New Patient

Patient Name: __________________________ Age: ________ Sex: ________ Weight: ______ Height: ______ Date: _________

Are you currently taking any medication (including prescription, over-the-counter, herbs, vitamins/supplements)?

If yes, please list name, dosage, directions, and route of administration: ____________________________________

____

____

____

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list: ____________________________________

Do you have now, or have you ever had the following diseases or conditions:

Lungs:	Yes	No	**Other Systemic:**	Yes	No	**Artificial/Implanted Devices:**	Yes	No
Bronchitis	☐	☐	Diabetes	☐	☐	Hip	☐	☐
Emphysema	☐	☐	Thyroid	☐	☐	Knee	☐	☐
Asthma	☐	☐	Kidney	☐	☐	Shoulder	☐	☐
Tuberculosis	☐	☐	Gastrointestinal	☐	☐	Pins or Screws	☐	☐
			Hepatitis or Jaundice	☐	☐	Heart Valve(s)	☐	☐
Vascular:			Glaucoma	☐	☐	Heart Stent(s)	☐	☐
High Blood Pressure	☐	☐	Arthritis/Joint	☐	☐	Defibrillator	☐	☐
Chest Pain	☐	☐	Epilepsy or Seizures	☐	☐	Pacemaker with Defibrillator	☐	☐
Heart Attack	☐	☐	Fainting	☐	☐	Pacemaker w/o Defibrillator	☐	☐
Heart Murmur	☐	☐	Bleeding Tendency	☐	☐	Implanted Brain Devices	☐	☐
Irregular Heart Beat	☐	☐	Difficulty Healing	☐	☐	Other: __________________	☐	☐
Mitral Valve Prolapse	☐	☐	Emotional Disorders	☐	☐	Other: __________________	☐	☐
			HIV+	☐	☐			

Are you under the care of Hospice? ☐ Yes ☐ No

Have you ever had dental anesthesia (Novocain)? ☐ Yes ☐ No Any bad reaction? ☐ Yes ☐ No

Have you had any surgical procedures in the last six months? ☐ Yes ☐ No If yes, please list: ____________________

Have you ever had any problems with prior surgery? ☐ Yes ☐ No If yes, please list: ____________________

Are you currently pregnant, planning a pregnancy, or breastfeeding? ☐ Yes ☐ No

Do you have a history of cancer? ☐ Yes ☐ No If yes, please list: ____________________

Have you had a flu shot this season? (October thru March) ☐ Yes ☐ No

For patients 65 and over, have you received the pneumococcal vaccine? ☐ Yes ☐ No

Do you bleed easily? ☐ Yes ☐ No

Do you use tobacco products? ☐ Yes ☐ No Type/frequency _________ Are you interested in cessation counseling? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If yes, amount per week: _____

Skin: Have you ever had skin cancer? ☐ Yes ☐ No

Has anyone in your family had skin cancer? ☐ Yes ☐ No ☐ Melanoma

Do you have a history of any specific skin diseases? ☐ Yes ☐ No If yes, please list: ____________________

List any other disease or condition we should know about: ____________________________________

Other: What is your occupation? ____________________________________

How did you hear about us? ____________________________________

Who is your primary care physician? ______________________________

Health issues and procedures or products of interest to you (please check all that apply):

☐ BOTOX® (Botulinum Toxin Type A) ☐ Laser Resurfacing ☐ AHA & Glycolic Peels ☐ Sunscreen Advice

☐ Excessive Sweating (Hyperhidrosis) ☐ Hair Removal ☐ Facial/Eye Treatment ☐ Birthmarks

☐ Collagen Therapy ☐ Skin Rejuvenation ☐ Skin Care Advice ☐ Liver Spots/Age Spots

☐ Laser Treatment ☐ Chemical Peels ☐ Skin Care Products ☐ Acne/Sun Damage (Retinoids)

☐ Spider Vein Treatment ☐ Other, please specify: ____________________________________

(Updated July 2017)

Suncoast Dermatology and Skin Surgery Center, PA

New Patient Information

PLEASE PRINT CLEARLY Date: ________________

Patient Name: ____________________________________Date of Birth: _______________ Sex: M / F

Local Address: _______________________________ City: ______________ State: _____ Zip: _________

Alternate Address: ____________________________ City: ______________ State: _____ Zip: _________

Home Phone: __________________ Cell Phone: __________________ Work Phone: __________________

Email: ____________________________ I agree to receive periodic specials and promotions: ❑Yes ❑No

Marital Status: S M W D SS#: ____________________ Primary Care Physician: __________________

Employer: ____ Occupation: _______________________

Emergency Phone (other than your own): ______________ Name: ______________ Relationship: _______

Insurance Information: Please check with receptionist for insurance acceptance.

Physician Assistants/Advanced Registered Nurse Practitioners: This office employs Board Certified Physician Assistants (PAs) and Advanced Registered Nurse Practitioners (ARNPs). Occasionally and/or routinely your visit will encompass evaluation/treatment by a PA or ARNP as either a component of your visit or, if necessary, in place of the physician on staff. Our PAs and ARNPs work closely with and are supervised by our physicians in all aspects of your case.

Pursuant to and as required by the privacy regulations created due to Health Insurance Portability and Accountability Act of 1996 (HIPAA): With my consent, Suncoast Dermatology and Skin Surgery Center, PA, may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). A complete Notice of Privacy is posted for a complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent form. Suncoast Dermatology reserves the right to revise its Notice of Privacy Practices at any time. A copy of a revised notice can be obtained at any time by forwarding a written request to the office.

By signing this form, I am consenting to Suncoast Dermatology's use and disclosure of my PHI to carry out TPO. I may revoke or restrict my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Suncoast Dermatology will decline to provide treatment to me as they will be unable to carry out treatment, payment, and healthcare operations without my consent.

Pursuant to regulations set forth by the Board of Medicine in Chapter 64B8, Florida Administrative Code: I understand that it may be necessary to perform a procedure during my visits with this office to necessitate diagnosis and/or treatment. I understand that this may require local anesthetics. I will be informed as to the type, the necessity, and any possible complications (to include, but not limited to: scarring, bleeding, and infection). I understand an outside laboratory will be utilized for all specimens obtained, and that it is my responsibility to follow up on tests which are performed or ordered by this office. The outside company performing the test will bill independently for their work on your specimen/visit.

Clinical Photography: I understand that clinical photographs may be taken by my healthcare provider during my visit for the express purposes of diagnosis, treatment, and professional education. Clinical photographs are considered part of the permanent health record and can be released as such according to state and federal regulations.

Telephone Authorization: I consent to receive calls from providers of Suncoast Dermatology regarding my protected healthcare and other services at the phone number(s) I have listed, including my wireless number provided. I understand I may be charged for such calls or texts, if applicable, according to my plan with my wireless carrier, and that such calls may be generated by an automated dialing system.

How did you hear of us? ❑ Phonebook ❑ Online ❑ Billboard ❑ Magazine ❑ Newspaper ❑ Other __________

Patient/Legal Guardian Acknowledgement: ____ Date: ______________

Welcome to our practice. We ask that you review this form which sets forth some of our financial policies. All patients have the opportunity to obtain a copy of this form upon request.

Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment for any claim. Please remember that insurance is a method of reimbursing the patient for fees paid to the doctor and not a substitute for payment. Insurance companies vary widely in their calculations and payments to the healthcare industry; therefore, our office is not liable for any insurance reductions based on the policy or plan you have chosen.

MEDICARE: We are a participating Medicare provider. You are responsible for 20% of the approved amount as well as any deductible. We collect your portion of Medicare at the time of your visit. You are responsible for any cosmetic services.

MEDICARE SUPPLEMENT: Several plans have signed an agreement with Medicare to automatically cross over. We have direct access to Medicare's computer and can dial in to see if they have your secondary insurance listed as a Medigap or crossover. If your insurance is included in this list, we will file it for you. If your insurance is not listed, you will be responsible for paying the 20% allowable at the time of service. We will provide you with appropriate paperwork so that you may file your secondary insurance in order to obtain reimbursement.

BLUE CROSS/BLUE SHIELD OF FLORIDA: We are participating with traditional BCBS of Florida, PPO plans, and some HMO plans. You are responsible for any co-insurance, copay, or deductible at the time of service. If you have an HMO, please confirm with your plan prior to your visit as you will not be reimbursed by your HMO if we are not in network. You are responsible for any cosmetic services.

AETNA / CIGNA / HUMANA / UNITED HEALTHCARE: We are in network for many of the plans offered by these insurance companies. Due to the overwhelming number of plans, please contact your carrier to confirm our providers are in network. If you have an HMO, please confirm with your plan prior to your visit as you will not be reimbursed by your HMO if we are not in network. You are responsible for any cosmetic services.

CHAMPUS/CHAMPVA/TRICARE: We do not accept this insurance unless prior arrangements and criteria have been met. You must have plan approval with the Suncoast Dermatology Accounting Department prior to your claim being filed. All others will be expected to issue payment at time of service. All patients who will have or who have prior approval and claims filed, will be expected to pay any applicable copay or deductible at the time service is rendered. You are responsible for any cosmetic services.

MEDICAID: We do not accept Medicaid nor any of the Medicaid HMO plans. You are responsible for payment at the time of service. We will accept a Medicaid referral only if your primary care physician has specifically spoken to and referred you to our office. You are responsible for any cosmetic services.

HMO / MANAGED CARE: We do participate with some HMO/managed care plans. Please confirm with your plan prior to your visit as you will not be reimbursed by your HMO if we are out of network.

COMMERCIAL OR PRIVATE INSURANCE PLANS: Payment is expected at the time services are rendered.

NO INSURANCE: Payment is expected at the time services are rendered. If you must set up a payment plan, we ask that you meet with our accounting office prior to your visit to determine eligibility.

COSMETIC PROCEDURES: All cosmetic procedures are payable prior to the service being rendered.

PAYMENT METHOD: Our office accepts checks, cash, MasterCard, and Visa. If payment is made over the phone, an additional 3% bank fee is incurred. The patient is responsible for this convenience fee.

NO-SHOW APPOINTMENT: It is our office policy to post a charge for no-shows in the amount of $25 for office visits and $100 for surgical procedures. This fee is assessed if we do not receive notification of cancellation from the patient prior to the scheduled appointment.

I understand the above written financial policy. I hereby authorize insurance benefits to Suncoast Dermatology and Skin Surgery Center, PA, for any assigned claims. I understand that any fees which are not paid by a non-participating insurance company within 45 days will revert to patient responsibility. I understand that my refusal to sign this form will result in Suncoast Dermatology being prohibited from filing any claim on my behalf and as a result I must issue payment in full at the time services are rendered.

Patient/Legal Guardian Acknowledgement: ______________________________ Date: __________

Suncoast Dermatology and Skin Surgery Center, P.A.

Acknowledgment of Financial Responsibility

Dear Patient:

By acknowledging this notice you understand that it is solely the responsibility of the insurance policy holder to contact their insurance carrier to discuss your health care benefits, network eligibility, and patient financial responsibility.

As for our out-of-network patients, our office will submit the claim to your insurance carrier as a courtesy, but the patient is responsible for the charges.

If you have elected to see a provider who is outside of your insurance's network, or a non-participating provider, or are on a plan which does not include Suncoast Dermatology or its providers, your insurance company may reduce or deny payment or subject you to a higher co-pay and/or deductible.

Because your insurance plan is a contract held between you and your insurance company, we are unable to project what they will or will not pay. While we are willing to work with you, we are not liable for any reduction of payment from that company based on your contract with them.

Thank you,

Suncoast Dermatology Billing Department

____________________________________ ____________________

Patient Signature Date

Updated: July 2017

Suncoast Dermatology and Skin Surgery Center, PA

Authorization to Release Protected Health Information to Family Members

The Health Insurance Portability and Accountability Act (HIPAA) requires that all medical providers, insurance companies, and others put in place controls to ensure that your personal medical information is safe. Under HIPAA guidelines, Suncoast Dermatology and Skin Surgery Center, PA, is unable to release this information to anyone without the patient's consent.

Many patients allow family members, such as their spouse, parents, or others, to obtain results of tests and procedures. If you would like your test results released to family members, please indicate below to whom you wish to share results with and then sign and date. This will give Suncoast Dermatology and Skin Surgery Center permission to release laboratory/pathology results to the family members indicated below.

You have the right to rescind your consent, in writing, except where we have already made disclosures based on your prior consent.

Please choose one:

- ☐ I authorize Suncoast Dermatology and Skin Surgery Center, PA, to release my laboratory/pathology results and reports to the following individual(s).

    1. Name/Relationship: __________________________ Phone: ___________
    2. Name/Relationship: __________________________ Phone: ___________
    3. Name/Relationship: __________________________ Phone: ___________

- ☐ I do not authorize Suncoast Dermatology and Skin Surgery Center, PA, to release my laboratory/pathology results and reports to any family members at this time.

Patient/Guardian Signature: __________________________ Date: ______________

Patient Name: _____________________________________ Account #: __________

Updated: July 2017

Allen Ridge Professional Village: 525 N. Dacie Pt. (County Road 491) ● Lecanto, FL 34461-8399 ● (352) 746-2200
Timber Ridge: 9401 SW Hwy 200 ● Ocala, FL 34481-7700 ● (352) 873-1500

Suncoast Dermatology and Skin Surgery Center

Allen Ridge Professional Village • 525 N Dacie Pt •Lecanto, FL 34461 • (352) 746-2200
Timber Ridge Medical Park • 9401 SW Hwy 200, Suite 1001 • Ocala, FL 34481 • (352) 873-1500

We would like to invite you to join our Free Newsletter!

Our newsletters provide our patients the opportunity to stay up to date with our latest cosmetics specials/discounts, noteworthy news, and special events! We would love to keep you informed too!

☐ Yes! I would like to sign up to receive Suncoast Dermatology's newsletter.

Email Address: ____

☐ No thank you! I do not wish to join Suncoast Dermatology's newsletter at this time.

Suncoast Dermatology and Skin Surgery Center takes your privacy very seriously. We utilize a highly reputable email service, Constant Contacts, to build and send our newsletters. While this company is HIPAA compliant, it is important to understand that any information transferred via the internet may become compromised. For this reason, we will never use this service to communicate your health care with you. In addition, we will not knowingly share your information with any other sources.

If at any time you decide to forgo receiving any further newsletters, you may opt out by clicking "unsubscribe" located at the bottom of every email.

We thank you for allowing us the opportunity to share our newsletter with you!

Signature of Patient or Legal Guardian: ________________________________ Date: ____________

Print Name of Patient or Legal Guardian: ____

Updated: July 2017