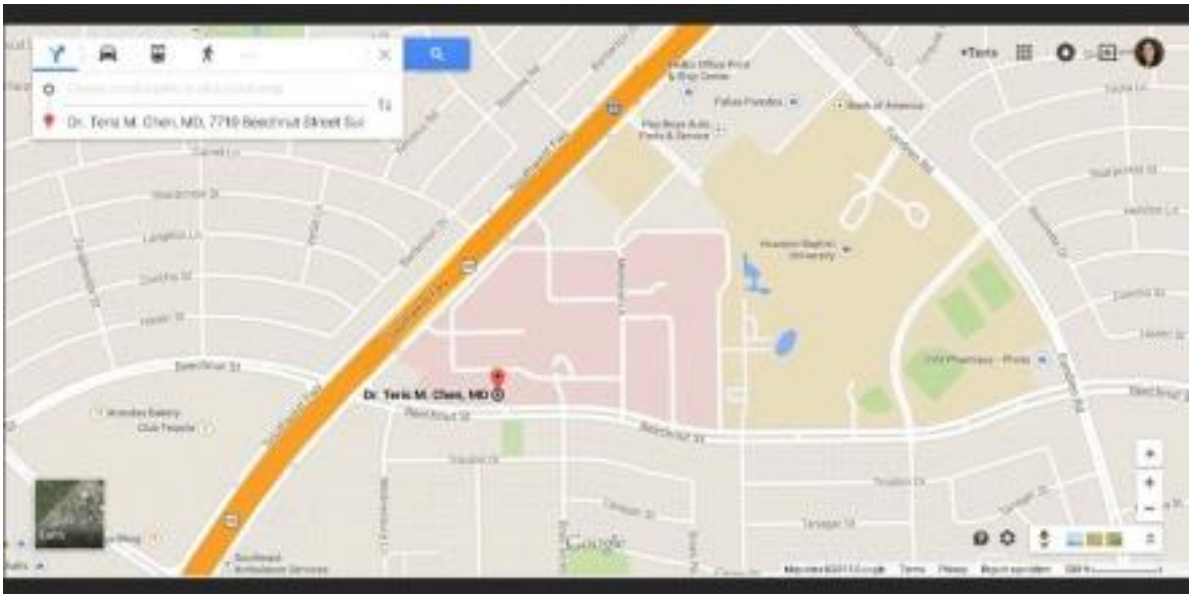
NEW PATIENT WELCOME LETTER

We respect your time: In order for you (and the other patients on the schedule) to be seen with minimal wait, patient registration and paperwork must be completed BEFORE your appointment time. Therefore, **plan to arrive at least 15 minutes before your scheduled appointment time**. To expedite the process, **NEW PATIENT forms** can be printed and completed before your office visit. To prevent other delays, have your driver's license, insurance card, and payment ready when you check in.

Tips on finding our office: Our address is: **7710 Beechnut St, Suite 230, Houston, TX 77074.** We are located on Beechnut Street inside the **Texas Eye Institute Building** (a light gray colored 2 story building). The main entrance is under the covered awning. The doors to the building unlock automatically at 7 am. We are on the second floor across from the elevator. Parking is free. **We are NOT located in the Memorial Herman Southwest Hospital.** (See attached photos.)



Bring the following to your appointment:

1) Your driver's license, insurance card, and credit card or debit card. The payment card will be put on file for "no show" and cancellation fee and any other charges assigned to your account, such as the balance determined by your insurer as your share of the expenses. You will always be notified before any charges are necessary for

your account. You can pay either with a check or the payment card we have on file for you. Our office accepts Visa, MasterCard, and Discover (no American Express).

2) After printing the **NEW PATIENT forms**, please complete and bring the forms with you to your appointment. Before you arrive for your appointment, we can review our Notice of Privacy Practices and Notice of Services Agreement on our website (www.drminsuechen.com).

3) If you have a summary of your Health History, please bring it along. Specifically, Dr. Chen needs a list of your allergies, current medications, medical problems, and prior procedures. Additionally, if you have seen a doctor for your skin problem, it can sometimes be helpful to bring a copy of your medical records for Dr. Chen to review.

What to expect from your appointment with us: Dr. Chen and her staff will review your Health History. This will be followed by examination of your skin concerns and discussion of treatment options, which may or may not include a procedure. Please remember that if you have medical insurance, you are responsible for your co-payment/co-insurance/deductible at the time of service. Additionally, office procedures may be performed on the same day only if the procedure has been pre-approved/pre-certified by your insurance company. Kindly contact your insurance company to see if pre-authorization is necessary.

Contacting our office: Please do not hesitate to let us know if you have any questions. We are a small practice; therefore, if we do not answer the phone, it is because we are either caring for a patient who is in the office or on the phone with another patient. **We have found that the fastest and most patient preferred method of communication is via TEXT messaging. Therefore, kindly send us a TEXT message to our office number (832)356-3872, and we will reply as soon as possible.** Other methods to contact us include: 1) Send a "HELLO" from our website. 2) Email (info@drminsuechen.com). 3) Leave a detailed message on our voicemail (832)356-3872. 4) Send a Fax (888)381-4541. All messages should be responded to by the end of the next business day. Please contact us again if you do not hear from us by the end of the next business day.

Payment and collections policy: In order to keep this office open and staff paid, we need our patients to take financial responsibility for their accounts and pay their bills in a timely manner. Payment is due at the time of service, and any outstanding balance is to be paid in full before any additional services and/or items are provided by Chen Skin and Cancer Surgery, P.A. The cost of any date of service is not complete until the finished documentation of that visit is reviewed for accuracy and completion and you may be sent an additional statement. Some treatments require several visits to treat and each is billed separately. Cosmetic procedures are to be paid in full at the time of service and will not be billed to your insurance carrier. Chen Skin and Cancer Surgery, P.A. reserves the right to assign additional fees to your account in the following instances: compensation for extra administrative expenses incurred, any check returned for nonpayment, form completion fee, declined charge on credit card, and medical records fee.

Our promise to you: Please review "**OUR PROMISE TO YOU**" webpage (SEE http://www.drminsuechen.com/our-promise-to-you.html) regarding office policies and fee structure regarding: Timeliness; Payment Policies ($20 late fees; $50 returned check fee); Cancellation Policy ($75-$250 fee depending on your reserved appointment type); Grounds for Termination of Patient-Physician Relationship; and availability and fee schedule for Virtual Visits and Appointments outside of regular hours.

We look forward to caring for your skin health needs!
Have a blessed day!
Dr. Chen and staff

Chen SKIN & CANCER SURGERY

Date:_____ THANK YOU FOR COMPLETING THESE IMPORTANT FORMS ☺

1) Whom can we thank for referring you to our medical practice? _____

2) PATIENT DEMOGRAPHICS

Patient Name (LEGAL): Last_____First_____Middle_____

Nick Name:_____ Age:_____ Date of Birth:_____ Gender (circle): M F

Cell:_____ Email:_____

Work Phone:_____ Home Phone:_____

Preferred Language (circle): English Spanish Other

Status (circle): Minor Single Married Divorced Widowed Separated Domestic Partner

Mailing Address:_____ City:_____ State:_____ Zip:_____

Social Security Number (required for some insurance):_____--_____--_____

Employer Name:_____ Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Federal agencies require us to collect his following information regarding race and ethnic group:

Race (circle): White Black American Indian Native Hawaiian/Pacific Islander Other PATIENT REFUSED

Ethnic Group (circle): Not Hispanic or Latino Hispanic or Latino Other PATIENT REFUSED

Advanced Directives: I, the patient, have an Advance Directive: YES NO If yes, please provide us with a copy.

3) WHO IS THE RESPONSIBLE PARTY OR GUARDIAN (if different from the patient)?

Name:_____ Date of Birth:_____

Relationship to Patient: _____ Cell:_____ Home:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Name of Employer:_____ Work Phone:_____

4) WHICH IS YOUR PREFERRED PHARMACY?

Preferred Pharmacy Name:_____ Phone #:_____

Nearest Major Intersection:_____ City:_____ Zip Code:_____

5) IN CASE OF EMERGENCY, PLEASE CONTACT:

Emergency Contact:_____Phone:_____

Mailing Address:_____City:_____State:_____Zip:_____

Relationship to Patient:_____ Mother's maiden name _____ (*for security use only*)

6) Authorization for Treatment: I authorize the health care providers at Chen Skin and Cancer Surgery to perform medical and/or surgical procedures on me or the minor I am responsible for as she deems necessary for the treatment of skin conditions.

X *Signature of Patient / Responsible party / Guardian:*_____*Date:*_____

Chen SKIN & CANCER SURGERY

Date: _____ Name: _____ Date of Birth: _____

*HEIGHT: _____ WEIGHT: _____ Thank you for ☺☺ completing this form!

*INTAKE

Have you recently been exposed to any infectious diseases (eg. measles, chicken pox, ebola)? NO YES

*SOCIAL HISTORY

How much do you Smoke every day? _____

How much Alcohol do you drink every week? _____

Occupation: _____

What Pets do you have? _____

What are your Hobbies? _____

*ALLERGIES

What are you allergic to? _____

*PRESCRIBED MEDS, OVER THE COUNTER VITAMINS & SUPPLEMENTS:

List all Current: _____

_____

*PAST HOSPITALIZATION, MEDICAL ILLNESSES, PROCEDURES, CAR ACCIDENTS:

List: _____

_____

*FAMILY HISTORY OF MEDICAL ILLNESSES and SKIN CONDITIONS?

List: _____

_____

*YOUR SKIN HISTORY

List the Skin Conditions you have been diagnosed with: _____

List the number and location of skin lesions Removed your body: _____

When was your last skin screening? _____ How often do you wear sunscreen? _____ What SPF? _____

*YOUR HEALTH CARE TEAM / DOCTORS

List who else helps take care of your health: _____

_____

*YOUR VISIT WITH US

What is the reason for visit? _____

Where is the problem located? _____

How long has it been a problem? _____

List the treatments: _____

List the lab studies so far: _____

List who else you know that has something like this same skin problem: _____

What do you think is going on? _____

List additional information that the doctor should know about to diagnose and/or treat this skin issue? _____

_____

Chen SKIN & CANCER SURGERY

Date:_____ Name:_____ Date of Birth:_____

This often does not have anything to do with why you are here, but insurance requires that this paperwork be in your chart. Please circle those symptoms that apply to you at this time. If none of the symptoms apply to you, please check the area that says "I have none of the above".

REVIEW OF SYSTEMS (circle what you have now)

Constitutional: Fever Weight loss Night sweats Fatigue
Skin: Rashes Itching Hair change Nail change
Eyes: Loss of vision Distorted vision Eye pain
ENT: Loss of hearing Ringing Dizziness Nosebleeds Hoarseness
Cardiovascular: Chest Pain Palpitations Swelling of legs
Pulmonary: Cough Shortness of breath Wheezing
Endocrine: Heat or cold intolerance Excessive thirst or hunger
Gastrointestinal: Swallowing difficulty Heartburn Diarrhea Vomiting
Genitourinary: Urinary frequency Blood in urine Urinary pain
Musculoskeletal: Joint pain Muscle pain/ cramps
Neurological: Headaches Numbness/tingling Weakness Blackouts Slurred speech
Psychiatric: Anxiety Depression Mania
Hematological: Easy bruising/ bleeding Anemia
Immunological: Frequent infections Swollen lymph glands

( ) I have none of the above.

******* ALERTS: For your safety, we review these alerts at EVERY visit. (CIRCLE all that apply) *******

- Active infection (ie. currently being treated)
- Allergy to Adhesive
- Allergy to LATEX
- Allergy to LIDOCAINE

- Allergy to topical antibiotic ointments
- ARTIFICIAL Heart Valve
- ARTIFICIAL joints new within past 2 years
- Bleeding problems

- BLOOD THINNERS
- Breastfeeding or PREGNANT or planning pregnancy (last menses date _____)
- CANCER history
- DEFIBRILLATOR

- DIABETES
- Frequent infections
- HISTORY OF FAINTING OR PASSING OUT
- HEPATITIS B
- HEPATITIS C
- HIV/AIDS
- KIDNEY problems
- MRSA or STAPH infection
- Need to take PRE-PROCEDURE ANTIBIOTICS as recommended by your doctor

- Problems with HEALING, such as slow healing, or scarring (thick scars, keloid scars)
- Problems with LOCAL anesthesia
- Problems with GENERAL anesthesia
- RADIATION treatment exposure for acne, cancer, work-related, other_____

- Previous COSMETIC / PLASTIC surgery
- Rapid heartbeat with epinephrine
- Organ transplant
- Other notable issues that the medical staff need to be aware of_____

- *NONE OF THE ABOVE*

Name: _____ Date of Birth: _____

HOW AND WHO CAN WE CONTACT ABOUT YOUR CARE AND RESULTS?

1. I PREFER TO BE CONTACTED IN THIS ORDER:

1st (first) preferred method to be contacted is by (CIRCLE one):	***Cell phone***	*Email*	*Home phone*	*Work phone*	*Another person*	*Not applicable*
2nd (second) preferred method to be contacted is by (CIRCLE one):	*Cell phone*	*Email*	*Home phone*	*Work phone*	*Another person*	*Not applicable*
3rd (third) preferred method to be contacted is by (CIRCLE one):	*Cell phone*	*Email*	*Home phone*	*Work phone*	*Another person*	*Not applicable*
4th (fourth) preferred method to be contacted is by (CIRCLE one):	*Cell phone*	*Email*	*Home phone*	*Work phone*	*Another person*	*Not applicable*
5th (fifth) preferred method to be contacted is by (CIRCLE one):	*Cell phone*	*Email*	*Home phone*	*Work phone*	*Another person*	*Not applicable*

2. IF WE ARE UNABLE TO SPEAK WITH YOU, I WOULD LIKE THE OFFICE TO DO THE FOLLOWING:

a) When calling my **CELL PHONE** (circle one):	***Okay to leave full details***	*Only leave call back number*	*Not applicable*
b) When sending a **TEXT MESSAGE** (circle one):	***Okay to leave full details***	*Only leave call back number*	*Not applicable*
c) When sending an **EMAIL message** (circle one):	***Okay to leave full details***	*Only leave call back number*	*Not applicable*
d) When calling my **HOME PHONE** (circle one):	***Okay to leave full details***	*Only leave call back number*	*Not applicable*
e) When calling my **WORK PHONE** (circle one):	***Okay to leave full details***	*Only leave call back number*	*Not applicable*
f) I hereby give my consent that **ANOTHER PERSON** may be contacted about my health information in non-emergency situations. I understand that I MUST provide their names, relationship, & contact information below (circle one): ***	*Okay to leave full details with my* ***Emergency Contact*** *(if other, list below)*	*Only leave call back number*	*Not applicable*

****Name:* _____*Relationship:*_____

*Phone:*_____ *Email:*_____

X *Signature of Patient / Responsible party / Guardian:*_____*Date:*_____