Premier Dermatology of Florida
109 Whitehall Drive, Unit 117 | Saint Augustine, FL 32086
T: 904-460-2388 | F: 904-460-2689

Patient name (print Last, First, M) _____

Preferred name _____ Birth date ____/ ____/ _____ Age ____ Gender ___

Marital status _____ Social security number __ __ __ - __ __ __ - __ __ __ __

Mailing address _____

Race _____ Ethnicity _____ Language _____

Home phone (_____)_____ Work phone (_____)_____

Mobile phone (_____)_____ Email _____

Employer _____ Occupation _____

Name of Referring Physician _____ Phone (_____) _____

Name of Primary Care Physician _____ Phone (_____)_____

In case of emergency, who should be contacted _____

Phone (_____)_____ Relationship _____

RESPONSIBLE PARTY INFORMATION: *(to be completed for minors only)*

Responsible party name (Last, First, M) _____

Address _____ Phone (_____) _____

Birth date ____/____/_____ Age _____ Social security number __ __ __ - __ __ __ - __ __ __ __

Relationship _____

PRIMARY INSURANCE TO FILE: HMO *(Referral required)* PPO

Insurance company name _____

Address _____

Policy/ID # _____ Group # _____

Subscribers name _____ Birth date ____/ ____/ _____

Relationship to patient _____ Phone (_____) _____

Subscribers address _____

SECONDARY INSURANCE TO FILE/IS PATIENT COVERED BY ADDITIONAL INSURANCE:

HMO PPO

Insurance company name _____

Address_____

Policy/ID # _____ Group # _____

Subscribers name _____ Birth date ____/ ____/ _____

Relationship to patient _____ Phone (_____) _____

Subscribers address _____

PHARMACY

Please indicate your pharmacy of choice below. All prescriptions will be called into this location for your convenience.

Pharmacy name: _____ Crossroads: _____

I VERIFY THAT THE ABOVE INFORMATION IS CORRECT

X _____ Relationship to patient _____ Date ____/____/_____

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Patient name (print): _____ Birth date ____/ ____/ _____

Are you pregnant/nursing? ___Y ___N

Are you allergic to any medications (including latex, adhesives, or Lidocaine)? ___Y ___N

Please list: _____

List all medications (including creams) you are taking: _____

_____

_____

_____

_____

_____

_____

_____

_____

Do you take any blood thinners? ___Y ___N Do you have any artificial joints? ___Y ___N

Do you have a pacemaker or defibrillator? ___Y ___N

Do you take antibiotics prior to dental work? ___Y ___N

Have you ever had skin cancer? ___Y ___N What type? _____

Has anyone in your family had skin cancer: ___Y ___N

Who and what type? _____

Do you have a history of any skin diseases? ___Y ___N Please list:_____

Do you have advanced directives? ___Y ___N

List any other disease or medical conditions you have: _____

List surgical procedures in the last 6 months: _____

List any hospitalizations in the last 6 months: _____

Do you have now, or have you ever had diseases or conditions of:

LUNG		OTHER SYSTEMICS	
Bronchitis	___Y ___N	Diabetes	___Y ___N
Emphysema	___Y ___N	Thyroid	___Y ___N
Asthma	___Y ___N	Kidney	___Y ___N
Chronic cough	___Y ___N	Bladder	___Y ___N
Morning cough	___Y ___N	Stomach	___Y ___N
VASCULAR	___Y ___N	Hepatitis	___Y ___N
High blood pressure	___Y ___N	Glaucoma	___Y ___N
Chest pain	___Y ___N	Arthritis/joint	___Y ___N
Heart Attack	___Y ___N	Seizures/epilepsy	___Y ___N
Heart Murmur	___Y ___N	Fainting	___Y ___N
Irregular Heartbeat	___Y ___N	Answered YES to any please explain	
Pacemaker	___Y ___N	_____	
Phlebitis	___Y ___N	_____	

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PLEASE ANSWER THE FOLLOWING QUESTIONS

Do you drink alcohol? ___Y ___N If yes, _____ drinks per week

If yes, how often did you have 6 more drinks on ONE occasion?

__ Never __ Less than monthly __ Monthly __ Weekly __ Daily or almost daily

How many drinks did you have on a typical day when you were drinking in the last year?

__ 1 or 2 __ 3 or 4 __ 5 or 6 __ 7 or 9 __ more than 10

How often did you have a drink containing alcohol in the past year?

__ Never __ Monthly or less __ 2-4 times/month __ 2-3 times/week __ 4 or more times a week

Do you use IV drugs? ___Y ___N Are you a __ current __ former or __ nonsmoker?

If current, how much? _____

Do you bleed easily? ___Y ___N Do you bruise easily? ___Y ___N

Have you ever used a tanning bed? ___Y ___N

Have you ever received a pneumonia vaccine? ___Y ___N If yes, date (M/Y) _____

Have you ever received an influenza vaccine? ___Y ___N If yes, date (M/Y) _____

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REASON FOR TODAY'S VISIT

_____

_____

_____

How long has it been going on?_____

Please provide a brief history: _____

_____

_____

_____

Does anything make it better? _____

_____

_____

Does anything make it worse? _____

_____

_____

What have you tried so far (please include over the counter meds or topicals)? _____

_____

_____

_____

Are you experiencing or do you have:

__ itching	__ acne	__ hair loss	__ seasonal allergies
__ bleeding	__ new lesion	__ fevers	__ unintentional weight loss
__ pain	__ joint pains	__ chills	__ history of allergies to products
__ rash	__ oral ulcers	__ dry skin	__ family history of scarring acne
__ sun sensitivity	__ irregular menses	__ redness	__ family history of melanoma
__ flushing	__ unwanted hair	__ itchy eyes	__ family history of autoimmunity

COSMETICS

Are you interested in cosmetic products? ___Y ___N

If yes, please provide email _____

Have you ever had Botox or cosmetic fillers? ___Y ___N

If yes, what products _____

Do you currently have a skin care regimen? ___Y ___N

What are you using? _____

_____

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It is the policy of Premier Dermatology of Florida that ALL minor patients must be seen at the first visit with a parent or legal guardian present. After the first visit, the minor patient may be seen and treatment for that SAME DIAGNOSIS without a parent/legal guardian present as long as there is a signed release from the parent/legal guardian in the minor patient's file. However, if the patient presents with a new diagnosis we will need to be able to reach the parent/legal guardian by phone to consult about any new treatment plan and obtain authorization for new medications or treatments.

Please fill out one of the two options below:

_____ **Consent to treatment of Minor Patient**

I, _____, authorize Premier Dermatology of Florida and the staff employed there to treat my minor child _____ with a date of birth ____/ ____/ _____

_____ **Non-consent to treatment of Minor Patient**

I, _____ , do not want my minor child _____ with a date of birth ____/ ____/ _____ treated or evaluated for any condition without a parent/legal guardian present.

This authorization is good for one calendar year and will need to be re-signed every year until the patient turns eighteen years of age.

Signature: _____ Date: ____/ ____/ _____

Print name: _____ Relationship: _____

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Patient name (print): _____ Date: ____/ ____/ _____
Address: _____ Birth date: ____/ ____/ _____
_____ Phone (_____)_____

I authorize Premier Dermatology of Florida to:

_____ Send copies of your record to (discuss information with) the physician/person/facility below

OR

_____ Receive copies of your record from (or discuss your information with) the physician/person/facility below.

Name of Physician/Person/Facility: _____
Address: _____
City/State/Zip: _____
Phone (_____)_____ Fax: Phone (_____)_____

Information to be disclosed:

_____ Progress Notes
_____ Pathology/Lab Reports
_____ Operative Notes
_____ Cosmetic Notes
_____ Entire Medical Record

Restrictions: *Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. The records above may be faxed in the case of medical necessity. This authorization may be canceled at any time by submitting a written request* to *Premier Dermatology of Florida.*

Patient gives consent to download information from pharmacies and other external sources as needed for medical care.

I have read the above foregoing Authorization for Release of Medical Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient/Representative signature: _____ Date: ____/ ____/ _____

Parent/Guardian signature required for minor (less than 18 years of age)

Relationship to patient (if other than self): _____

Printed name of authorized representative: _____ _

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Patient name (print): _____ Birth date: ____/ ____/ _____

If our physician finds it necessary to do any of the following: biopsies, removals, or order labs, the results of these tests may be given to you by a call to the phone numbers you have listed on your demographic form. We will not leave a message with the actual pathology or lab result on your voicemail/answering machine. Instead, we will leave a message asking you to call use back when it is convenient for you.

The time frame in which we receive these results can vary. However, the normal time frame for results is 10-14 days. If special tests are ordered, this can prolong the delivery of your test results to our office.

If you have not heard from our office within 2 weeks of your appointment, please call for results.

It is important that we know where you are comfortable having a message left if we are unable to reach you by phone. Please SELECT one of the following options regarding whom we may talk to and where we can leave a message.

_____ ***I DO CONSENT TO LEAVE A DETAILED MESSAGE AND/OR DISCUSSION:***

I give Premier Dermatology of Florida and their staff permission to leave messages on or to' discuss my medical care and/or billing account with the following:

My home phone voicemail # (_____) _____ Medical care ___ Billing ___

My cell phone voicemail # (_____)_____ Medical care ___ Billing ___

My work phone voicemail # (_____)_____ Medical care ___ Billing ___

Spouse (name) _____ Phone (_____) _____ Medical care ___ Billing ___

Other (name) _____ Phone (_____)_____ Medical care ___ Billing ___

Signature: _____ Date: ____/ ____/ _____

_____ ***I DO NOT CONSENT TO LEAVE DETAILED MESSAGES:***

I would like to be contacted personally, I do not authorize Premier Dermatology of Florida or any of its employees to leave messages or have discussions regarding my medical care and/or billing account with anyone other than myself.

Signature: _____ Date: ____/ ____/ _____

Premier Dermatology of Florida
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We want to thank you for choosing us as your dermatology provider. In order to give you and all of our patients the best possible care, we request that you review our policy.

Cancellation and No Show Policy: Consultation and exam time slots are limited and valuable. In an effort to serve you better, we ask for proper notice for any cancellation. All patients are required to give at least 24 hours advanced notice when cancelling an appointment.

While we do provide a reminder call before your appointment, it is *your responsibility* to remember your appointment.

Patients failing to give 24 hours notice ("same day cancellation") or giving no notice at all ("no show") will be charged $30 for any missed appointments. If this should happen more than twice, a $60 charge **will** be incurred for the third incident. All fees must be paid before a new appointment can be scheduled. After three (3) missed appointments, the practice may at its discretion choose to discontinue your care.

Late Arrival Policy: We make every effort to be on time for all of our appointments. When one patient arrives late, it disrupts the entire schedule when we attempt to "squeeze in" that patient which, unfortunately, affects that patient as well as those patients who did arrive on time and are now waiting. Therefore, it is very important that all patients honor their reserved appointments.

If you are a *new patient,* we ask that you arrive **20 minutes** prior to your appointment time in order to complete your forms and complete registration. This allows our receptionists the necessary time to review your paperwork to ensure completion. If you arrive at or after your appointment time, you ill be asked to reschedule unless the physician's schedule can still accommodate you.

If you are an *established patient,* we ask that you arrive **15 minutes** prior to your appointment time in order to review your forms and complete the registration form. If you arrive at or after your appointment time, you will be asked to reschedule unless the physician's schedule can still accommodate you.

Priority will be given to the patients who arrive on time and you may have to be worked in between them. This may mean you will have a considerable wait.

We ask that you please be courteous of your provider's time and attention. The physician, office staff, and your fellow patients will thank you.

I understand and agree to abide by this Cancellation, No Show, and Late Arrival Policy.

Patient name (print): _____ Birth date: ____/ ____/ _____

Patient/Parent/Guardian signature: _____

Date: ____/ ____/ _____

PREMIER DERMATOLOGY OF FLORIDA

Premier Dermatology of Florida
109 Whitehall Drive, Unit 117 | Saint Augustine, FL 32086
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Patient name (print): _____ Birth date: ____/ ____/ _____

Account # _____

Parent or Legal Guardian of Patient (print): _____

Insurance: We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but do not have an up to date insurance card, payment in full for each visit is required until we can verify your coverage.

Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Copayments, deductibles. and co-insurance: All copayments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments, deductibles, and coinsurance from patients can be considered fraud. Please help us uphold the law by paying copayment each visit.

Self-Pay Services: We offer a self pay schedule for patients who are do not have insurance or have insurance with a plan we do not do business with. Payment is expected to be made in full at time of service.

Non-covered services: Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by our insurance company. Biopsies, excisions, or removals of any type done in this office are sent to a dermatopathologist for testing and associated charges are separate from the charges incurred in this office, and are your responsibility. We will use the pathologist specified by your insurance to the best of our ability, however, we may find it necessary to go out of network for you to receive the best medical testing and diagnosis possible.

Referral and Pre-authorization: It is your responsibility to ensure that any referrals or pre-authorizations required by your insurance company be provided to our office prior to services being rendered. Failure to obtain required referrals or pre-authorizations will result in you being responsible for the full balance.

Proof of Insurance and Government approved ID: All patients must complete our patient information form before seeing the doctor. A current and valid insurance card and Government issued ID card must be presented at the time of service. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

Claims submission: We will submit your claims and assist you in any way we reasonable can to help get your claims paid. Your insurance may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your company pays your claim. Your insurance contract is between you and your insurance company. We are not part of that contract.

Coverage Changes: If your insurance changes please notify us so we can make the appropriate changes to help you receive your maximum benefits.

Payment: All copayments and past due balances are due at the time of check-in. Patients may pay by cash, check, or credit card, which can include credit cards to pay from your "flexible spending account" and/or "health savings account." Should your check be returned to us for insufficient funds, we will attach a $25 service fee to our account and all subsequent visits will be on a cash or credit card basis.

Nonpayment: All balances are the responsibility of the patient/parent/guardian. If you are unable to meet our financial obligation, payment arrangements can be made by contacting our Billing Representative. Accounts become delinquent after 90 days. The account will be sent to a collection agency after we have mailed out 3 statements; one (1) "Final Notice" letter as well as a courtesy phone call in our attempt to resolve your delinquent account. Collection fees of $50 will be automatically charged on your account once submitted to the collection agency due to our time and effort. All collection accounts must be paid in full before future care in our office will be permitted.

Minor patients: The accompanying parent or legal guardian of the minor child receiving treatment will be responsible for payment. You will be considered the minor's responsible party for all services rendered and payment.

Cancellation and Missed Appointments: We understand that unexpected events, illnesses, etc. occur. When this happens, please call our office as soon as possible to inform us. In the case of missed appointments or cancellations within 24 hours of the appointment, a $30 fee will be billed to my account, which is not covered by your insurance company.

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Credit Card on File: Recent changes in healthcare markets have altered insurance coverages to shift more of the cost of care to our patients. Many policies have higher deductibles which means, even if a procedure is covered by insurance, you may still receive a bill. These external factors make it necessary for Premier Dermatology of Florida to maintain a credit card on file for all commercially insured patients. The card information is stored with security. Should you have a balance after your visit, we will mail out two statements, if no payment is received after 60 days, we will bill the card on file. By signing this form you authorize Premier Dermatology of Florida to bill your card on file. Receipt of any transaction will be forwarded to the home address in our records.

Our commitment to you as our patient is to provide excellent service and we will do our best to file your claim in a timely and professional manner. Signing below signifies our understanding of the Financial Policy and your willingness to comply to the current and future services provided by Premier Dermatology of Florida. I acknowledge that Premier Dermatology of Florida may change these terms without notice to me.

Signature: _____ Date: ____/ ____/ _____

(Patient/Parent/Legal Guardian financially responsible for payment)

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Patient name (print): _____ Birth date: ____/ ____/ _____

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of October 18, 2021.

Signature of patient/patient representative: _____

Relationship to patient: _____ Date: ____/ ____/ _____

Documentation of Good Faith Efforts to obtain patient's acknowledgement that they received provider's Notice of Privacy Practices (for use when acknowledgement cannot be obtained by patient)

The patient presented to the office on and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgment was not obtained because:

____ Patient refused to sign

____ Patient was unable to sign or initial because: _____

____ Patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.

____ Other reason (describe): _____

Signature of employee completing form: _____Date signed: ____/ ____/ _____