



**Minor Patient Information**

TODAY'S DATE: \_\_\_\_\_

LEGAL LAST NAME: \_\_\_\_\_ LEGAL FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ RACE/ETHNICITY: \_\_\_\_\_  MALE  FEMALE

HOME ADDRESS: \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_

PHONE #: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ PHONE #: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_ PHONE #: \_\_\_\_\_

**Parental Information**

PARENT/LEGAL GUARDIAN NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

HOME ADDRESS:  SAME AS ABOVE  OTHER: \_\_\_\_\_

WHAT IS THE BEST WAY TO CONTACT YOU?:  HOME PHONE  CELL PHONE  WORK PHONE  EMAIL  MAIL

HOME PHONE #: \_\_\_\_\_ WORK PHONE #: \_\_\_\_\_

CELL PHONE #: \_\_\_\_\_ EMAIL: \_\_\_\_\_

PLEASE LET US KNOW IF YOU WISH TO OPT OUT OF APPOINTMENT REMINDERS SENT BY HOME PHONE (CALL), CELL PHONE (TEXT), OR EMAIL.

**Insurance**

PRIMARY INSURANCE: \_\_\_\_\_ POLICY ID #: \_\_\_\_\_

POLICY HOLDER NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

**Consent to Treat**

I do hereby solemnly swear that I have legal custody of the aforementioned minor child. I authorize the release of any information concerning my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits to be made directly to my child's doctor.

I authorize Brevard Medical Dermatology, PA and its staff to administer treatment to my minor child. I understand that if I allow my minor child to attend any subsequent appointments without me, they must be accompanied by a letter with a personal dated signature stating that they may receive treatment in the office of Brevard Medical Dermatology, PA without my being present.

\_\_\_\_\_  
SIGNATURE OF PARENT/LEGAL GUARDIAN

\_\_\_\_\_  
DATE



**Patient Release of PHI**

TODAY'S DATE: \_\_\_\_\_

**Authorization for Disclosure**

Please list any family members or friends below that we may speak with regarding your protected health information. If the patient is a minor and you are filling out this form on their behalf, please list all parents or legal guardians below.

I \_\_\_\_\_ (print patient name here) give authorization to the physicians and staff of Brevard Medical Dermatology, PA to release my protected health information to:

<u>FULL NAME</u>	<u>RELATIONSHIP</u>	<u>PHONE #</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I further understand this authorization will remain in effect unless terminated with a personal dated signature.

\_\_\_\_\_  
SIGNATURE OF PATIENT (OR LEGAL GUARDIAN IF MINOR)

**Acknowledgement of HIPAA Notice of Privacy Practices**

I have received a copy (let us know if you would like a copy) or have reviewed a copy (located in Lobby or at [www.brevardmd.com](http://www.brevardmd.com)) of Brevard Medical Dermatology's HIPAA Notice of Privacy Practices ("Notice"). The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. In addition, I am aware that the Notice may be updated at any time. I may obtain a revised copy of the Notice by notifying the Privacy Officer at Brevard Medical Dermatology, PA.

\_\_\_\_\_  
SIGNATURE OF PATIENT (OR LEGAL GUARDIAN IF MINOR)

\_\_\_\_\_  
DATE



## Patient Financial Agreement

Thank you for choosing us as your dermatologist. We are committed to providing you with quality and affordable health care. We ask all patients to review and sign this policy, asking questions as necessary. A copy will be provided to you upon request.

- 1. Insurance:** We accept assignment and participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurer with any questions you may have regarding your coverage to receive maximum benefits.
- 2. Patient payment:** All copayments and deductibles are to be paid at time of service. This arrangement is part of your contract with your insurance company.
- 3. Registration:** All patients must complete our patient information form, which will be entered into our computer to maintain accurate information for proper billing. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of a claim. Most insurance companies have a timely filing restriction; if a claim is not received with 30 days of date of service, it can be rendered ineligible for payment and you will be responsible for the balance that remains.
- 4. Claims:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and the insurance company; we are not a party to that contract.
- 5. Uninsured patients:** We offer a self-pay discount, which is equal to Medicare allowable, to our patients who do not have insurance. Payment in full is due at time of service. If prior arrangement has been made on any unpaid balance, you will receive a monthly statement that is due upon receipt.
- 6. Bad debt accounts:** Our billing department will reasonably attempt to collect on all outstanding balances. This includes three billing statements, followed by three phone calls from our billing department. At this point, if balance remains unpaid the patient's account is considered a "bad debt". The patient may pay their balance at any time thereafter to get out of "bad debt" status, but we do not schedule any further non-urgent appointments until the bad debt balance is paid in full.
- 7. Returned check fee:** The return of a check issued to Brevard Medical Dermatology will result in a \$25.00 returned check fee being placed on the account of the patient no matter the reason. Written notification on how to resolve the returned check will be sent to the patient. A hold will be placed on the account, until the returned check has been resolved. Each account will be allowed two returned checks after which payment by check will not be accepted. **IMPORTANT NOTE: A RETURNED CHECK MAY RESULT IN A HOLD ON THE ACCOUNT, WHICH MAY PRECLUDE SERVICES ROUTINE IN NATURE OR NON-URGENT MATTERS.**
- 8. Phone management fee:** There will be a \$20 charge for managing and treating a minor acute illness (e.g., Accutane follow up, exchange of photos regarding rash, lesions, etc. between patient and medical provider) over the phone. The phone management fee will not be billed to your insurance and is your full responsibility.
- 9. Missed appointments:** Our policy is to charge \$25 for missed appointments not canceled within 24 hours of scheduled appointment. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointments.

Thank you for taking the time to review our financial policy. Please let us know if you have any questions or concerns.

**I have read and understand the financial policy and agree to abide by its guidelines.**

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SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

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PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY

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DATE



**Patient Past Medical History**

Internal diseases and medication side effects can manifest themselves on the skin. Therefore, it is important for us in dermatology to know your other medical conditions, medications and allergies to medications. Please fill out this form to the best of your knowledge.

**PATIENT NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

Preferred pharmacy name and location? \_\_\_\_\_

Is it ok to leave a message on your voicemail with results?  Yes  No

Do you have an Advanced Care Plan or Living Will?  Yes  No

Did a doctor recommend you see a dermatologist?  Yes  No Dr. \_\_\_\_\_

**General Medical History**

Check any of the following that apply and use the lines below for explanations:

- |   |   |
|---|---|
| <input type="checkbox"/> Anxiety                                    | <input type="checkbox"/> Hepatitis                                |
| <input type="checkbox"/> Arthritis                                  | <input type="checkbox"/> Hypertension                             |
| <input type="checkbox"/> Atrial Fibrillation (irregular heart beat) | <input type="checkbox"/> HIV/AIDS                                 |
| <input type="checkbox"/> Bone Marrow Transplant                     | <input type="checkbox"/> Hypercholesterolemia                     |
| <input type="checkbox"/> BPH (enlarged prostate gland)              | <input type="checkbox"/> Hypothyroidism                           |
| <input type="checkbox"/> Breast Cancer (which breast?: _____)       | <input type="checkbox"/> Hyperthyroidism                          |
| <input type="checkbox"/> Colon Cancer                               | <input type="checkbox"/> Leukemia                                 |
| <input type="checkbox"/> COPD (lung disease)                        | <input type="checkbox"/> Lung Cancer                              |
| <input type="checkbox"/> Coronary Heart Disease                     | <input type="checkbox"/> Lymphoma                                 |
| <input type="checkbox"/> Depression                                 | <input type="checkbox"/> Pacemaker/Defibulator (circle one)       |
| <input type="checkbox"/> Diabetes                                   | <input type="checkbox"/> Pneumonia Vaccine (date received: _____) |
| <input type="checkbox"/> End Stage Renal Disease                    | <input type="checkbox"/> Prostate Cancer                          |
| <input type="checkbox"/> Flu Vaccine (date received: _____)         | <input type="checkbox"/> Radiation Treatment                      |
| <input type="checkbox"/> GERD (gastroesophageal reflux disease)     | <input type="checkbox"/> Seizures                                 |
| <input type="checkbox"/> Hearing Loss                               | <input type="checkbox"/> Stroke                                   |

Use this space for explanations AND other medical conditions (PLEASE PRINT):

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**Past Surgical History**

List all past surgeries and dates (PLEASE PRINT):

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**Past Dermatologic History**

Check any of the following that apply:

- |   |  |
|---|--|
| <input type="checkbox"/> Acne                                       | <input type="checkbox"/> Hay Fever/Allergies                           |
| <input type="checkbox"/> Actinic Keratosis (pre-cancerous growth)   | <input type="checkbox"/> Flaking or Itchy Scalp                        |
| <input type="checkbox"/> Asthma                                     | <input type="checkbox"/> Melanoma (type of skin cancer)                |
| <input type="checkbox"/> Basal Cell Carcinoma (type of skin cancer) | <input type="checkbox"/> Poison Ivy                                    |
| <input type="checkbox"/> Blistering Sunburns                        | <input type="checkbox"/> Cancerous Moles                               |
| <input type="checkbox"/> Dry Skin                                   | <input type="checkbox"/> Psoriasis                                     |
| <input type="checkbox"/> Eczema                                     | <input type="checkbox"/> Squamous Cell Carcinoma (type of skin cancer) |

Do you wear sunscreen?  No  Yes, what SPF: \_\_\_\_\_  
Do you tan in a tanning salon?  No  Yes, when last: \_\_\_\_\_

**Family History**

Is a blood relative affected by any of the following?

Skin Cancer:

- Basal Cell Carcinoma     Squamous Cell Carcinoma     Melanoma

Which relative: \_\_\_\_\_

Autoimmune Disorder:

- Lupus     Psoriasis     Rheumatoid Arthritis     Thyroid Disease     Other \_\_\_\_\_

Which relative: \_\_\_\_\_

- Adopted, family history unknown

**Medications**

Check any of the following that apply and use the lines for explanations:

<input type="checkbox"/> Aspirin (strength: _____)	<input type="checkbox"/> Other prescription medications (PRINT names):		
<input type="checkbox"/> Coumadin/Warfarin	NAME	DOSAGE	xDAILY
<input type="checkbox"/> Plavix	_____	_____	_____
<input type="checkbox"/> Other blood thinners (list):	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
<input type="checkbox"/> Over-the-counter medications/supplements and dosage:	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Allergies to Medications**

Check the box if allergic AND list your reaction (PLEASE PRINT):

- Lidocaine     Epinephrine     Penicillin     Betadine/Iodine     Sulfa

Reaction: \_\_\_\_\_

- |   |  |
|---|--|
| <input type="checkbox"/> Codeine, Morphine, or Narcotics, Reaction: | <input type="checkbox"/> Other Antibiotics, Name and Reaction: |
| _____   | _____  |
| _____   | _____  |
| <input type="checkbox"/> Other Medications, Name and Reaction:      | <input type="checkbox"/> Creams/Ointments, Name and Reaction:  |
| _____   | _____  |
| _____   | _____  |
| _____   | _____  |

**Social History**

Do/did you smoke?  Never  Yes, \_\_\_\_\_ packs/day Total Yrs Smoking?: \_\_\_\_\_ Start: \_\_\_\_\_ Quit: \_\_\_\_\_  
Do you use alcohol?  No  Yes, \_\_\_\_\_ drinks/day  
Do you use caffeine?  No  Yes, \_\_\_\_\_ cups/day

\_\_\_\_\_  
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