BREVARD MEDICAL DERMATOLOGY

Minor Patient Information

TODAY'S DATE: _____

LEGAL LAST NAME: _____ LEGAL FIRST NAME: _____ MI: _____ SUFFIX: _____

NICKNAME (IF PREFERRED):_____ SSN: _____

☐ MALE ☐ FEMALE DATE OF BIRTH: _____ ETHNICITY/RACE: _____

EMERGENCY CONTACT NAME: _____

PHONE #: _____ RELATIONSHIP TO PATIENT: _____

PATIENT'S HOME ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

REFERRING PHYSICIAN: _____ PHONE #: _____

Guarantor Information

PARENT/LEGAL GUARDIAN NAME: _____ MI: _____ SUFFIX: _____

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.

X

_____ _____

SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

BREVARD MEDICAL DERMATOLOGY

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:

FULL NAME	RELATIONSHIP	PHONE #

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

X

_____ _____

SIGNATURE OF PATIENT (OR LEGAL GUARDIAN IF MINOR) DATE

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) 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.

X

_____ _____

SIGNATURE OF PATIENT (OR LEGAL GUARDIAN IF MINOR) DATE

BREVARD MEDICAL DERMATOLOGY

Consent to Treat Minor Patient-Without Parent/Legal Guardian Present

MINOR'S NAME: _____DOB:_____

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

For those occasions when you may not be with your child, **please list those individuals who may give us consent to see your child:**

_____ _____
NAME RELATIONSHIP TO PATIENT

_____ _____
NAME RELATIONSHIP TO PATIENT

and/or

☐ Check here if you wish to give consent for the minor to receive medical care without an accompanying adult.

This consent shall be in effect for: ☐ Date _____(only)

☐ Indefinitely, until revoked by written communication

LIMITATIONS:

Identify any specific limitations on the kinds of medical services for which this authorization is given.

(If none, state "none") _____

AUTHORIZATION:

I (parent/legal guardian name) _____ request and authorize Brevard Medical Dermatology and its personnel to deliver medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I am also aware that the adult presenting the child is responsible for payment of the patient portion at the time of service. I have the legal right to preauthorize Brevard Medical Dermatology and its personnel to deliver routine medical treatment and services to my child. Routine medical care and interventions may include, but are not limited to: medical evaluation, physical exam, injections, (examples: wart treatment with liquid nitrogen, obtaining biopsies, suturing) I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

_____ _____
PRINTED NAME OF PARENT/LEGAL GUARDIAN RELATIONSHIP

X

_____ _____
SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

BREVARD MEDICAL DERMATOLOGY

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.

X _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

_____ _____

PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY DATE

BREVARD MEDICAL DERMATOLOGY

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? _____ Height _____ Weight _____
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:

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

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

_____

_____

Past Surgical History

List all past surgeries and dates (PLEASE PRINT):

_____ _____

_____ _____

Past Dermatologic History

Check any of the following that apply:

- ☐ Acne
- ☐ Actinic Keratosis (pre-cancerous growth)
- ☐ Asthma
- ☐ Basal Cell Carcinoma (type of skin cancer)
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Hay Fever/Allergies
- ☐ Flaking or Itchy Scalp
- ☐ Melanoma (type of skin cancer)
- ☐ Poison Ivy
- ☐ Cancerous Moles
- ☐ Psoriasis
- ☐ 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:
☐ Aspirin (strength: _____)
☐ Coumadin/Warfarin
☐ Plavix
☐ Other blood thinners (list):

_____
_____

☐ Over-the-counter medications/supplements and dosage:

_____
_____
_____

☐ Other prescription medications (PRINT names):

NAME	DOSAGE	xDAILY

Allergies to Medications

Check the box if allergic AND list your reaction (PLEASE PRINT):
☐ Lidocaine ☐ Epinephrine ☐ Penicillin ☐ Betadine/Iodine ☐ Sulfa
Reaction: _____

☐ Codeine, Morphine, or Narcotics, Reaction:

_____
_____
_____

☐ Other Antibiotics, Name and Reaction:

_____
_____
_____

☐ Other Medications, Name and Reaction:

_____
_____
_____

☐ 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

X

_____ _____
SIGNATURE OF PATIENT (OR LEGAL GUARDIAN IF MINOR) DATE