocated to someone else.
Late cancellations will be considered as a "no show."

No Show Policy
A "no show" is someone who misses an appointment without canceling it at least 24 hours in advance or who fails to keep a scheduled appointment. In the event a 24 hour notice is not given, a fee of $35.00 will be charged for missed office visits and $75.00 for any missed procedures.

NOTE: THESE FEES ARE NOT COVERED BY YOUR INSURANCE COMPANY!

Patients who fail to pay the above fee will not be allowed to schedule future appointments until the fee is paid. Multiple Cancellations or No Shows may result in dismissal from our practice.

I have read and understand the Cancellation and No Show Policies of the practice and I agree to the terms.

_____	_____
Name of Patient	**Relationship to Patient (if minor)**
_____	_____
Signature of Patient or Responsible Party	**Date**

3301 W. Rock Creek Road, Norman, OK 73072 Phone: (405)701-1010 Fax: (405)701-1011

SHERRIE G. WILLIAMSON DO, PLLC

DERMATOLOGY

NOTICE OF PRIVACY PRACTICES EFFECTIVE: 4/14/2003

3301 W. Rock Creek Road, Norman, OK 73072 Phone: (405)701-1010 Fax: (405)701-1011

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.

Sherrie G. Williamson DO, PLLC, hereinafter referred to as "The Clinic" are required by law to maintain the privacy of your health information, to follow the terms of this Notice, and to provide you this notice of it's legal duties and privacy practices with respect to your health information. We will not use or disclose medical information about you without your written authorization, except as described in this notice.

How "The Clinic" May Use or Disclose Your Health Information

"The Clinic" and its staff protect the privacy of your health information. The law permits "The Clinic" to use or disclose your health information for the following purposes:

- **Treatment, Payment, and Regular Health Care Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of "The Clinic". Information obtained by this clinic will be used to provide prescriptions, provide medical care, dermatological goods and services to you, bill your insurance carrier if you have third party coverage, and to record and monitor medical care provided to you. Information will also be provided to you upon your written request. Other activities may include, but are not limited to, quality assessment activities, employee review activities, training medical students, licensing, and conducting or arranging for other medical business activities.
- **As and When Required by law:** Without your authorization we may use and disclose your health information to Public Health Officials, Law Enforcement, Health Oversight Activities (for audits, investigation, etc.), Judicial and Administrative, Deceased Person Information, Food & Drug Administration (FDA for reporting adverse drug events and quality issues), should there be a serious threat to your health or safety, in times of National Security, if you are in the Military or a Veteran of the armed force when requested, or if you become an inmate in a correctional facility.
- **Personal Communications:** We may contact you to provide appointment reminders, correspond by phone, mail, fax, and other information about treatment alternatives or other health-related benefits and services that may be of interest to you as well as communicate with individuals involved in your care or payment for your care.
- **Lab Disclosure:** All lesions removed, surgical procedures, biopsies, scrapings, etc… from a patient must be sent off to a laboratory by law, to determine a medical diagnoses. When these procedures are performed, we may disclose health information about you to the laboratories so that they can perform their responsibilities and bill you or your third party payer for services rendered. To protect your health information both the lab and "The Clinic" and its staff agree to appropriately safeguard the health information.

- **Victims of Abuse, Neglect, or Domestic Violence:** We may disclose your health information to a government authority, such as a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

"The Clinic" May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, "The Clinic" and its staff will not use or disclose your health information without your **written authorization**. If you do authorize "The Clinic" to use or disclose your health information for another purpose, you may revoke your authorization **in writing at any time**. If your state law provides additional restrictions upon any of the foregoing uses and disclosures, we must follow your state law.

You have the following rights with respect to your health information (Requests must be in writing)

- You have the right to request restrictions on certain uses and disclosures of your health information. You must submit this request in writing. **"The Clinic" is not required to agree to the restriction that you requested**. If "The Clinic" believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will be restricted. You then have the right to use another Healthcare Professional.
- You have a right to receive an accounting of disclosures we have made, if any, of your protected health information.
- You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
- You have the right to request that our clinic communicate with you at a certain location, as in contact you at home rather than at work. **This request must be in writing.**
- You have the right to ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by our clinic. **This request must be in writing.**

Changes to this Notice of Privacy Practices

"The Clinic" reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice effective for all medical information we maintain. Until such amendment is made "The Clinic" is required by law to comply with this Notice. The revised notice will be posted in the lobby of the clinic and a paper copy will be available upon request.

Complaints

If you believe your privacy rights have been violated, you may file a **written complaint** and submit it to our office or to the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint.

Should you have any questions or concerns you are to put them in **writing** and we will respond within thirty (30) days.

Upon entering the clinic you assume the responsibility of not sharing confidential information you may hear or view pertaining to someone other than yourself. It is the responsibility of the clinic and each individual entering the clinic that all clinic information remains confidential.

Signature:_____ Date:_____

Sherrie G. Williamson DO, PLLC

General Dermatology and Dermatologic Surgery

Financial Policy

In addition to accepting traditional insurance plans and Medicare we are contracted with numerous Preferred Provider Organizations (PPO) and Health Maintenance Organizations (HMO). Because each plan is different, and constantly updating providers' participation status, please check with your particular plan to make sure we are currently participating in your network. We ask that you assist us in maximizing your insurance coverage by cooperating fully in all referral, prior authorizations and pre-certification processes. **Please be aware that all insurance carriers do not consider some services rendered a covered benefit. It is important that you are aware of your insurance policy provisions of coverage.**

Accurate, up-to-date information is the patient's responsibility; please notify our office of any changes in your insurance or personal billing information. Please bring your current insurance card, or any other information that is required by your insurance company to each appointment. By maintaining updated information this ensures that your medical claims are filed correctly and prevents any unnecessary delays in processing your claim.

Payment for all co-insurance, deductibles and non-covered services are due at the time of service unless special arrangements have been made. Payments can be made by cash, check, money order, MasterCard, Visa, Discover, or American Express.

There is a $35 charge for any FMLA or disability forms completed. This charge is applicable per form and is payable prior to completion.

My signature below acknowledges receipt of this Financial Policy

Signed_____ Date_____

(Signature of person financially responsible for payment)

3301 W Rock Creek Road, Norman, OK 73072 Phone 405-701-1010 Fax 405-701-1011

DISCLOSURE AND CONSENT
OF MEDICAL AND SURGICAL PROCEDURES

PATIENT NAME: _____

PHYSICIAN: Sherrie G. Williamson D.O.

TO THE PATIENT: You have the right as a patient to be informed about your condition and the diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. The disclosure is not meant to scare or alarm you. It is simply an effort to make you better informed so you may give or withhold your consent to the procedure. **NO PROCEDURE WILL BE PERFORMED WITHOUT WRITTEN CONSENT.**

I (We) authorize the performance of the following described medical/surgical procedures upon **myself/my child/my dependent**.

I (We) voluntarily request Dr. Sherrie G. Williamson as my physician, and such associates, technical assistants, and other health care providers as they may deem necessary, to treat my condition which has been explained to me as : **Possible skin cancer/Mole/Cyst/SK/AK/Skin tags/Wart/Other**:_____.

I (We) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (We) voluntarily consent and authorize these procedures: **Skin biopsy/excision, electro destruction, curettage, removal, other: _____.**

I (We) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I (We) authorize my physician, and such associates, technical assistant, and other health care providers to perform such other procedures which are advisable in their professional judgment.

I (We) understand all tissue removed is sent to a pathology lab for analysis unless deemed unnecessary by the physician. **PROCEDURES WILL NOT BE PERFORMED WITHOUT TISSUE ANALYSIS**. The pathology lab will charge a fee for tissue analysis separate and independent of procedure charge. If your insurance company does not cover this separate charge, it is the responsibility of the patient, parent, or guardian to cover this expense.

I (We) consent to be photographed for medical purposes if my physician deems it necessary.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (We) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, bleeding, blood clots, scarring, ulceration, wound dehiscence (wound coming apart), recurrence, allergic reactions, and pigment (skin color) variation. Sometimes, additional procedures may be required.

I (We) have been given an opportunity to ask questions about my condition, risks of non-treatment, the procedure to be used, and the risks and hazards involved, and I (We) have sufficient information to give this informed consent.
I (We) certify that we have read this consent form or have had it read to me (Us), that the blank spaces have been filled in, and that I (We) understand its contents.

IF YOUR INSURANCE COMPANY DOES NOT COVER ANY PROCEDURES PERFORMED BY DR. WILLIAMSON, IT IS THE RESPONSIBILITY OF THE PATIENT, PARENT OR GUARDIAN TO COVER THIS EXPENSE._____(Initial Here)

SIGNED: _____
Patients Signature
SIGNED: _____ RELATION: _____
Signature of person legally responsible for patient
WITNESS SIGNATURE**:** _____ DATE**:** _____
WITNESS SIGNATURE**:** _____ WITNESS: _____

Patient Authorization for General Disclosure and/or

Request for Confidential Communications

Patient Name	Date of Birth
Address (Street, City, State, Zip Code)	
Cell Phone Number	Home Phone Number

I request that my health information or medical billing record be disclosed as follows:

I Authorize the names listed below to have access to my medical information. These people may call and speak with the nurse/ doctor about my case. I have the right to terminate this agreement at any time by informing the physician's office in writing.

Authorized Name, Address, and Phone Number **Relationship to Patient**

_____

_____

_____

_____

Details of Health Information Being Disclosed:

____Complete Health Records ____Lab/ Path Results

____Office Visit Notes/Encounter Notes ____Other (please specify):_____

Patient Rights: Patients may request disclosures of protected health information to carry out treatment, payment, and healthcare operations; disclosures to a family member, other relative, close friend, or any other person identified by the patient of protected health information directly relevant to such person's involvement with the patient's care; disclosures of protected health information to notify or assist in the notification of a family member, a personal representative, or another person responsible for the care or the patient.

Signature of Patient or Legal Representative	**Date**

If Signed by a Legal Representative, Relationship to Patient