Please print clearly and fill out all sections

Patient Information:

Name: (as it appears on your insurance policy) _____

Cell phone #: _____ Home Phone #:_____

Street Address: _____ Apt/Unit #_____ City:_____

State:_____ Zip Code:_____ Date of Birth:_____

Alternate Address:_____

Email:_____ Social Security #:_____

Marital Status: (Please circle) Single Married Divorced Widowed Other_____

Birth Sex: (Please circle) Male Female Race:_____ Ethnicity:_____

Emergency Contact:_____ Phone #:_____

Relation to pt:_____

Primary Care Physician:_____ Phone #:_____

Pharmacy Name:_____ Phone #:_____

Employer:_____ Work #:_____

Policy Holder Name:_____ DOB:_____

Medical Information

List ALL medical conditions you currently have:_____

_____

List ALL surgeries you've had:_____

_____

List ALL history of skin diseases you've had:_____

_____

Do you wear sunscreen? (please circle): YES NO

Do you have a family history of melanoma (please circle): YES NO

List all medications you are on:_____

_____

Allergies:_____

Allergy Symptoms:_____

Smoking status (please circle): Former Smoker Social Smoker Current Smoker

Alcohol Intake (please circle): None Social drinker Everyday drinker

Caffeine Use (please circle): None Several times a day Once a week Once in a while

How often do you exercise (please circle): Never Everyday Few times a week

HIPAA PATIENT CONSENT FORM

-Our notice of Privacy Practice Act Provides information about how we use and disclose your protected health information. The notice contains a patient's rights section describing your rights under the law. You have the right to review our Notice before signing the consent. The terms of our notice may change. If we change our notice you may obtain a revised copy by contacting our office. You have the right to revoke this consent in writing signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

-The patient understands that their protected health information may be disclosed or used for treatment, payment, or health care operations. The practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice. The practice reserves the right to change the notice of privacy practices. The patient has the right to restrict the use of their information but the practice does not have to agree to those restrictions. The patient may revoke this consent in writing at any time and all future disclosure will then cease. The practice may condition receipt of treatment upon execution of this consent.

-PATIENTS RIGHTS OF DISCLOSURES: In general, the HIPAA privacy rule gives individuals the right to request restriction on uses and disclosures of health information. The individual is also provided the right to request confidential communication of health information made by alternative means. Communication with the practice using email, fax and cell phone are not guaranteed to be secure or confidential. If these methods are initiated below, I waive the practice's obligation to ensure confidentiality. I also understand that email and fax are not appropriate means of communication or emergencies.

Communication Authorization Exception

How would you like to be contacted by us?

I, _____, (patients first and last name) wish to be contacted in the following manner:

(Please Check box and initial ALL preferential methods of contact)

Home #__ Okay to leave detailed message __ Leave message with call back number only **Initial:_____**

Cell #__ Okay to leave detailed message __ Leave message with call back number only **Initial:_____**

Work #__ Okay to leave detailed message __ Leave message with call back number only **Initial:_____**

Email Address __ Okay to leave detailed message __ Leave message with call back number only **Initial:_____**

Mail to home address **Initial:_____**

Fax Home # _____ **Initial:_____** **Patient's Date of Birth:_____**

Work Fax # _____ **Initial:_____**

I allow the release of my health information to the following people: (please print names clearly)

Name	**Relationship**
_____	_____
_____	_____

Patient Name or Guardian Name (Please print)	**Sign & Date**
_____	_____

****YOU ARE RESPONSIBLE FOR YOUR INSURANCE POLICY****

Due to the many changes in insurance policies, we cannot be responsible for interpreting each individual policy. **It is the responsibility of the patient to understand their individual coverage and its limitations, as well as the providers accepted by the plan.** We urge you to check with your insurance company regarding your benefits because failure to comply could result in you, the patient, being responsible for all costs incurred.

Insurance policies are a contract between the patient and the carrier. It is the responsibility of the patient to know which providers are in their specific network.

Financial Responsibility: Patients are financially responsible for all charges, whether paid by their insurance for all services rendered on their behalf or dependent's behalf.

Payment: Any and all co-pays, co-insurance, deductibles and account balances are due at the times of service.

Balances: Balances outstanding for more than 90 days will be subject to collection fees (at the patient's expense) and may be referred to a collection agency.

Referral/Authorizations: If the patient's health insurance policy requires a referral/authorization, it is the patient's responsibility to obtain it prior to the scheduled appointment. Since most insurances will deny wellness visits for Dermatologists.

Appointment No show/ Cancellation Policy: We require a 24 hour cancellation notice. A $50 fee will be charged for all medical appointments and $100 for any surgical or cosmetic appointment that is cancelled without providing proper notice. These fees can be waived at the discretion of the billing office, one time only or if there is an emergency (hospitalization, accident, etc…….) **INITIAL:_____**

Lab Fees: Please be advised that all specimens (biopsy, cultures, etc…) will be sent to an independent lab to be processed and you might receive a separate bill from that lab. **INITIAL:_____**

Returned Check Policy: A fee of $50 will be charged for each check that is returned (subject to change).

I certify that all the insurance information that I have provided is current and correct. I authorize Dermatology Center of the Palm Beaches to administer medical care as deemed necessary. I authorize the release of any medical information requested by my insurance carrier in order to process insurance claims. I understand that I am personally responsible for all fees, Including deductibles, co-pays and co-insurance incurred for services rendered to be or dependent. I authorize payment of insurance benefits paid on my behalf, to be made directly to Dermatology Center of the Palm Beaches. I authorize Dermatology Center of the Palm Beaches to release medical information to a 3rd party or its agents.

I certify that I have read this form in its entirety and will abide by the above policies.

Print Patient Name:_____ DOB:_____ Date:_____

Patients Signature(or other legally Authorized Persons)_____