Dermatology Associates OF TALLAHASSEE

Dermatology SouthEast

Date: ___________________ Medical Record #______________

Patient Information

PLEASE PRINT

Name of Patient ____ Age __________
(Last) (First) (Middle)

Date of Birth ____________________ SS# _______________________ Sex ________ Marital Status _______________

Mailing Address ____
(Street/PO Box) (Apt #) (City) (State) (Zip)

Best Daytime Contact Phone Number ___________________________ ☐ **Cell** ☐ **Home** ☐ **Work**

Alternate Phone Number ________________________ ☐ **Cell** ☐ **Home** ☐ **Work**

Is it ok to leave voicemail? ☐ **YES** ☐ **NO**

Is it ok to email? ☐ **YES** ☐ **NO**

Email Address ____
(PLEASE PRINT CLEARLY)

Emergency Contact ____
(Name) (Relationship) (Phone Number)

If referred, who may we thank for this referral? ____

Primary Care Physician ____
(Name) (City/State)

Occupation/Previous Occupation ____ Retired: ☐ Yes ☐ No

Patient's Employer ____
(If child, give parents information) (Name) (City/State)

The Federal Government requests that we collect the following information:

Race: ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Type-Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Type-Unknown **Preferred Language:** ______________________________

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It is the policy of this practice to collect payment at time of service.

Primary Insurance: ________________________________ Policy #: _____________________________________

Secondary Insurance: ______________________________ Policy #: _____________________________________

Name of Policy Holder: ____________________________ Policy Holder Date of Birth: ____________________

MEDICAL HISTORY

Do you have a history of the following health problems? **Please check all that apply.**

- ☐ Basal Cell Skin Cancer
- ☐ Squamous Cell Skin Cancer
- ☐ Melanoma Skin Cancer
- ☐ Biopsy-proven Atypical Moles
- ☐ Sun Sensitivity
- ☐ Dry/Sensitive Skin
- ☐ Cancer (Non-Skin Cancer)
- ☐ History of Keloids
- ☐ Diabetes
- ☐ Hepatitis B/C
- ☐ HIV
- ☐ Tuberculosis
- ☐ Pacemaker
- ☐ Artificial Heart Valve
- ☐ Taking Blood Thinners
- ☐ Joint Replacement
  Hardware? _________Year
- ☐ Lupus
- ☐ Lymphoma
- ☐ Leukemia
- ☐ Organ transplant
- ☐ Stroke
- ☐ Heart Attack
- ☐ History of MRSA(staph infection)
- ☐ Psychiatric Problems

Any Family History of Skin Cancer? ____________**If so, Who?**_______________________**TYPE?**_____________________

Are you pregnant? ☐ Yes ☐ No **If YES PLEASE NOTIFY NURSE**

Current smoking status: ☐ Smoke every day ☐ Smoke sometimes ☐ Former smoker ☐ Never smoked

ALLERGIES: Are you allergic to any Medications? ☐ Yes ☐ No **If yes, list medication and the reaction you had:**

____

CURRENT MEDICATIONS: (list all medications and dosage you take on a regular basis or every once in a while):

MEDICATION	*DOSAGE*	*FREQUENCY*	*REASON FOR TAKING?*

CONTINUE ON BACK PAGE IF NEEDED

OTHER MAJOR MEDICAL PROBLEMS/ OPERATIONS/ HOSPITALIZATIONS: _______________________________

____

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REASON FOR YOUR APPOINTMENT TODAY:____

____

Have you sought care for this problem elsewhere? ☐ Yes ☐ No If yes, where? ____

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION TO THE INSURANCE CARRIER AND ASSIGNMENT OF BENEFITS FOR PHYSICIANS.

COMMERCIAL INSURANCE

I hereby authorize the release of medical information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO DERMATOLOGY ASSOCIATES OF TALLAHASSEE. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature (patient or guardian) ____

MEDICARE INSURANCE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dermatology Associates of Tallahassee for any services furnished to me by Dermatology Associates of Tallahassee. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for the benefits payable for related services.

Signature (patient or guardian) ____

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RECEIPT OF NOTICE PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I hereby acknowledge that I received the Notice of Privacy Practices from Dermatology Associates of Tallahassee and Dermatology Southeast, which sets forth the ways in which my personal health information may be used or disclosed by Dermatology Associates of Tallahassee and Dermatology Southeast Physicians, and outlines my rights with respect to such information. Dermatology Associates of Tallahassee/ Dermatology Southeast may also send me marketing communications through electronic methods (email, text, etc.) periodically. If you receive a marketing communication you will have the ability to opt-out within that message.

________________________________ ____________________

Patient Signature Date

PHONE CONTACT AUTHORIZATION

Your signature authorizes Dermatology Associates of Tallahassee and dermatology Southeast to disclose your personal health information in the following manner:

Voice mail at home: **YES** **NO**

Voice mail at work: **YES** **NO**

Also, please list the individual(s) with whom we may discuss your information with:

Name	Relationship	Phone

If you are unable, who would you like to make medical decisions on your behalf?

Name	Relationship	Phone

I understand that I may revoke this authorization by contacting Dermatology Associates of Tallahassee or Dermatology Southeast in writing.

Print Patient Name	Patient signature	Date

Dermatology Associates OF TALLAHASSEE

Dermatology SouthEast

MEDICATION HISTORY PATIENT CONSENT

I agree that Dermatology Associates of Tallahassee/ Dermatology Southeast may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

____ ________________________
Patient Signature Date

PHARMACY INFORMATION

Pharmacy Name: ____

Street Address: _______________________________________ City: _______________________

Phone Number: (If you know it): ____

Dermatology Associates OF TALLAHASSEE

Dermatology SouthEast

Dermatology Associates of Tallahassee & Dermatology Southeast Financial Policy

Understanding your financial responsibility is an essential component in establishing and maintaining a strong patient/practice relationship. Please review the terms of our financial policy carefully before signing the following page.

Insurance Guidelines:

Your insurance is a contract between your insurer and you. It is your responsibility to know and understand the terms, guidelines, and limitations of your plan. Deductibles, coinsurance, and copayments are the responsibility of the policy holder at the time of service. It is also your responsibility to advise us of any changes to your insurance, your address, or your employer.

If you are on traditional Medicare or are a member of a health plan within our network, we will submit your claim to your insurance company. Our office will make two (2) attempts to settle any outstanding bills with your insurance company. If your insurance deems a service "not a benefit" or a "non-covered service," you will be responsible for and you expressly agree to pay the balance of such non-covered services.

A small number of commercial, non-Medicare insurance plans cover a yearly preventative exam for skin cancer screening. A preventative exam is a specific type of appointment to address preventative and screening care. The preventative exam is different than a problem focused visit which would include the diagnosis, management, and treatments of temporary or ongoing problems. If it is identified that you need a problem focused service at the same time as a preventative exam. We will bill these services separately to your insurance. This is a requirement by your insurance. This will require you to be responsible for any office visit copay that will apply to the problem focused services provided that day.

Claims and Payments:

I. **Secondary/Supplemental Insurance Plans.** We are happy to file secondary and supplemental claims as a courtesy. In the case of non-contracted secondary carriers, the balance will become patient responsibility 30 days after that claim is filed.

II. **Non-Contracted Insurance Plans**. If we do not participate with your insurance carrier, payment in full will be required by you at the time services are rendered. Our billing department will file a claim to your insurance company as a courtesy to you upon request.

III. **Minors**. A parent or legal guardian must accompany all patients under the age of 18 to all appointments. If this is a custodial parent, we can submit the charges to another parent's insurance. However, the parent presenting the child for care will be billed for the balance not covered by insurance.

Self-Pay:

Payment is due at the time of service. A good-faith estimate of expected charges will be provided to you. However, charges may vary depending on the actual services provided in your exam. You will receive a statement for any remaining balance after services are provided. Payment is expected within 30 days of receiving the statement.

Medical Records:

Copies of pathology reports are provided to you or another physician at no charge. Any additional medical records requests and/or completion of forms (e.g., disability, life insurance, cancer policies, etc.) are subject to processing fees

determined by state law and contractual agreements. Please be advised that medical records requests require time to be processed and cannot be provided the same day requested.

Pathology Procedures:

Dermatology Associates of Tallahassee & Dermatology Southeast have an on-site lab and pathologist who perform the slide preparation and interpretation of our patients' biopsy specimens. Fees associated with this service are separate from the procedure performed by your provider.

Your provider may send the specimen to an outside lab for slide processing and interpretation. In those instances, patients or their insurance will receive a bill from the outside lab.

Dermatology Associates of Tallahassee & Dermatology Southeast providers reserve the right to send their patients' specimens to the most qualified dermatopathologist of his or her choosing. Therefore, if your insurance requires the use of a specific lab, it is your responsibility to provide us with that information prior to being seen. Failure to do so may result in additional out-of-pocket costs to you.

Cosmetic Services:

Patients are financially responsible for all cosmetic procedures at the time of service. This office does not bill insurance companies for cosmetic procedures.

Some cosmetic procedures require a deposit before being scheduled. If you cancel or reschedule a cosmetic procedure within two (2) business days of your scheduled appointment time, or fail to appear at the scheduled appointment time, 50% of your deposit will be collected as a missed appointment fee.

Collection Fees:

Statements are sent out monthly for patients with personal balances. Payment is due upon receipt of the statement. If you are unable to pay the balance in full, please contact our billing department. Personal balances over 90 days from the date of service will be sent to our collection agency. In the event an account is turned over to an outside collection agency, patients will be responsible for any collection fees incurred, including court costs, attorney fees, and collection agency charges.

Returned Check Fee:

If a check is returned for insufficient funds, a $35 fee will be added to your account balance. This total must be paid by cash or credit card within 14 days.

Acknowledgement of Policy
My signature below indicates that I have read, understand, and will comply with the information contained within this financial policy. A copy of this policy is available upon request.

____ ________/________/_______

Signature of Patient or Legal Representative Date

____ ____________________________

Printed Name of Patient or Legal Representative Relationship to Patient