DERMATOLOGY
ASSOCIATES OF TAMPA BAY

DEMOGRAPHICS

Legal Name: _____
Marital Status: Married Single Divorced Widowed **Date of Birth**: _____
Birth Sex: Female Male
Language: English Spanish Other Declined
Ethnic Group: Hispanic or Latino Non-Hispanic or Latino Declined
Race: White African American Asian Other Declined
Emergency Contact: _____ Phone: _____
Guarantor if applicable: _____ Phone:_____
DOB:_____ Relationship: _____
Preferred Phone: _____ Cell/Home Alternative Phone: _____ Cell/Home
Permission to leave detailed message: Yes No
Email Address: _____ **Opt in for email notifications**: Yes No
Street Address: _____
City / State: _____ Zip Code: _____

Preferred Pharmacy: _____ Zip Code: _____
Phone Number: _____

Insurance Information-- Please present all insurance cards
*****NOTICE*** Physician and staff are not responsible for determining if practice is in or out of network with your insurance plan. I understand that I must contact my insurance to determine my benefits and coverage for care at this office. Initials:_____**

Insurance Company Name: _____
Full Name of Insured: _____ DOB (insured): _____
Relationship to Patient: Self Spouse Child Other
Secondary Insurance Company Name (if applicable): _____

I hereby grant permission to Dermatology Associates of Tampa Bay, LLC. to render such medical and/or surgical treatment only after it has been discussed and deemed necessary and to release any information via fax or other method including payment, treatment or health care operations per HIPAA guidelines. I understand I am responsible for all services rendered, insurance copays, coinsurance and/or deductibles. If my account becomes overdue I understand that my account may be turned over to a collection agency.

Signature: _____ Date: _____

MEDICARE and Medigap (secondary insurance)PATIENTS:
I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Dermatology Associates of Tampa Bay, LLC. Regulations pertaining to Medicare assignements of benefits apply. I authorize Medigap (secondary insurance) benefits to be made on my behalf for any services furnished to me. I authorize any holder of medical information to released to the above Medigap (secondary) carrier any informaiton needed to determine these benefits payable for related services.

Signature: _____ Date: _____

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PATIENT NOTICE OF PRIVACY PRACTICES AND COMMUNICATIONS

Dermatology Associates of Tampa Bay, LLC. will use your information for the following:

1. TREATMENT: Including providing your medical records to consulting clinicians and insurance companies.
2. PAYMENT: We will file necessary claims to insurance companies in your name to obtain payment. They may request part or all of your medical record to pay the claim.
3. HEALTH CARE OPERATIONS: Any others involved in your healthcare.

The entire Private Policy Notices is posted in the waiting room as well as at www.dermassociatesoftb.com

From time to time, we may need to contact you or discuss your medical information with your family or someone else of your choosing. The information shared will be the minimum necessary based on the professional opinion of the healthcare provider.
For laboratory results and other information communicated to you by phone, you will be contacted by one of our clinical staff.

1. With whom may we speak regarding your health (ie: spouse, child, parent, etc)?

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

2. May we call you, and if necessary, leave a message on your voicemail regarding:
Results: Call you: YES NO Leave a message: YES NO
Your health: Call you: YES NO Leave a message: YES NO
Appointments: Call you: YES NO Leave a message: YES NO
Billing matters, including that a charge in excess of $50 will be posted to your card on file: Call you: YES NO
Leave you a message: YES NO
Information regarding the practice: Call you YES NO Leave you a message YES NO

3. May we send you emails regarding latest medical trends, new products, and information regarding the practice:
YES NO use email on file OR other email address: _____
We do not send medical or otherwise confidential infomation to you via email. We use a third-party tool (ie: Constant Contact) to provide these email updates to you. You may opt-out of receiving these updates at any time.

You may choose to email us information using regular email from time to time. While email is convenient, it does pose several risks. Please see the "Important Notice About Email Communications" notice for additonal details.

Receipt of Notice of Privacy Practices and Notice About Email Communications:
My signature below indicates that I have reviewed and if requested received a copy of my physician's "Notice of Privacy Practices" and "Important Notice About Email Communications."

Patient Signature/Legally Authorized Representative: _____ Date: _____
Relationship to patient: Parent Spouse Legal Guardian Power of Attorney Next of Kin

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FINANCIAL POLICY

In our efforts to go green and keep the cost of healthcare down we have implemented the following financial policy to cover incidentals. Our policy is very similar to a hotel check-in procedure.
If we are providers for your insurance company, you will be asked to pay the copay, deductible and/or coinsurance amounts as dictated by your insurance plan. These charges will be held in Modernizing Medicine's (our service provider) vault until your insurance has paid their portion and/or notified us of your finacial responsibility. At that time, any remaining balance due to Dermatology Associates of Tampa Bay, LLC. will be charged to your card on file.

If we are NOT providers for your insurance plan OR you do not wish to participate in our financial policy, you will be required to pay in FULL at the time of service.

We will file your medical claim to your insurance company. If after receiving your Explanation of Benefits (EOB) from the insurance company it reflects any over-payment on your part, any credits will be refunded to you on the credit card used for payment or if paid by cash or check a check refund will be issued.

Our credit card on file policy in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. Copays, deductible and coinsurance amounts will, of course, still be due at the time of your visit.

It is in your best interest to understand your insurance plan. This credit card policy will be an advantage to you as you will no longer have to prepare and mail us checks. This policy benefits everybody by keeping the cost of healthcare down, and by allowing us to concentrate first and foremost on your medical needs.

We care about the security of your credit card information. We take a number of steps to protect your credit card information. Once entered into Modernizing Medicine (our service provider) the information is encrypted and only show our staff the last four digits of the card and the expiration date. This information is stored once the card is swiped by the front desk. The security of our system is monitored 24/7 by Virtumarc. We also utilize the Sophos Firewall.

Please note: You will receive a courtesy call to advise of any charges that will be posted in excess of $200.00. Insurance companies normally take 2-3 weeks to process claims.

Please do not hesitate to ask if you have any questions.

Patient Name:_____ Date of Birth: _____

Signature: _____ Date: _____

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NO SHOW ACKNOWLEDGEMENT

At Dermatology Associates of Tampa Bay we schedule our appointments so that each patient receives enough time with our physicians and staff. That is why it is especially important that each patient arrives on time and is prepared for their scheduled appointment with our office.

In an effort to better serve our patients, we require a 24-hour advance notice, if you are unable to keep your scheduled appointment. Each time a patient misses an appointment without providing proper notice, a patient on the waiting list is prevented from receiving care. Keeping appointments is in the patient's best clinical interest.

If the patient does not cancel or reschedule their appointment at least 24 hours prior to the scheduled time we may assess

- a **$75** "no show and/or late cancellation" fee for **general dermatolgy appointments**.
- a **$150** "no show/late cancellation" fee for **surgical and/or cosmetic procedure appointments.**

This fee is non-refundable and is not reimbursable by patient's insurance company. This fee must be paid prior to the patient rescheduling their appointment.

By signing this form I acknowledge the importance of keeping my scheduled appointments and agree to notify the office at least 24-hours in advance of my appointment, if I am unable to keep it. I also acknowledge that there could be the potential of dismissal from the practice if there are three no show appointments that occur in any twelve month period.

_____ _____

Patient Signature Witness Signature

_____

Date

6001 Memorial Highway, Tampa, FL 33615
(813) 884-1626 | DermAssociatesofTB.com

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PAST MEDICAL HISTORY

PATIENT NAME: _____ DOB:_____

PAST MEDICAL HISTORY (Please check all that apply)

☐Anxiety
☐Arthritis
☐Asthma
☐Atrial Fibrillation (Irregular Heartbeat)
☐Bone Marrow Transplant
☐Hyperthyroidism
☐Breast Cancer
☐Colon Cancer
☐COPD
☐Coronary Artery Disease
☐Depression
☐Diabetes
☐End Stage Renal Disease
☐GERD (Acid Reflux)
☐Other
☐Hepatitis
☐HIV/AIDS
☐Hypertension (High Blood Pressure)
☐Hypercholesterolemia (High cholesterol)
☐BPH (Enlarged prostate)
☐Hypothyroidism
☐Leukemia
☐Lung Cancer
☐Lymphoma
☐Prostate Cancer
☐Radiation Treatment
☐Seizures
☐Stroke
☐Hearing Loss
☐**NONE of the above**

PAST SURGICAL HISTORY (Please check all that apply)

☐Appendix Removed ☐Bladder Removed
☐Kidney Biopsy ☐Kidney Removed: ☐Right ☐Left ☐Both
☐Kidney Stone Removal ☐Kidney Transplant
☐Liver Transplant ☐Tubal Ligation
☐Hysterectomy for: ☐Fibroids ☐Uterine Cancer ☐Cervical Cancer
☐Breast Biopsy
☐Lumpectomy: ☐Right ☐Left ☐Both
☐Mastectomy: ☐Right ☐Left ☐Both
☐Ovaries Removed for: ☐Endometriosis ☐Ovarian Cyst
☐Colon Removed for: ☐Colon Cancer ☐Diverticulitis ☐IBD (Inflammatory Bowel Disease)
☐Colostomy ☐Gallbladder Removed
☐Spleen Removed ☐Coronary Artery Bypass
☐Pacemaker ☐Pancreas Removed
☐Mechanical Valve Replacement ☐Biological Valve Replacement
☐Joint Replacement, Knee: ☐Right ☐Left ☐Both
☐Joint Replacement, Hip: ☐Right ☐Left ☐Both
☐Prostate Removed: ☐Prostate Cancer
☐Prostate: Biopsy ☐Prostate: TURP

☐Skin Cancer Surgery: ☐Not sure of type ☐Squamous Cell Carcinoma
☐Basal Cell Carcinoma ☐Other Type: _____
☐**NONE of the above**

SOCIAL HISTORY

Do you smoke? Never Former Smoker Daily Less than daily

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PAST MEDICAL HISTORY

SKIN DISEASE HISTORY (please check all that apply)

☐Acne
☐Asthma
☐Blistering Sunburns
☐Eczema
☐Hay Fever/Allergies
☐Poison Ivy
☐Psoriasis
☐Squamous Cell Carcinoma in situ
☐Skin Cancer but not sure what kind
☐**NONE of the above**
☐Actinic Keratosis (Precancerous skin growths)
☐Basal Cell Carcinoma
☐Dry Skin
☐Flaking or Itchy Scalp
☐Melanoma
☐Precancerous Moles (atypical nevi or dysplastic nevi)
☐Squamous Cell Carcinoma
☐Other Kind of Skin Cancer
☐Other Skin Disease or Condition

CURRENT MEDICATIONS

Please list all current prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary or nutritional supplements.) * If you brought a list of medications with you, we can use your list. *

Medication	Dosage	Frequency	How Taken

ALLERGIES (Please list all medication allergies)

_____ _____ _____
_____ _____ _____

Are you allergic or sensitive to:

Adhesive: YES NO Epinephrine YES NO
Lidocaine: YES NO Latex YES NO
Any other types of allergies? _____

FAMILY HISTORY

Has anyone in your family ever had?
Melanoma YES NO If YES, please list biological relationship _____
Any other kind of skin cancer? YES NO Pre-cancer? YES NO
Additional Family History: ☐Asthma, ☐Hay Fever, ☐Eczema, ☐Psoriasis, ☐Diabetes, ☐Thyroid Disease, ☐Arthritis, ☐Lupus, ☐any other Skin Disease? _____ (Please check all that apply)

For patients over 65 years of age:

Medical Proxy:
Person who makes medical decisions on your behalf, if you are not able to?

Name: _____ Phone number: _____
Do you have a living will? YES NO
Have you had your pneumococcal vaccination? YES NO