FLORIDA INSTITUTE
OF DERMATOLOGY

Referred by: ☐ Friend ☐ Family ☐ Physician Referral Name: _____

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____

If Under Age 18 years, Parent/Guardian's Name: _____

Date of Birth: _____/_____/_____ SSN: _____-_____-_____ Birth Sex: _____ Gender Pronouns: _____

Ethnicity: _____ Preferred Language: _____ Marital Status: _____

Address: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Email Address: _____

Preferred Pharmacy: _____ Pharmacy Number & Address: _____

Occupation: _____ Employer: _____

Primary Care Physician: _____ PCP Phone Number: (_____) _____-_____

I understand that I may have an obligation to obtain a referral form my Primary Care Physician prior to my appointment. I acknowledge that if I do not have a required referral for today's visit, I am responsible for the services rendered should this be denied by my insurance company.

Signature: _____ Date: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Relationship: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Emergency Contact Name: _____ Relationship: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

CONSENT TO TREAT AND PAYMENT AUTHORIZATION

With my signature below, I voluntarily give consent for myself and/or my child to be examined and treated by the clinicians at Florida Institute of Dermatology. I also hereby assign and authorize payment of medical benefits to Florida Institute of Dermatology and payments may be made on my behalf directly for services rendered.

Signature: _____ Date: _____

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PATIENT HISTORY INFORMATION

Reason for visit: _____ How Long? _____

Skin History:

Have you ever had skin cancer? **Yes** **No** What type? _____ Who treated it? _____

Has anyone in your family had skin cancer? **Yes** **No** Who and what type? _____

Do you have a personal history of:

Eczema: **Yes** **No**

Psoriasis: **Yes** **No**

Other skin conditions: _____

When you are exposed to the sun, does your skin (circle one): **Burn Only** **Burn & Tan** **Tan Only**

Review of Systems: ***(please circle all that apply)***

Problems with bleeding	Night sweats	Joint aches	Anxiety
Problems with healing	Unintentional weight loss	Muscle weakness	Depression
Problems with scarring/keloids	Thyroid problems	Neck stiffness	
Rash	Sore throat	Headaches	
Immunosuppression	Blurry vision	Seizures	
Hay fever	Abdominal pain	Cough	
Chest pain	Bloody stool	Shortness of breath	
Fever or chills	Bloody urine	Wheezing	

Alerts: ***(please circle all that apply)***

Allergy to adhesive	Blood thinners	Pregnant or planning pregnancy
Allergy to lidocaine	Defibrillator	
Allergy to topical antibiotics	Pacemaker	
Artificial heart valve	Premedication prior to surgeries	
Artificial joints within the past 2 years	Rapid heartbeat with epinephrine	

Women:

Are you pregnant? **Yes** **No** If yes, when is your due date? _____

If not, are you planning to become pregnant? **Yes** **No**

Are you currently breastfeeding? **Yes** **No**

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PATIENT HISTORY INFORMATION

Have you been diagnosed with any of the following? (*please circle all that apply*)

Bronchitis	Heart murmur	Diabetes mellitus	Prior blood transfusions	**Other:**
Emphysema	Rhythm disorder	Thyroid disorder	Joint replacement	_____
Asthma	Heart defect	Rheumatoid arthritis	Organ transplant	_____
COPD	Mitral valve prolapse	Lupus	Cancer	_____
High blood pressure	Artificial heart valve	Kidney disease	Osteoporosis	_____
Heart disease	Thrombophlebitis	Bladder disorder	Hearing loss	_____
Heart attack or stents	Vein disease	Liver disease	HIV/AIDS	_____
High cholesterol	Stroke	Bowel disease		_____

Past Surgeries:

_____

_____

_____

Drug Allergies & Reaction:

_____

_____

_____

Social History:

Please circle: Current Smoker Former Smoker Never Smoker

How many packs/day? _____ For how many years? _____

Do you drink alcohol? **Yes** **No** How many per day? _____

Do you use recreational drugs? **Yes** **No**

What kind & how often? _____

For patients 65 and older:

Have you received a pneumonia vaccination? **Yes** **No**

Do you have a health care proxy? **Yes** **No**

If so, what is their name and number?

_____

Do you have a living will? **Yes** **No**

Which statement(s) best reflects your wishes on advanced care recommendations?

- ☐ **Do Not Intubate:** I do not wish to have a breathing tube, even if it is necessary to save my life.
- ☐ **Do Not Resuscitate:** If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life.
- ☐ **Full Cardiopulmonary Resuscitation:** I want full cardiopulmonary resuscitation efforts to be made.

Medication List:

Medication Name	Dose	How often?

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NOTICE OF PRIVACY PRACTICE

USES AND DISCLOSURES

1. During your course of treatment, it will be necessary for our practice to share your medical information in the following examples:
    - Laboratory Procedures: In order to correctly identify any specimens that we forward to the laboratory, we will need to include your medical information on the laboratory request form.
    - Physician Referral: If we determine that you should be treated by another physician in a different specialty, we will need to forward your medical information to that physician's office.
    - Billing and Collections: In order for our practice to receive payment from your insurance company, we will need to share your medical information with your carrier.
2. On a much less frequent basis, our practice may be required to disclose confidential information with your written consent for the following legal reasons:
    - Uses and disclosures for the public health activities
    - Reporting about victims of abuse, neglect or domestic violence
    - Disclosures for health oversight activities
    - Disclosures for judicial and administrative proceedings
    - Disclosures for law enforcement purposes
    - Uses and disclosures about decedents
    - Disclosures to avert a serious threat to health or safety
    - Uses and disclosures for specialized government functions
3. Any other uses and disclosures for your health information will require your individual written authorization of which you may revoke such authorization.
4. On occasion, our employees may contact you at home to provide appointment reminders or information about your treatment.

PATIENT RIGHTS

1. The right to request restriction on certain uses and disclosures, including a statement that the practice is not required to agree to a requested restriction.
2. The right to receive confidential communications.
3. The right to inspect and copy protected health information.
4. The right to amend protected health information.
5. The right to receive an accounting of disclosures of protected health information.
6. The right of an individual to obtain a paper copy of this notice from the practice upon request.

MEDICAL PRACTICE DUTIES

1. Our practice is required by law to maintain the privacy of confidential information and to provide our patients with notice of its legal duties and privacy practices with respect to such information.
2. Our practice is required to abide by the terms of the notice currently in effect.
3. Our practice reserves the right to change the terms of this notice and to make the new notice provisions effective for all confidential information that it maintains. Any revisions to our Privacy Practice Policy will be noted in this notice with an effective date of such change.

PRIVACY OFFICER

Our office manager, Tonya Taylor, is the designated Privacy Officer and can be reached at: (407) 395-3770.

I hereby acknowledge, by my signature below, that I have received, read, and understand the Notice of Privacy Practice:

Signature of Patient or Legal Guardian: _____ Date: _____

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FINANCIAL POLICIES

PAYMENTS

All co-payments must be paid at the time of service. This arrangement is a part of your contract with your insurance company. We accept MasterCard, Visa, Discover, American Express, cash, and checks. You are financially responsible to Florida Institute of Dermatology for the charges not paid by insurance and understand that those charges are due within 30 days of invoice. In addition to the bill from your provider at FID, you may also receive separate bills from the pathology laboratory and/or other specialized services.

COSMETICS

A credit card on file is required to schedule appointments and payment is expected in full at the time services are rendered.

MEDICAL APPOINTMENTS

A photo ID and valid insurance card is required at the time of your office visit. New patients should arrive 10 minutes prior to their scheduled appointment so that a complete chart can be processed into our computer system.

MISSED APPOINTMENT/LATE CANCELLATION POLICY

Please give us at least 24 hours advance notice prior to the cancellation of your appointment. This allows time for the appointment to be extended to other patients during the time we had reserved to you. Without notifying us, you will be considered a "no-show". **There is a $25 charge for no-shows for a general medical appointment and $200 for a surgical or cosmetic appointment.** This fee must be paid before further appointments are allowed. We will make every effort to remind you of your appointment via email and/or phone.

REFERRAL POLICY

You are responsible for all referrals/authorizations required to comply with your insurance plan. When required, you must obtain this prior to your scheduled appointment. If referral/authorization is denied or rejected by your insurance company, you will be responsible for all charges incurred.

MINOR PATIENTS

All minors have to be accompanied by a parent, legal guardian, or authorized adult over the age of 18 years. For unaccompanied minors, non-emergency treatment will be denied unless payment has been pre-authorized.

I hereby acknowledge, by my signature below, that I have received, read, and understand the Financial Policies:

Signature of Patient or Legal Guardian: _____ Date: _____

1991 Daniels Road, Winter Garden, FL 34787 ‖ P: (407) 395-3770 ‖ F: (407) 395-3779

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NON-DISCRIMINATION POLICY

Florida Institute of Dermatology complies with the applicable Federal rights laws and does not exclude or discriminate against any person on the basis of race, color, national origin, age, disability, sex, or gender identity. This state is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Section 1557 of the Affordable Care Act, and the Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, 91, and 92.

Florida Institute of Dermatology provides:

1. Free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other)
2. Free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact our office manager, Tonya Taylor, at: (407) 395-3770

If you believe that Florida Institute of Dermatology has failed to provide these services or you felt discriminated in another way on the basis of race, color, national origin, age, disability, sex, or gender identity, you can file a grievance by:

- Mail
- Email
- Fax
- In-person

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office of Civil Rights electronically though their online portal, available at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf. You may also reach them by mail, phone, or email at:

- U.S. Department of Health and Human Services
  200 Independence Avenue, S.W.
  Room 509F HHH Bldg.
  Washington, D.C. 20201
- 1-800-368-1019
- OCRComplaint@hhs.gov

I hereby acknowledge, by my signature below, that I have received, read, and understand the Nondiscrimination Policies:

Signature of Patient or Legal Guardian: _____ Date: _____