

James R. Bond, Jr., M.D., P.A.
1615 Lancaster Drive
suite 107
Grapevine, TX 76051
(817) 488-5555
Metro: (817) 329-2222
Fax: (817) 421-0400

Office Policies

Office Hours: 8:00 AM - 12:00 Noon
1:00 PM - 5:00 PM
Closed for lunch from 12:00 - 1:00 PM

Appointments are scheduled: 8:20 AM - 11:40 AM
1:20 PM - 4:30 PM

Prescription Refills:

- *Refills will be called in to pharmacies between 12:00 - 1:15 PM and 5:00 - 6:00 PM.
- *Patient must provide pharmacy number when calling for refills.
- *Please do not go to pharmacy and request refills while you wait. We have set aside special hours (listed above) for calling in refills.
- *Please do not ask us to fax prescriptions to your mail order pharmacy.
- *Refills called to our office after 3:00 PM will be called in on the next business day.

Minor Emergencies During Office Hours:

- *Call the office to speak with the nurse for assessment of problem.
- *An appointment may be scheduled as an emergency work-in or at a later date.
- *Major emergencies, please to the Emergency Room.

After Hours Emergencies:

- *Go to the nearest Emergency Room.

Rescheduling Appointments:

- *Please reschedule your appointment if you are more than 30 minutes late.
- *Please call 24 hours in advance if you know you will be unable to keep your scheduled appointment.

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PATIENT REGISTRATION

Please fill in all blanks. If not applicable, please write N/A in that space. Thank you!

Name: _____

Address: _____

City, State, Zip: _____

Date of Birth: _____ Age: _____ Sex: Male/Female

Social Security #: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Employer: _____

Referring Physician: Name/Address/Phone #:

Race (select one): White
 Black or African American
 Asian
 Native Hawaiian or Other Pacific Islander
 American Indian or Alaska Native
 Other Race

Ethnicity (select one): Hispanic or Latino
 Not Hispanic or Latino

Guarantor Information: (Responsible Party and/or insurance subscriber)

Name: _____

Address: _____

City, State, Zip: _____

Social Security #: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____ Cell
Phone: _____ Sex: Male/Female

Relationship to Patient: _____

Employer: _____

JAMES BOND JR., M.D., P.A.

DERMATOLOGY

1615 LANCASTER

SUITE 107

GRAPEVINE, TEXAS 76051

817/488-5555

METRO: 817/329-2222

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Disclosure of Medical/Financial information to Friends or Family

Name of Patient: _____

Date of Birth: _____

Address of Patient: _____

I, the undersigned, hereby authorize Dr. James Bond to disclose information from my medical or financial record to the following people:

Name: _____ Relationship: _____

Contact Information: _____

Type of Information (circle): Medical Financial Both

Name: _____ Relationship: _____

Contact Information: _____

Type of Information (circle): Medical Financial Both

ADDITIONAL PERSONS MAY BE LISTED ON THE OTHER SIDE, IF NECESSARY

This authorization is given freely with the understanding that:

1. I may revoke this authorization, in writing, at any time, but not retroactively.
2. The facility, its employees, officers, and physician are hereby released from any legal responsibility of liability for disclosure of the information I authorized previously.

Patient's Name Printed

Date

Patient's (or personal representative's) signature

Social security # (ID purposes only)

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**Patient Consent for Use and Disclosure
Of Protected Health Information**

With my consent, James R. Bond, Jr., M.D., P.A. may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to James R. Bond, Jr., M.D., P.A.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. James R. Bond, Jr., M.D., P.A. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Tammy Mathis, Privacy Officer at 1615 Lancaster Drive, Suite 107, Grapevine, TX 76051.

With my consent, the office of James R. Bond, Jr., M.D., P.A. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, the office of James R. Bond, Jr., M.D., P.A. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, the office of James R. Bond, Jr., M.D., P.A. may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the office of James R. Bond, Jr., M.D., P.A. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to give the office of James R. Bond, Jr., M.D., P.A. use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the office of James R. Bond, Jr., M.D., P.A. may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Account Number

Patient's Name

Date

Print Name of Patient or Legal Guardian

NAME _____

DATE _____

Are you allergic to, or have you had a reaction to any drugs? If so, please list: _____

Does your **personal** medical history include any of the following?

YES	NO	
		History of skin cancer? If yes, list location, year, and type (basal cell, squamous cell, melanoma).
		History of other cancers, other than skin cancer?
		History of keloids?
		History of eczema?
		History of acne?
		History of psoriasis?
		History of hair disorders? Please specify.
		History of nail disorders?
		Lung problems; emphysema, tuberculosis, asthma, or other? Please specify.
		Endocrine problems; diabetes, thyroid disorders, or other? Please specify.
		Heart, blood pressure, or circulation problem? List type.
		Do you have a pacemaker?
		Stomach or intestinal problem? Please specify.
		Arthritis, bone, or muscle problem? Please specify.
		Psychiatric: depression, bipolar disorder, schizophrenia, or other? Please specify.
		Neurologic: seizures, stroke, MS, or other? Please specify.
		Autoimmune diseases: lupus, rheumatoid arthritis, scleroderma, or other? Please specify.
		Eye, ear, nose, or throat problem; include vision and/or hearing difficulties.
		Kidney, bladder, prostate, or female organ disorders? Please specify.
		Anemia, leukemia, or other blood diseases? Please specify.
		Are you pregnant?
		Are you planning a pregnancy?
		Do you smoke? How much?
		Do you drink alcohol? How often? How much?

Is there a **family** history of any of the above conditions? (List immediate family **only**: mother, father, brothers, and/or sisters.)

Please list any medications you are currently taking/using: _____

Please list any surgeries you have had: _____

Review of medical history: _____ (nurse's initials) _____ (doctor's initials)