Today's Date: _____

NOTE: You can fill out this form online by using your Tab Key to move through fields. Use Enter Key or Click Mouse for checkboxes and radio buttons.

Patient Information

Name_____ Date of Birth_____/_____/_____ Gender ☐M ☐F

Address_____ City_____ State_____ Zip_____

Social Security Number _____-_____-_____ E-mail _____ Marital Status _____

Best phone number (____)_____-_____ ◉ Home ○ Mobile ○ Work Alternate phone number (____)_____-_____ ○ Home ○ Mobile ○ Work

Veteran ☐Yes ☐No Student ☐Yes ☐No Employment status ☐Employed ☐Retired ☐Other_____

Pharmacy _____ Phone number _____

Address/Side Streets _____

Employer:_____ ☐Full Time ☐Part Time

Primary Language: ☐English ☐Spanish ☐Other: _____

Ethnicity: ☐Hispanic ☐non-Hispanic ☐Prefer Not to Disclose

Race: ☐White ☐Black/African-American ☐Asian ☐American Indian or Native Alaskan

☐Native Hawaiian/Pacific Islander ☐Hispanic ☐Prefer Not to Disclose

Primary Care Physician_____ Referring Physician_____

Insurance Info (If your Insurance is Family Coverage, Complete This for the Primary Insured)

Name_____ Date of Birth____/____/_____ Relationship to Patient _____

Primary Insurance: _____ Secondary Insurance: _____

Emergency Contact

Name_____ Relationship _____

Best phone number (____)_____-_____ ○ Home ○ Mobile ○ Work Alternate phone number (____)_____-_____ ○ Home ○ Mobile ○ Work

Patient Name: _____

Insurance Authorization and Assignment Consent to Treat

I hereby authorize Florida Dermatology and Skin Cancer Specialists, PL to furnish information concerning this illness/accident to insurance carriers and/or audit/compliance agencies. I hereby irrevocably assign to Florida Dermatology and Skin Cancer Specialists, PL all payments for medical services rendered to dependents or myself. I understand that I am financially responsible for all charges whether or not covered by insurance. I also hereby request and consent to treatment and services reasonable and proper by today's standards provided by a physician or provider of Florida Dermatology and Skin Cancer Specialists, PL and any employee acting under my physicians' orders.

Patient (or Guardian) Signature: _____ Date _____

Pathology services – I authorize Florida Dermatology and Skin Cancer Specialists, PL to send my tissue or other specimens to the Laboratory for microscopic slide processing and interpretation.

Medical Photography – I understand that photographs may be taken and added to my medical record. I understand that if I request release of my medical records these photographs may be included. I understand that these photographs may be used for the following purposes: education, training, medical or scientific publication, in which case my identity will be protected.

Financial policy – The physicians and staff at Florida Dermatology and Skin Cancer Specialists, PL appreciate the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

- **Payment is due in full at the time of service for any copays, unmet deductibles, co-insurances, self-pay patients, and cosmetic procedures.**
- Patients must provide proof of insurance ID number at the time of visit. If the patient's insurance card is not presented at the initial visit or when there is a charge in coverage, the patient will be responsible for full payment of service.
- Please provide at least 24 hours advance notice if you need to reschedule or cancel your appointment.
- FDSCS, PL accepts cash, checks, and all major credit cards. If a check payment is returned by the bank, a $30.00 fee will be applied to the patient's account. Patients who have a returned check must use cash or credit card only for all future payments.

_____ _____ ____/____/_____

Patient or Responsible Party Signature Print Name Date

*We request that at least **24 hour** advance notice be given to the office if you will be unable to keep your scheduled appointment. Our practice is very busy, and if you are unable to keep your appointment, we would like to offer that slot to another patient*.

Patient Name: _____

Acknowledgement of Notice of Privacy Practices and Authorization to Release Information

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnosis, treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol treatment/abuse notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.
- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.
- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment we provided to you.
- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on your answering machine, mobile voice mail, text mail, email or with a household family member. *I understand I may be charged for calls, texts or automated dialing systems by wireless carrier.*

☐ Please check here if you **DO NOT** want us to leave messages on your answering maching or with a household member

☐ Please check here if you **DO NOT** want us to leave a message on your mobile voice mail, text mail or email.

☐ **Please check here if you authorize us to send your healthcare information by email. Please understand that email is an unsecured medium of transmission and is potentially accessible by others. In addition to checking the box, we reserve the right to require you to send us an email authorizing transmission of your healthcare information to you by unsecured email.**
Provide email address that we would send/receive information:
_____

- **If you choose,** please list below the persons with whom we may share your healthcare or payment information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

- You may request a copy of and your have the right to read our *"Notice of Patient Provacy Practices"* prior to signing this authorization. The NPP provides a more complete description of health information uses and disclosures.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

_____ _____ _____
Signature | Print name of person signing if other than patient | Date

Patient Name (please print):_____

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have a **Healthcare Power of Attorney** for the patient. Yes [ ] No [ ] RELATIONSHIP_____

FOR OFFICE USE ONLY
Patient refused to sign the form. Reason: _____ Date: _____