SOUTHEASTERN Dermatology

New Patient Intake Form

Patient Name: _____

Date of Birth: _____ Gender:_____SSN:_____

Address:_____

_____

Home Phone:_____Mobile Number:_____

Work number: _____ Email Address:_____

Parent/Legal Guardian if minor: _____

Emergency Contact:_____

Medical Contact Information:

Referring Physician:_____Phone Number:_____

Primary Care Physician:_____Phone Number:_____

Preferred Pharmacy:_____Phone Number:_____

Pharmacy Address: _____

Insurance Information:

Primary Insurance Company: _____

Policy Number_____: Group #:_____

Policy Holder's Name (if different from patient)_____

Policy Holder's DOB (*Required): ___ /___ /____ Policy Holder's SSN:_____

Relationship to Patient: □ Self □ Spouse □ Child □ Other:

Secondary Medical Insurance (if applicable): Insurance Company: _____

Policy Number:_____

SOUTHEASTERN Dermatology

PATIENT HIPAA COMMUNICATION FORM

Disclosure to Self and to Others

Patient Name: _____ Patient DOB: _____

A. FAMILY AND FRIENDS: It is the office policy of Southeastern Dermatology not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment),(iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caregivers/babysitters, please indicate that below, so that we may best serve you. By signing below, you authorize the following persons to receive information as requested, regarding your care and treatment. Updates to this form must be made in person.

_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone

B. ALTERNATIVE COMMUNICATION: I wish to be contacted in the following manner. (check all that apply)

Home Phone _____
_____ Okay to leave message with details
_____ Leave a call back number only

Cell Phone _____
_____ Okay to leave message with details
_____ Leave a call back number only

Work Telephone _____
_____ Okay to leave message with details
_____ Leave a call back number only

Written Communication
_____ Okay to mail to home address

X_____	_____	_____
Patient or Representative Signature	Relationship to patient	Date

SOUTHEASTERN Dermatology

Financial Policy/ Patient Financial Agreement:

Patient Name:_____**DOB:**_____

Southeastern Dermatology is committed to serving our patients with professionalism and care and from our patients we expect the same commitment. This includes being on time for your appointment and calling to cancel an appointment if you can't make it. It also includes financial responsibility, like presenting your identification and insurance cards at every appointment and making your copay and deductible payments at the time of your office visit with cash, check or credit card. Your responsibility is to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits. As a courtesy, and if we are contracted with your insurance company, Southeastern Dermatology will file your insurance claim for you. If you are a Medicare patient, we will bill Medicare and your secondary insurance for you.

1. You must provide proof of insurance at the time of your initial visit, or any time you have a change in coverage. We participate in many insurance plans, including Medicare.

2. We do not accept the following insurance providers/plan: Ambetter, AVMED, BCBS select, CIGNA HMO, First Health, Florida Kid Care, Florida Medicaid, Great West, Humana Medicaid, Lighthouse, Prestige, Sunshine Health, United Health Care HMO plans, Universal Health care.

3. Staywell patients must have a referral from their primary care physician before they can be seen.

4. Co-payments, coinsurance and deductibles. We cannot waive copays, coinsurance and deductibles. You are responsible for any coinsurance, copays, deductibles, and non-covered services as required by your insurance carrier at the time of your visit, unless arrangements have been made in advance with our providers and billing manager.

5. No Insurance. Payment in full will be due and payable at the time of service. We will do our best to provide you with an estimate of cost before any procedure or treatment is performed.

6. Cosmetic procedures. Payment in full is due and payable at the time of service.

7. HMO Coverage. With the exception of Capital Health Plan, we do not accept HMO insurance. If this is your only coverage, you will be considered a no insurance patient and payment in full is due and payable at time of service.

SOUTHEASTERN Dermatology

Office Policies:

Patient Name: _____DOB:_____

I have read and understand the financial policy statement. I agree to make prompt payment in full to Southeastern Dermatology at the time of my visit, or when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered. I also give consent for Southeastern Dermatology to release any medical information necessary to process my insurance claims. Any unpaid balances will result in collection actions. This authorization is valid until revoked in writing.

By supplying my personal contact information, I authorize my health care provider to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, to notify me of a pending appointment, a missed appointment, balances due, lab results, or any other healthcare related function with an automated outreach system. I also understand that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Our medical providers will review your health history and conduct an initial evaluation to determine whether the practice will accept you as a patient.

Consent to Treatment: I understand and herby give consent that during my visit today, or on future visits it may be necessary to have a skin biopsy, cryotherapy (Liquid nitrogen) or other minor procedures for the treatment of my skin conditions. I understand that there may be potential risks such as scarring, bleeding and infection.

In order to provide timely appointments without excessive wait time, we ask that patients arrive to their appointments on time. Please be advised that we reserve the right to reschedule an appointment if a patient is more than 15 minutes late.

OFFICE POLICIES ACKNOWLEDGEMENT

I acknowledge that I have received, read and agree to the stated Office Policies of Southeastern Dermatology.

Patient Name: _____DOB:_____

Legal Guardian (if minor) _____

Signature: _____Date: _____

Patient Name: _____DOB:_____

<u>If you are unable to make your appointment, Southeastern Dermatology requires a 24-hour notice prior to your appointment for cancellations. If you do not cancel your appointment within this time period, you are subject to a $35 cancellation/no show fee. This fee will be the responsibility of the patient and is not covered by insurance. An excessive amount of missed appointments could result in being discharged from our practice.</u>

If you require emergency medical services please call 911 immediately. If this is an urgent medical need and you need to speak with a provider after our normal business hours, please call (850)422-3376. Your call will be returned promptly.

It is customary to have photos taken to help in the guidance and care of your medical needs. These photos are for in office use only. If photos are needed for any other purpose, additional permission will be obtained. Therefore, I consent for before/after photos to be taken.

A parent or guardian must be present with a patient under the age of 18 for the first visit and any subsequent visit in which a procedure is performed. The parent/guardian grants permission to Southeastern Dermatology to see the minor without their presence for standard medical office visits. This authorization is valid until revoked in writing. I have legal right to select and authorize health care services for this minor child.

Written Acknowledgement Form: I am a patient, parent or legal guardian of _____ at Southeastern Dermatology. I hereby acknowledge receipt of Southeastern Dermatology's Notice of Privacy Practices.

OFFICE POLICIES ACKNOWLEDGEMENT

I acknowledge that I have received, read and agree to the stated Office Policies of Southeastern Dermatology.

Patient Name: _____DOB:_____

Legal Guardian (if minor) _____

Signature: _____Date: _____

SOUTHEASTERN Dermatology

Dermatology Medical History Form:

Patient Name: _____DOB: _____

Did a physician or other health care provider recommend you to see a dermatologist? Yes/No

Referring Provider: _____

Have you had or currently have any of the following medical conditions:

____ Anxiety ____ End Stage Renal ____ Lung Cancer ____ Arthritis ____ Hearing Loss

____ Lymphoma ____ Asthma ____ Hepatitis ____ MRSA ____ Atrial Fibrillation

____ Hypertension ____ Pacemaker ____ Bone Marrow Transplant ____ HIV/AIDS

____ Prostate Cancer ____ Breast Cancer ____ Hypercholesterolemia ____ Radiation Treatment

____ Colon Cancer ____ Hyperthyroidism ____ Seizures ____ COPD ____ Hypothyroidism ____ Stroke

____ Coronary Artery Disease ____ Immunosuppression ____ Valve Replacement ____ Depression

____ Leukemia ___ Diabetes

Other_____

Please list any surgeries you have had:_____

Are you currently: ____Pregnant____Not Pregnant Planning Pregnancy: ___ Yes ___ No

Breast Feeding ___Yes ___No

Medications: (including over the counter)

_____

_____

_____

_____

_____

Drug Allergies:_____

_____

SOUTHEASTERN Dermatology

Do you have or have had any of the following skin conditions?

____ Acne ____ Eczema ____ Precancerous Moles ____ Actinic Keratosis

____ Flaking or Itchy Scalp____ Psoriasis ____ Hay Fever/Allergies

___Basal Cell Skin Cancer ____ Squamous Cell Skin Cancer ____ Melanoma Skin Cancer

____ Dry Skin ____ Poison Ivy ____Shingles____ Blistering Sunburns

Other:_____

Do you have a family history of melanoma or other skin cancers? ____ Yes ____ No

If yes, which relative? What type of skin cancer?

_____

Smoking Status: _____Current Every Day Smoker ___ None ____ Current Some Day Smoker

____ Socially ____ Former Smoker ____ Moderate ____ Never Smoked

Do you drink alcohol: ____ No ___Yes, _____times per day_____Week_____Month

Do you wear sunscreen daily: ____No ___Yes What SPF? _____

SOUTHEASTERN Dermatology

Cosmetic Questionnaire

Do you have any concerns with fine-lines, wrinkles, or volume loss (cheeks/Lips)? ___Yes___No

Do you have any concerns with skin laxity, color variation, or texture? ___Yes____No

Do you have sun spots, spider veins, or any unwanted hair you would be interested in treating?__Yes___No

Would you be interested in scheduling a cosmetic consultation? __Yes___No

Would you like information about any of the following:

____Botox	___ Facials
____Juvéderm/Fillers	___ Chemical Peels
____Laser hair removal	___ Microderm Abrasion
____Spider Vein Treatment	___Microneedling
____Rosacea/Facial redness	___Dermaplaning
____ Skin Care Products	____Cosmetic mole or Skin tag Removal

Comments: _____

_____

_____

_____

_____