FLORIDA DERMATOLOGY SPECIALISTS

New Patient Information

Last Name _____ First Name _____ MI _____

DOB _____ Sex M / F SSN _____ Date _____

Marital Status: Married __ Single __ Widowed __ Divorced __

Local Address _____ City _____ State _____ ZIP _____

Alternate Address _____ City _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____

Emergency Contact Information:

Name_____ Relationship:_____ Phone:_____

Employer _____ Employer Phone: _____

Primary Care Physician _____ Phone:_____

Referred by Physician _____ Insurance ___ Internet ___ Friend ___

Insurance Information:

Insurance _____ Policy Number _____ Group Number _____

Guarantor/Subscriber _____ Address _____

DOB_____ SSN _____

Preferred Pharmacy _____ City _____ Phone _____

Intersection _____

Preferred Language: English____ Spanish ____ Other _____

Florida Dermatology Specialists HIPAA Consent Form

Patient: _____ DOB: _____

In connection with the medical services that I am receiving from Florida Dermatology Specialists, PLLC and its medical staff, I hereby authorize Florida Dermatology Specialists, PLLC and their respective agents to disclose any and all information concerning my medical condition and treatment (including, but not limited to, super-confidential information concerning sexually transmitted diseases, mental health, chemical dependence, DNA samples (including blood or tissue specimens that may contain DNA) or analyses, or other such information), including copies of applicable hospital and medical records to:

A. any third-party payor covering the medical services of the patient;

B. other health care professionals and institutions involved in the delivery of health care to the patient;

C. The proponent of any legally sufficient subpoena, or in response to a court order;

D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care operations, services and payment for such services;

E. Pharmacies; and

F. As otherwise required by law.

I further consent that photographs may be taken of me or parts of my body, under the following conditions:

1. The photographs may be taken only with the consent of my practitioner and under such conditions and at such times as may be approved by my provider.
2. The photographs shall be taken by my practitioner or by a photographer approved by my physician.
3. The photographs shall be used for medical records and, if, in the opinion of my practitioner, medical research, education or science will benefit from their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any purpose which he may deem proper in the interest of medical education, knowledge, or research. In such instances, however, it is specifically understood that in any such publication or use I shall not be identified by name and reasonable steps shall be taken to preserve my identity.
4. The aforementioned photographs may be modified or retouched in any way that my physician, at his discretion, may consider desirable.

I understand and agree with Florida Dermatology Specialists' representatives providing detailed information to me, through voicemail/telephone messages on answering machines, text messages, and email. I reserve the right at any given moment to opt out of any of these communication methods.

I also consent to the release of Protected Health Information to the following individual(s):

Name_____ Relationship_____ Phone Number_____

Circle Type of Information Authorized to discuss: BILLING MEDICAL APPT DETAILS ALL INFORMATION

Name_____ Relationship_____ Phone Number_____

Circle Type of Information Authorized to discuss: BILLING MEDICAL APPT DETAILS ALL INFORMATION

Florida Dermatology Specialists HIPAA Consent Form Page 2

Patient: _____ DOB: _____

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to the physician's privacy notice and that I have had the opportunity to place special restrictions upon the consent hereby given.

This consent is valid from the date executed until revoked in writing by the patient.

Signed: _____ Date: _____
Witness: _____ Date: _____

Privacy Notice
In accordance with the Health Insurance Portability and Accountability Act, patients of Florida Dermatology Specialists, PLLC are entitled to and afforded the rights to privacy regarding their health-related information as set forth under applicable law. The Practice will strive to ensure that patient information is used
only for purposes authorized by the patient and as otherwise required by law. Upon request we can provide you with a complete copy of our Privacy Policies. Additionally, Patients have a right to review their medical records and furnish comments to their records during normal business hours, upon providing reasonable advance notice.
Moreover, patients have the right:
*to be informed of any breach of their unprotected PHI;
*to have marketing communications made to them only if authorized by the
patient;
*to decline to have PHI delivered to health insurers if the patient pays for
services in full without submitting a claim.
*to contact the Practice HIPAA Compliance Officer, Richard A. Krathen, MD at (772) 403-2227.

Patient Signature:_____ Date:_____

Florida Dermatology Specialists Financial and Office Policies

The practice policies below outline our expectations and options for payment.

I assign all medical and/or surgery benefits, to include "major medical" benefits, which I am entitled inclusive of Medicare and all other health payments this associated is entitled. Payment is due at the time services are provided unless other arrangements have been made. I understand you do not accept assignment in the case of liability actions.

Florida Dermatology Specialists accepts many insurance plans. However, I understand that it is my responsibility to confirm with my insurance company that the physician is currently under contract. I agree to be responsible for all copayments, deductibles, and non-covered services as determined by my insurance plan.

If my insurance plan requires a referral to a specialist, I understand that I must obtain that referral prior to my scheduled visit. If the referral is not obtained, I understand that I have the option of rescheduling my appointment or paying for the visit out of pocket.

If I am uninsured or do not have proof of insurance, I understand that full payment is expected at the time of service unless prior arrangements have been made.

I understand that I will be sent a single monthly statement followed by a reminder letter for services received. I will promptly pay all amounts determined to be my responsibility by my insurance carrier upon receipt of my statement. If my account is not paid within 90 days of the date of service, the practice may ask for the assistance of an outside collection agency. I will be responsible for any reasonable cost of collection, including credit checks, court costs, and attorney's fees. If I have any questions regarding my bill or have a financial hardship, I will call the office to make other arrangements.

I understand that if my check is returned, I will be charged a fee of $35.00. Special services, such as surgical procedures and cosmetic appointments, are subject to a $100.00 cancellation fee if not cancelled with 24 hour or greater notice.

I authorize the release of medical information to my insurance carrier, any physician participating in my health care, and any physician to whom I may be subsequently referred.

Copayments are paid at the time of the visit. I am responsible to be knowledgeable of my insurance coverage, deductible, and copayments for any services provided by Florida Dermatology Specialists. I understand that I am financially responsible for payment of any services rendered to me by Florida Dermatology Specialists. I have read and accept the terms of this policy.

Printed Name: _____

Signature: _____ Date: _____

Florida Dermatology Specialists

New Patient Medical History

Name: _____ DOB: _____

Please Circle All that Apply for Medical History:

Skin Cancer: BCC/SCC/Melanoma	COPD	Hypertension	Seziures
Anxiety	Coronary Artery Disease	High Cholesterol	Previous Radiation
Arthritis	Depression	Hypothyroidism	Hyperthyroidism
Atrial Fibrillation	Diabetes	Leukemia	Solid Organ Transplant
Stroke	End Stage Renal Disease	Lymphoma	Bleeding Disorders
Heart Attack	GERD	Lung Cancer	Immunosuppression
Bone Marrow Transplant	Hearing Loss	Lupus	Pancreatitis
Breast Cancer	Hepatitis	Prostate Cancer	Other: _____
Colon Cancer	HIV / AIDS	BPH	

Please Circle All that Apply for Surgical History:

None	Shoulder Joint Replacement	Heart Stent	Breast Surgery
Artificial Heart Valve	Other Joint Replacement: _____	Hysterectomy	Other Surgery: _____
Hip Joint Replacement	Abdominal Surgery	Prostatectomy	
Knee Joint Replacement	Heart Bypass	Splenectomy	

Please Circle All that Apply for Skin Disease History:

None	Actinic Keratoses	Psoriasis	Regular Sunscreen Use
Basal Cell Carcinoma	Atypical Moles	Blistering Sunburns	Other: _____
Squamous Cell Carcinoma	Acne	Tanning Bed Use	
Melanoma	Eczema/Atopic Dermatitis	Family History of Melanoma (1st Degree Relative)	

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Name: _____ DOB: _____

Medication List: _____

_____

Medication Allergies: _____

Please Circle Any Current Symptoms for Review of Systems:

Abdominal Pain	Anxiety	Bloody Stool	Blurry Vision
Changing Moles	Chest Pain	Cough	Depression
Fever/Chills	Headaches	Joint Aches	Rash
Seizures	Shortness of Breath	Sore Throat	Thyroid Problems
Wheezing			

Please Circle Any of the Following that Apply:

Adhesive Allergy	Lidocaine Allergy	Topical Antibiotic Allergy	Artificial Heart Valve
Artificial Joint less than 2 years old	Blood Thinners	Defibrillator	Pacemaker
MRSA	Premedication Prior to Procedures	Rapid Heartbeat with Epinephrine	Pregnant/Planning Pregnancy
Breast Feeding	Hepatitis	HIV / AIDS	Dementia

Smoking Status: Current Smoker ___ Former Smoker ___ Never Smoked ___

Alcohol Use: Daily ___ Occasionally ___ None ___

Patient or Parent/POA Signature _____ Date_____