PREMIER DERMATOLOGY PARTNERS®

To our patients,

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how health information may be used or disclosed to carry out treatment, payment or healthcare operations - and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to an address other than your home address.

The physicians and staff of Premier Dermatology Partners® respect your privacy and wish to make all reasonable attempts to respect your wishes regarding your confidential information. With that in mind, please indicate your preferences for the areas noted below.

☐ I wish to be contacted by the telephone, FAX, and email I provide and it is OK to leave a detailed messages on these. I also wish to permit Premier Dermatology Partners® to contact my listed emergency contacts and direct family relatives in the same way.

☐ I wish to be contacted by my home and cell phone numbers only. It is OK to leave a detailed voicemail on the numbers.

☐ I wish to be contacted by my home and cell phone numbers only. However, any voicemail may only have a message identifying Premier Dermatology Partners® calling and I do not wish any medical information to be left on voicemail. I understand that this means that it will/might be more difficult for me to receive important medical information.

☐ I give permission for photos to be taken of my skin. I understand that these photos will become part of my medical chart.

☐ I give permission for photos (without any identifying features) to be used for research, teaching, or marketing purposes.

☐ Other _____

Name	Relationship
_____	_____
_____	_____
_____	_____

_____ _____

Print Patient Name Date of Birth

_____ _____

Patient Signature Date

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Para nuestros pacientes,

Yo entiendo que como parte de mi cuidado de salud esta organización crea y mantiene archivos medicos con descripción de mi historial de salud, sintomas, examenes y resultados de pruebas, diagnosticos, tratamiento, y cualquier plan de cuidado futuro o tratamiento.

Entiendo que esta información servira como:

- Como base para tratar mi cuidado y tratamiento.
- Como un medio de comunicación entre todos los prodesionales de cuidado de salud que contribuye a mi cuidado.
- Como una fuente de información para aplicar mi información de diagnosticos y cirugias a mi factura.
- Como un medio en que tercer pagadores puedan verificar que los sevicios facturados fueron realmente brindados.
- Como un instrumento de operación de cuidado de salud como evaluación de calidad de cuidado y revisión de la competencia de cuidado de salud de profesionales.

Yo entiendo que tengo el derecho de:

- De recharsa el uso de mi información de salud para propositos directorios.
- De requerir restricciónes en como mi información de salud puede ser usada y divulgada para llevar acabo tratamiento, pago o operaciones de cuidado de salud - y que la organización no esta requerida a estar de acuerdo con las restricciónes requeridas.
- Revocar este consentimiento por escrito, excepto en la medida en que la organización ya ha tomado medidas al respecto.

En general, las reglas de privacidad HIPPA da derechos a individuos para pedir y restringir el uso y divulgación de su información protegida de salud (IPS). El individuo tambien es proveido el derecho a pedir comunicacion confidencial o que una comunicacion IPS sea hecha por otras alternativas como mandar corespondecia a una dirección diferente a su dirección de casa.

El medico y personal de Premier Dermatology Partners® respeta su privacidad y de sea hacer todos los intentos rasonables para respetar sus deseos acerca de su información confidencial. Con eso en mente, favor de indicar sus preferencias para las areas listadas abajo.

☐ Deseo ser contactado/a por télefono, fax y correo electronico que yo provee y esta bien dejar un mensaje detallado en estos. Tambien deseo permitir a Premier Dermatology Partners® contactar a mis contactos de emergencia listados y familiares directos en la misma manera.

☐ Deseo ser contactado a mi télefono de casa o celular solamente. Esta bien dejar un mensaje de voz detallado en estos numeros.

☐ Deseo ser contactado a mi número de casa y celular solamente. Sin embargo, cualquier mensaje de voz solamente identifique a Premier Dermatology Partners® llamando y deseo que ninguna información medica sea dejada en el mensaje. Yo entiendo que esto significa que va/puede ser más dificil para mi recibir información medica importante.

☐ Doy el permiso para fotos de mi piel. Entiendo que estas fotos pasarán a formar parte de mi expediente médico

☐ Doy el permiso para fotos (sin ninguna identificación características) que se utilizará para la investigación, enseñanza, o con fines de mercadeo.

☐ Otro_____

Nombre	Relación
_____	_____
_____	_____
_____	_____
_____	_____
Imprimir Nombre de Paciente	Fecha de Nacimiento
_____	_____
Firma de Paciente	Fecha

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NONE

Other _____

Do you wear Sunscreen? Yes No

If yes, What SPF? _____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)?

_____

Medications: (Please enter all current medications)

_____

_____

_____

_____

Allergies: (Please enter all allergies)

_____

_____

_____

_____

Social History: (Please circle all that apply)

TO COMPLY WITH MEDICARE'S "MEANINGFUL USE" REQUIREMENT'S, PLEASE ANSWER THE FOLLOWING QUESTIONS.

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:

EtOH - None
EtOH - less than 1 drink per day
EtOH - 1-2 drinks per day
EtOH - 3 or more drinks per day

Other _____

Family History: (Only first degree relatives)

Diabetes? Yes / No If yes, which relative(s): _____

_____

_____

_____

_____

_____

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ALERTS: (Please circle all that apply)

Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heart beat with epinephrine
Are you pregnant or currently trying to get pregnant?

Other Symptoms:

_____

Signature _____ Date _____

Name: _____
Patient

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History and Intake Form

Past Medical History: (Please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplantation
BPH
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV / AIDS
High Cholesterol
Thyroid Problems
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

NONE

Other _____

Past Surgical History: (Please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
NONE

Other _____

Skin Disease History: (Please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever / Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

over →

PREMIER DERMATOLOGY PARTNERS®

DUE TO RECENT REFORMS MANDATED BY THE GOVERNMENT, DOCTORS ARE REQUIRED TO ASK ALL PATIENTS FOR THEIR RACE AND ETHNICITY, REGARDLESS OF YOUR INSURANCE, TO MEET MEANINGFUL USE REQUIREMENTS.

Preferred Language: _____

Race (Circle One): American Indian / Alaska Native, Asian, Black / African American, Nat. Hawaiian / Pacific Islander, White, Decline to Answer, Other Race: _____

_____

Ethnic Group (Circle One): Decline to Answer, Hispanic or Latino, Not Hispanic or Latino

Preferred Pharmacy Name: _____

Phone #: _____

City or Zip Code OR Cross Streets: _____

Review of Systems:

Are you currently experiencing any of the following?

(Please check yes or no for the following)

Symptom	Yes	No	Symptom	Yes	No
Problems with Bleeding			Wheezing		
Rash			Anxiety		
Immunosuppression			Depression		
Chest Pin			Pacemaker		
Fever or Chills			Sinus Problems		
Thyroid Problems			Diabetes		
Sore Throat			Hypertension		
Blurry Vision			HIV / A.I.D.S.		
Abdominal Pain			Hepatitis		
Bloody Urine			Nausea / Vomiting		
Joint Aches			New Skin Lesion(s)		
Headaches			Changes in Mole(s)		
Seizures			Itching		
Cough			History of Skin Cancer		
Shortness of Breath					

Other Symptoms:

_____

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Patient Information Sheet

Please fill out the entire form. If a question does not pertain to you please write N/A (non-applicable).

Last Name _____ First Name _____ Patient ID # _____

DOB _____ Sex M / F SS# _____ Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ _____

Phone:
Home # _____ Cell # _____ Work # _____

How do you wish to receive reminders? (You can select more than one)
Email _____ ☐ Phone ☐ Email ☐ Mail ☐ Text

Florida Address _____ City _____ State _____ Zip _____

Alternate Address _____ City _____ State _____ Zip _____

Employer _____ Employer Phone # _____

PCP (Primary Care Doctor) _____ City, State _____

Which doctor referred you here? _____ City, State _____

Pharmacy _____ City and cross streets _____ Pharmacy Phone # _____

Where did you hear about us: ☐ Radio ☐ TV ☐ Internet ☐ Paper ☐ _____

DUE TO RECENT REFORMS MANDATED BY THE GOVERNMENT, DOCTORS ARE REQUIRED TO ASK ALL PATIENTS FOR THEIR RACE AND ETHNICITY REGARDLESS OF YOUR INSURANCE TO MEET MEANINGFUL USE REQUIREMENTS.

If Race, Ethnicity, or Language is incorrect please correct below:

Race: _____

☐ American Indian/Alaska Native ☐ Nat. Hawaiian/Pacific Islander
☐ Asian ☐ Other Race _____
☐ Black/African American ☐ White
☐ Declined

Ethnicity: _____

☐ Declined
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Primary Language: _____

Do you understand English? ☐ Yes ☐ No

Do you need communication/translation assistance? ☐ Yes ☐ No

Insurance Information

Insurance company plan _____ City _____ State _____ Zip _____

Subscriber: self / spouse name _____

SS# _____ Relationship to Subscriber _____ DOB _____ Phone # _____

Subscriber's Address _____ City _____ State _____ Zip _____

Secondary Ins. _____ Policy # _____ Group # _____

Ins. Address _____ City _____ State _____ Zip _____

Subscriber _____ Relationship _____ DOB _____

Subscriber's Address _____ City _____ State _____ Zip _____

Is this a work related injury? Y / N Is this related to an auto accident? Y / N

CONTINUED ON THE OTHER SIDE

PREMIER
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Financial & Office Policies

Thank you for choosing us as your healthcare provider. We care about our patient's physical and financial well being and welcome the opportunity to work with you on any billing issue that may arise. We have implemented a new financial and office policy stating 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 association is entitled. Payment is due at the time services are provided unless other plan(s) have been set up. I understand you do not accept assignment in the case of liability actions.

Insurance Billing
Though Premier Dermatology Partners® accepts most insurance plans, 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 copays, deductibles and non-covered services determined by my insurance plan.

Insurance Referrals
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.

Self Pay
If I am un-insured 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.

Patient Billing
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 collections 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 $50.00

I authorize the release of medical record information to: 1) the above named insurance companies, 2) any physician who has participated in my health care, and 3) to any physician to whom I may subsequently be referred.

Co-payments are paid at the time of the visit. I am responsible to be knowledgeable of my insurance coverage, deductible, and co-pays for any services provided by Premier Dermatology Partners®. I understand that I am financially responsible for payment of any services rendered to me by Premier Dermatology Partners®. I have read and accept the terms of this policy.

Signature _____ **Date** _____

PREMIER DERMATOLOGY PARTNERS®

PLEASE READ CAREFULLY
AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean _____. ***(Patient name)***.

"Physician" shall be understood to mean provider (MA, DO, ARNP, PA-C) also provides medical care at Premier Dermatology Partners®.

I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the Physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should I initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialties in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the American Academy of Dermatology.

I agree the expert(s) will be obligated to adhere to the guidelines or code of conduct defined by the American Academy of Dermatology and that the expert(s) will be obligated to fully consent to formal review of conduct by such society and its members.

I agree to require any attorney I hire and my physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, Physician also agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/guardian and Physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and Patient/guardian agree that these provisions apply to my claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

_____ Physician

_____ Patient/Guardian

_____ Effective from Date of Treatment:

_____ Date of Signature

rlin Center for Medical Ae ics
Cosmetic Interest Questionnaire

Patient Name: **Date:**

Procedures or Products of Interest to you:
(Please check all that apply)

- ☐ Botox
- ☐ Facial Fillers - Juvederm, Radiesse
- ☐ Laser Resurfacing
- ☐ Laser Hair Removal
- ☐ Broken Blood Vessel Removal – Face
- ☐ DermaPen
- ☐ Other – Please Specify:
- ☐ Skin Care Consultation
- ☐ Skin Care Products
- ☐ Skin Rejuvenation
- ☐ Microdermabrasion
- ☐ Facials
- ☐ Chemical Peels

Are you interest in meeting with one of our professional cosmetic consultants in order to address your concerns, and create a personal treatment plan?

☐ Yes ☐ No thanks

☐ Approval to contact you

Best phone number to reach you:

Email Address:

Patient Signature: