

Patient Demographics Information

TODAY'S DATE: _____

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

NICKNAME (IF PREFERRED): _____ MARITAL STATUS: _____ SSN: _____

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

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT PHONE #: _____ RELATIONSHIP TO PATIENT: _____

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

HOME PHONE # (LANDLINE): _____ WORK PHONE #: _____

CELL PHONE #: _____ EMAIL: _____

IS IT OKAY TO LEAVE A DETAILED MESSAGE ON YOUR VOICEMAIL/ANSWERING MACHINE? ☐ YES ☐ NODO YOU WISH RECEIVE APPOINTMENT REMINDERS SENT BY SECURE TEXT MESSAGE (KLARA)? ☐ YES, OKAY TO TEXT ME ☐ NO, OPT ME OUT

MAILING ADDRESS: _____

SEASONAL/OUT OF STATE ADDRESS (IF APPLICABLE): _____

EMPLOYER NAME: _____ PHONE #: _____

OCCUPATION: _____

Insurance

PRIMARY INSURANCE: _____ POLICY ID #: _____

POLICY HOLDER NAME: _____ RELATIONSHIP: _____ DATE OF BIRTH: _____

SECONDARY INSURANCE: _____ POLICY ID #: _____

POLICY HOLDER NAME: _____ RELATIONSHIP: _____ DATE OF BIRTH: _____

I authorize the release of any information concerning my (or 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 doctor.

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



Patient Release of PHI

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. Regarding medical records, a copy of your (or the minor's) medical records will only be released with your written permission, excluding your primary care provider, referring doctor, and/or medical insurance company in regard to continuity of care.

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.

X

SIGNATURE OF PATIENT (OR LEGAL GUARDIAN IF MINOR)

DATE

Patient Guarantor Information (If Under 18 Years Old)

Please complete if patient is a minor. If patient is not a minor, please move on to the next page.

TODAY'S DATE: _____

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

DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

MAILING ADDRESS: ☐ SAME AS PATIENT ☐ OTHER: _____

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

HOME PHONE # (LANDLINE): _____ WORK PHONE #: _____

CELL PHONE #: _____ EMAIL: _____

IS IT OKAY TO LEAVE A DETAILED MESSAGE ON YOUR VOICEMAIL/ANSWERING MACHINE? ☐ YES ☐ NO

DO YOU WISH RECEIVE APPOINTMENT REMINDERS SENT BY SECURE TEXT MESSAGE (KLARA)? ☐ YES, OKAY TO TEXT ME ☐ NO, OPT ME OUT

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.

X

SIGNATURE OF PARENT/LEGAL GUARDIAN

DATE



Consent to Treat Patient (If Under 18 Years Old)-Without Parent/Legal Guardian Present

Please complete if patient is a minor. If patient is not a minor, please move on to the next page.

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.

X

SIGNATURE OF PARENT/LEGAL GUARDIAN

RELATIONSHIP

PRINTED NAME OF PARENT/LEGAL GUARDIAN

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 (or the equivalent of your copayment amount if you have an HMO plan) 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

RELATIONSHIP

PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY

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:** _____ **IF MINOR: Height** _____ **Weight** _____

Preferred pharmacy name and location? _____

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

Do you have an Advanced Care Plan or Healthcare Proxy? ☐ No ☐ Yes, Name: _____

Relationship: _____

Do you have a Primary Care Provider (PCP)? ☐ No ☐ Yes, Dr. _____ Phone #: _____

Did a doctor recommend you see a dermatologist? ☐ No ☐ Yes, Dr. _____ Phone #: _____

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

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:

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

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 ☐ No blood relative affected by any of these to my knowledge

Medications

Please fill out if either of these below apply and use the lines for explanations, otherwise write NONE.

Prescription medications (PRINT names):

NAME	DOSAGE	xDAILY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Over-the-counter medications and/or supplements and dosage (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, socially/daily/weekly/monthly (circle one)

Do you use caffeine? ☐ No ☐ Yes, _____ cups/day

X

SIGNATURE OF PATIENT (OR LEGAL GUARDIAN IF MINOR)

DATE