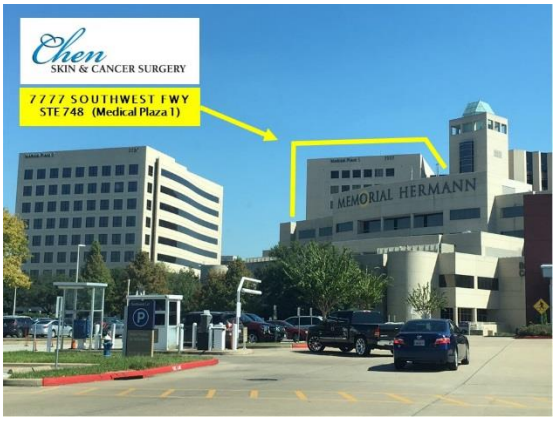
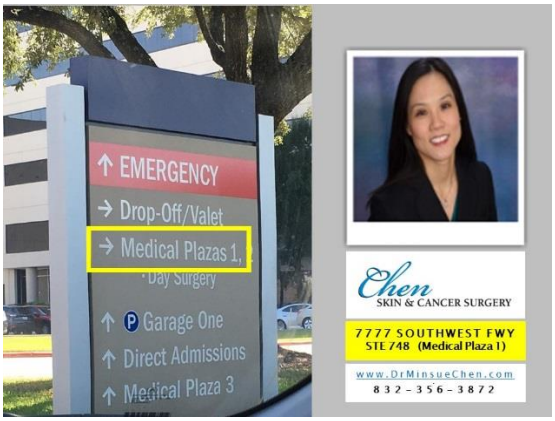
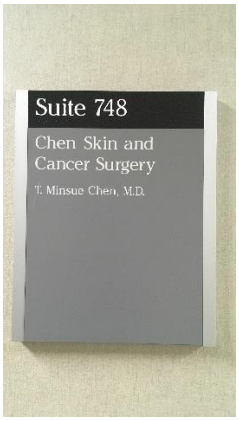
NEW PATIENT WELCOME LETTER

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.

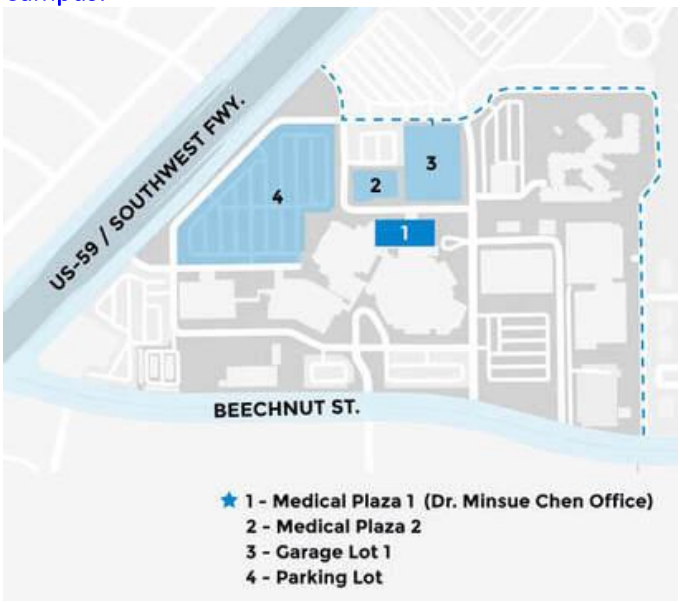
FREE Parking & Our Office: Our address is: **7777 SW FWY, STE 748 – MED PLAZA ONE, HOUSTON, TX 77074.** For easy access and your first visit to your office, we suggest you park in **GARAGE ONE**. **MED PLAZA ONE** is directly across the street from **GARAGE ONE**. Take the elevator to the seventh floor of **MED PLAZA ONE** for **SUITE 748**. Our office is located just down the hall from the Ladies Restroom. Upon your arrival, sign-in and inquire about Parking Validation.







Located On Memorial Hermann Southwest Hospital Campus:



- **FROM US-59 N (SOUTHWEST FWY)** | Travel South. Exit Gessner/ Beechnut and go left under US-59 N and another left on to US-59 N feeder road (or make a U-turn). Turn right at the 2nd driveway to the right onto the Southwest Hospital Campus.
- **FROM BELTWAY 8** | Exit US-59 N. Exit Gessner/ Beechnut. Continue on US-59 N feeder road, past Beechnut. Turn right at the 2nd driveway to the right onto the Southwest Hospital Campus.
- **FROM IH 10 W** | Travel east to US-59, then South on US-59. Exit Gessner/ Beechnut and go left on to US-59 N feeder road (or make a U-turn). Turn right at the 2nd driveway to the right onto the Southwest Hospital Campus.
- **FROM IH 10 E** | Travel west to US-59, then South on US-59. Exit Gessner/ Beechnut and go left on to US-59 N feeder road (or make a U-turn). Turn right at the 2nd driveway to the right onto the Southwest Hospital Campus.

Bring The Following To Your Appointment:

- After printing the **NEW PATIENT FORMS**, please complete and bring the forms with you to your appointment. 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, please bring a copy of your medical records for Dr. Chen to review.

- Your **DRIVER'S LICENSE, INSURANCE CARDS, METHOD OF PAYMENT AND CREDIT/ DEBIT CARD**. Our office accepts Visa, MasterCard, and Discover (no AMEX). 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.

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.

Payment & Collections Policy: Dr Chen is not a concierge practice, and therefore does not charge an upfront fee to be a member of her patient panel. 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 & Cancer Surgery. Cosmetic procedures will not be billed to your insurance carrier. 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. Results vary and not guaranteed.

We use time-based billing, just like most other professional services. If we spend time with you and/or on your behalf to handle your issue, Chen Skin & Cancer Surgery reserves the right to assign additional fees to your account. Your account will be billed at the usual rates to compensate for our time and expertise. This may include: appointments, surgeries; lengthy phone, email, text correspondence; insurance eligibility and benefits verification; coordinating care on the patient's behalf; form completion; letters to insurance companies; prior authorization; medical record copying; medical record review; materials and services beyond typical evaluations; additional services not covered by insurance; etc. Usual standard rate is billed $50 for each 5 minute increment. Surgery and procedure add-on fee determined at time of new or established patient appointment.

Contacting Our Office: We are always happy to answer questions! There are several convenient ways to reach Dr Chen and her staff. All messages should be responded to by the end of the next business day. Please reach out to us again if you do not hear from us by the end of the next business day.

- **TEXT** | most patient preferred at **(832) 356-3872**
- **ONLINE** | submit the **"SAY HELLO/ CONTACT US"** form
- **EMAIL** | the office at **info@drminsuechen.com**
- **VOICEMAIL** | message at **(832) 356-3872**

Why don't we answer the phone? Because we are a small practice and either caring for a patient in the office or on the phone with another patient, we do not answer the phone. We look forward to connecting with each & every one of you!

Our Promise To You: Together, Dr Chen and her staff have developed office policies to allow our office to focus on you and your concerns. Before you arrive for your appointment, please review our website, including Notice of Privacy Practices; Notice of Services Agreement; Services & Surgeries; About Dr Chen; Photo Examples; Find Our Office; Forms, Fees, FAQs; Contact Us. Kindly review your promise to our office, including the "No Jerks Rule"; "Grounds For Termination"; Returned Checks Fee $75; Late Payment Fee $75; Records Copying Fee; Missed Appt Fee $150 office, $500 surgery, $2500 complex surgery; Form & Letters Fee; External Services Fee; Physician Availability Outside-of-Regular Office Hours Fee; Etc.

We look forward to caring for your skin health needs! 
Have a blessed day!

Dr Chen & 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: _____

SKIN HISTORY

- When was your last SKIN SCREENING? _____
- What sunscreen do you use? _____ What SPF? _____
- When is your PROCEDURE with Dr. Chen SCHEDULED? _____
- In your lifetime, how many SKIN CANCERS have you had? _____ None
- In your lifetime, how many skin lesions have you had CUT OFF? _____ None
- In your lifetime, how many times have you had MOHS SURGERY? _____ None

GENERAL HISTORY

- Occupation: _____
- Exercise / Activity: _____/ week
- Pets: _____
- Smoking / Tobacco: _____ packs/ day
- Hobbies: _____
- Alcohol: _____ drinks/ day
- Upcoming activities (ie. social, travel, athletic, etc): _____

MEDICAL / SURGICAL HISTORY

Height: _____ Weight:_____

- Allergies to medications: _____
- Medications: _____
- Vitamins / Supplements: _____
- Medical problems: _____
- Surgeries in the past: _____
- Family history of medical problems, cancer, etc: _____
- Your Health Care Team / Doctors: _____

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 so far: _____
- List the lab studies so far: _____
- Do you know anyone with a similar skin problem? _____
- What do you think is going on? _____
- What else do we need to know? _____

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. **********

CHECK ALL THAT APPLY ☐ **None of the issues below**

☐ Problems with healing (ie. slow heal, thick scars, keloid scars)
☐ Cosmetic / Plastic surgery

☐ Pregnancy / Planning pregnancy
☐ Breast feeding

☐ Active Infection
☐ Frequent infection
☐ MRSA/ Staph infection

☐ Pacemaker / Defibrillator
☐ Blood thinners
☐ Bleeding problems

☐ Hepatitis B / Hepatitis C
☐ HIV / AIDS

☐ PRE-procedure antibiotics recommended by your doctor
☐ Artificial heart valve
☐ VP shunt
☐ Artificial joint in past 2 years

☐ White coat syndrome
☐ Seizures
☐ Fainting / Passing out

☐ Allergy to Latex
☐ Allergy to Lidocaine
☐ Allergy to Adhesive
☐ Allergy to Topical Antibiotic

☐ Rapid heart with local numbing
☐ Problems with anesthesia

☐ Cancer in the past
☐ Radiation exposure (ie. acne, cancer, work-related)
☐ Organ transplant

☐ Diabetes (last HgbA1c ___)
☐ Kidney problems (Cr ____)

☐ Other NOTABLE ISSUES that the surgical team needs to be aware of?
_____

_____

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:*_____