



Patient Demographics Information

TODAY'S DATE: _____

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

MALE FEMALE MARITAL STATUS: _____ RACE/ETHNICITY: _____

HOME ADDRESS: _____

SEASONAL ADDRESS (IF APPLICABLE): _____

OCCUPATION: _____

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.

EMERGENCY CONTACT NAME: _____

PHONE #: _____ RELATIONSHIP TO PATIENT: _____

Insurance

PRIMARY INSURANCE: _____ POLICY ID #: _____

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

SECONDARY INSURANCE: _____ POLICY ID: _____

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

EMPLOYER NAME: _____ PHONE #: _____

Physician Information

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

REFERRING PHYSICIAN: _____ PHONE #: _____

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.

SIGNATURE OF PATIENT

DATE



Patient Release of PHI

TODAY'S DATE: _____

Authorization for Disclosure

This form is for family and friends only. If the patient is a minor, please list both parents/legal guardians.

I (the patient) 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

SIGNATURE OF PARENT/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) 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 each patient 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. 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.
- 8. 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.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

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:** _____

Preferred pharmacy name and location? _____

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/Defibrillator (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):

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"/> 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

SIGNATURE OF PATIENT (OR LEGAL GUARDIAN IF MINOR)

DATE