

Welcome to Abrams Dermatology!

Please fill out the information below prior to your visit. We recommend you complete this information online at our patient portal <http://www.premierdermdocs.ema.md> . Please call us and we will provide you your personal access information. You can also mail or fax your completed forms to

ABRAMS DERMATOLOGY, 3328 Bee Ridge Rd, Sarasota FL 34239 – Fax: 941-926-8424

NOTE: If you have an HMO plan, you are responsible for obtaining an Authorization from your primary care physician prior to your visit or we may have to reschedule your appointment.

PATIENT INFORMATION

Patient Name (First, Middle, Last)		Social Security#:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthday (mm/dd/yy)
Name of Responsible Party (patient, parent, guardian, POA) Circle one		Name of Responsible Party (patient, parent, guardian, POA) Circle one		
Mailing Address		Mailing / Secondary/ Billing/Guardian/POA address (circle one)		
City/State/Zip		City/State/Zip		
Patient Email Address		Emergency Contact/Parent /Guardian		
Home Phone#	Cell Phone#	Phone	Relationship	
How did you hear about us? <input type="checkbox"/> Website/Internet <input type="checkbox"/> Newspaper <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Friend/Family <input type="checkbox"/> Mailer <input type="checkbox"/> Doctor <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Window sign <input type="checkbox"/> Other _____		Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No Ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska <input type="checkbox"/> Hawaiian/Pacific Islander		
<i>if you DO NOT wish to receive any reminders, cards, information, marketing and fundraising material by mail from our practice, Write PRIVATE: _____</i> <i>Your Email Address is kept CONFIDENTIAL - if you do not wish to receive email from our practice, Write the PRIVATE here: _____</i>				

INSURANCE INFORMATION

Primary Insurance		Secondary Insurance	
Member ID#	Group#	Member ID#	Group#
Subscriber's Name		Subscriber's Name	
Subscriber's DOB	SS#	Subscriber's DOB	SS#
Subscriber Relationship to patient		Subscriber Relationship to patient	

Please present your insurance card(s) and a photo ID to the receptionist. These will be copied and placed in your medical record for identification purposes and for protection of your Private Health Information. Photo ID of parent/guardian requested for minor or if patient unable to consent.

EMPLOYER	PRIMARY CARE PHYSICIAN	PHARMACY
Name	Name	Name/Location
Phone	Phone	Phone

Did a Doctor refer you to us? YES / NO If YES, Name _____ Phone # _____
Reason for today's visit: _____

What is your occupation?		What are your hobbies?	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Other		Household Members (including yourself): _____	
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you smoke Cigarettes/Cigars?	Do you use illicit drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, <input type="checkbox"/> LESS or <input type="checkbox"/> MORE than 7 glass/week <input type="checkbox"/> LESS or <input type="checkbox"/> MORE than 14 glass/week	<input type="checkbox"/> Never smoked <input type="checkbox"/> Yes, ___ cig/day <input type="checkbox"/> I quit, ___ day <input type="checkbox"/> mth <input type="checkbox"/> yr ago Other Type of Tobacco: _____	If yes, what type and how often?	

WE RECOMMEND A FULL BODY EXAM FOR ALL OUR NEW PATIENTS TO SCREEN FOR SKIN CANCER AND TO ALL OUR PATIENTS DIAGNOSED WITH SKIN CANCER IN THE PAST.

Do we have permission to: Leave a message on your answering machine Yes No at Home Cell

Discuss your medical condition with household member: Yes No If yes, Whom: _____ Relationship _____

MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____

Reason for today's visit: _____ **Pain** (circle one): 1 2 3 4 5 6 7 8 9 10 (1= uncomfortable - 10= unbearable)

CURRENT MEDICATIONS TAKING (prescriptions, over-the-counter meds, vitamins, herbal treatments) *Use back of form if needed*

Name	Strength	Route	Dose	Frequency	Name	Strength	Route	Dose	Frequency

DO YOU HAVE, OR HAD ANY OF THE FOLLOWING CONDITIONS? *Check only those that apply & write Location/Date*

Past Medical History	Area/Year	Past Surgical History	Area/Year	Review of Systems (current symptoms)
<input type="checkbox"/> Anxiety	_____	<input type="checkbox"/> Appendix Removed	_____	<input type="checkbox"/> Fever or chills
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Bladder Removed	_____	<input type="checkbox"/> Unintentional weight loss
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Breast Biopsy (Right, Left, Both)	_____	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Atrial Fibrillation	_____	<input type="checkbox"/> Lumpectomy (R, L, B)	_____	<input type="checkbox"/> Immunosuppression (low immune system)
<input type="checkbox"/> Bone Marrow Transplantation	_____	<input type="checkbox"/> Mastectomy (R, L, B)	_____	<input type="checkbox"/> Enlarge lymph nodes
<input type="checkbox"/> BPH (prostate enlargement)	_____	<input type="checkbox"/> Colon Cancer Resection	_____	<input type="checkbox"/> Problem with bleeding
<input type="checkbox"/> Breast Cancer	_____	<input type="checkbox"/> Colectomy: Diverticulitis	_____	<input type="checkbox"/> Problem with healing
<input type="checkbox"/> Colon Cancer	_____	<input type="checkbox"/> Inflammatory Bowel Disease	_____	<input type="checkbox"/> Problem with scarring (keloids)
<input type="checkbox"/> Chronic Obstructive Pulmonary disease	_____	<input type="checkbox"/> Gallbladder Removed	_____	<input type="checkbox"/> Rash
<input type="checkbox"/> Coronary Artery Disease	_____	<input type="checkbox"/> Biological Valve Replacement	_____	<input type="checkbox"/> New or Changing mole
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Coronary Artery Bypass Surgery	_____	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Heart transplant	_____	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> End Stage Renal Disease	_____	<input type="checkbox"/> Mechanical Valve Replacement	_____	<input type="checkbox"/> Cough
<input type="checkbox"/> GERD (acid reflux, heartburn)	_____	<input type="checkbox"/> Heart: PTCA	_____	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Hearing Loss	_____	<input type="checkbox"/> Hip Joint Replacement (R, L, B)	_____	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Hepatitis	_____	<input type="checkbox"/> Knee Joint Replacement (R,L,B)	_____	<input type="checkbox"/> Blurry Vision
<input type="checkbox"/> Hypertension	_____	<input type="checkbox"/> Kidney Biopsy	_____	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> HIV/AIDS	_____	<input type="checkbox"/> Kidney Transplant	_____	<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Hypercholesterolemia	_____	<input type="checkbox"/> Kidney: Nephrectomy	_____	<input type="checkbox"/> Bloody stool
<input type="checkbox"/> Hyperthyroidism	_____	<input type="checkbox"/> Liver: Hepatectomy	_____	<input type="checkbox"/> Bloody urine
<input type="checkbox"/> Hypothyroidism	_____	<input type="checkbox"/> Liver Transplant	_____	<input type="checkbox"/> Joint aches
<input type="checkbox"/> Leukemia	_____	<input type="checkbox"/> Liver Shunt	_____	<input type="checkbox"/> Muscle weakness
<input type="checkbox"/> Lung Cancer	_____	<input type="checkbox"/> Ovaries Removed	_____	<input type="checkbox"/> Neck stiffness
<input type="checkbox"/> Lymphoma	_____	<input type="checkbox"/> Ovarian Cancer Removed	_____	<input type="checkbox"/> Headaches
<input type="checkbox"/> Prostate Cancer	_____	<input type="checkbox"/> Ovarian Cyst Removed	_____	<input type="checkbox"/> Seizures
<input type="checkbox"/> Radiation Treatment	_____	<input type="checkbox"/> Tubal Ligation	_____	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Seizures	_____	<input type="checkbox"/> Pancreas: Pancreatectomy	_____	<input type="checkbox"/> Depression
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Prostate Biopsy	_____	ALERTS
<input type="checkbox"/> OTHER: _____	_____	<input type="checkbox"/> Prostate Cancer	_____	<input type="checkbox"/> Pacemaker
Skin Disease History		<input type="checkbox"/> Prostate: TURP	_____	<input type="checkbox"/> Defibrillator
<input type="checkbox"/> Acne	_____	<input type="checkbox"/> Rectum: APR	_____	<input type="checkbox"/> Premedication before procedures
<input type="checkbox"/> Actinic Keratoses	_____	<input type="checkbox"/> Skin: Basal Cell	_____	<input type="checkbox"/> Artificial heart valve
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Skin: Melanoma	_____	<input type="checkbox"/> Artificial joints within the past 6 months
<input type="checkbox"/> Basal Cell Skin Cancer	_____	<input type="checkbox"/> Skin Biopsy	_____	<input type="checkbox"/> Allergy to lidocaine (Xylocaine)
<input type="checkbox"/> Blistering Sunburn (s)	_____	<input type="checkbox"/> Skin: Squamous Cell	_____	<input type="checkbox"/> Rapid heartbeat with epinephrine
<input type="checkbox"/> Dry Skin	_____	<input type="checkbox"/> Spleen Removal	_____	<input type="checkbox"/> Allergy to adhesive/tape
<input type="checkbox"/> Eczema	_____	<input type="checkbox"/> Testicles Removal	_____	<input type="checkbox"/> Allergy to topical antibiotic ointments
<input type="checkbox"/> Flaking or Itchy Scalp	_____	<input type="checkbox"/> Hysterectomy: Fibroids	_____	<input type="checkbox"/> Blood thinners
<input type="checkbox"/> Hay Fever/Allergies	_____	<input type="checkbox"/> Hysterectomy Uterine Cancer	_____	<input type="checkbox"/> MRSA (staph infection)
<input type="checkbox"/> Melanoma	_____	<input type="checkbox"/> Hysterectomy Cervical Cancer	_____	<input type="checkbox"/> Pregnancy or planning pregnancy
<input type="checkbox"/> Poison Ivy	_____	<input type="checkbox"/> OTHER: _____	_____	<input type="checkbox"/> Hospice
<input type="checkbox"/> Precancerous Moles	_____			<input type="checkbox"/> OTHER: _____
<input type="checkbox"/> Psoriasis	_____			
<input type="checkbox"/> Squamous Cell Skin Cancer	_____			
<input type="checkbox"/> OTHER: _____	_____			
Medical conditions or recent surgery (within last 6 months):		Current Influenza Immunization: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>We recommend yearly immunization</i>		Do you have any "blood relative" who has/had skin cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No Type & whom? _____
_____		Vaccinated for Pneumonia: <input type="checkbox"/> Yes <input type="checkbox"/> No		_____
_____		Do you wear sunscreen? <input type="checkbox"/> Yes: SPF _____ <input type="checkbox"/> No		_____
_____		Do you go to tanning salons? <input type="checkbox"/> Yes <input type="checkbox"/> No		Allergies: <input type="checkbox"/> NONE (or list all Allergies)
_____		Are you pregnant? <input type="checkbox"/> Yes: _____ <input type="checkbox"/> No <input type="checkbox"/> Maybe <small>Due date</small>		_____

Patient Signature/POA/Guardian: _____ Name: _____ Date: _____

Form Completed by: Patient Nurse/MA - Initials: _____

Financial Policy, Notice of Privacy Practices, Authorization and Payment Terms

We ask that you read and sign the following form to acknowledge your financial responsibility for the medical services provided here as well as our policy on the protection of your private health information. We will be happy to provide further clarification if necessary. In order to avoid any misunderstanding regarding our payment policies, please review our Financial Policy below.

Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments & deductibles will be collected at the time of service.

➤ ***We accept payment via cash, check, debit cards, Master Card, Visa, Discover or American Express.***

We may request a payment authorization form to be filled out at the time of checkin for patients who are minor, uninsured or with an outstanding balance, as well as patients with a non-participating insurance (including non-QMB Medicaid patients). Any outstanding balance from your visit will be mailed to your primary address. If there is any discrepancy or if you are unable to pay the balance in full, we ask that you contact our office immediately. Failure to settle your balance within 30 days may result in further collection efforts and a collection fee will be assessed to your account. **Please note that you may be billed separately for laboratory analysis if we are required to send specimens to an external laboratory. Ask us if any specimen was submitted to an external laboratory at time of checkout.**

Participating Insurance: We are a provider for a variety of commercial insurance carriers and we bill them as a courtesy to you. Prior to your visit, you will be informed whether or not we are a provider for your insurance plan. We accept payment for covered services from these insurance plans in accordance with our contracts. It is your responsibility to know and understand the guidelines of your insurance plan. You should attempt to seek medical care with physicians participating in your plan when possible. Insurance may not cover all fees. To be fully aware of your benefit limitations, please read your insurance policy or talk with your insurance representative. **You are responsible for co-insurance, deductible amounts, and payment for services not covered by your insurance at the time of service.**

Medicare Patients: We bill Medicare directly for you. However, you are responsible for charges applied to your deductible, any co-insurance, or charges not covered by Medicare. **We do not bill supplemental insurance carriers.** If your secondary insurance does not crossover with Medicare, you are responsible for that portion of your charges at the time of service (normally 20% of the covered charges).

Medicaid Patients: We are not a Medicaid provider. If you are not a Qualified Medicare Beneficiary you are responsible for payment of all charges non-covered by Medicare at the time of service.

Uninsured & Non-participating Insurance: If we are not a provider for your insurance you are responsible for payment of all charges at the time of service. For non-participating insurance, we will provide you with a receipt for reimbursement.

Refund Policy: We do not offer refunds for medical and cosmetic procedures. We do not accept product returns. All sales are final.

Notice of Privacy Practices: We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create paper and electronic medical records about your health, our care for you, and the services and/or items we provide to you as our patient. We need this record to provide for your care and to comply with certain legal requirements. We may use and disclose medical information about you for one or more of the following reasons; medical treatment, payment, internal operations, appointment reminders, others involved in your care, as required by law, to avert a serious threat to health or safety, organ and tissue donation, public health risks, worker's compensation, government activities, lawsuits and disputes, law enforcement, coroner or medical examinations. **A complete copy of our Notice of Privacy Practices is available for you in our lobby. Additional copies are available in the folder for you to take home.**

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, and prescriptions. I also authorize payment of medical benefits to the physician. Your signature below authorizes the release of your medical information and payment as listed above, and signifies your willingness to comply with our financial policy.

By law, we are only permitted to discuss your diagnosis and treatment with you (the patient). In the event that a spouse, family member, or close friend may need this information, please list their name in the space provided below.

Name: _____ **Relationship:** _____

By listing the individual above, you have given us permission to discuss your medical history and treatment with this person. We cannot disclose any of your private health information to anyone who is not listed on this form. You have the right to inspect and copy the medical information that we maintain. To inspect a copy of your medical record, you must submit your request in writing. In some cases there may be a fee associated with your request.

I voluntarily consent to care treatment by Abrams Dermatology including diagnostic procedures, labs and medical treatment ordered by the attending physician/ARNP/PA-C. I understand that I have financial responsibility for payment of medical services provided and hereby assume payment of all expenses incurred during my office visit. Should legal action be required to secure payment of this account, I agree to pay the legal expenses incurred by this office. Additionally, in the event of non-payment, the undersigned guarantees payment of all costs of collections, including reasonable late fees and attorney's fees.

I have read and understand this financial policy and notice of privacy practices and agree to accept responsibility as described.

Printed Name _____ Signature of Patient/Responsible Party _____ Date _____
IF PATIENT IS UNABLE TO CONSENT, COMPLETE THE FOLLOWING: Patient is unable to consent because: _____ and I hereby consent on his/her behalf and in his/her stead.
Printed Name _____ Signature of Patient/Responsible Party _____ Date _____

PATIENT CONSENT & AUTHORIZATION

Patient Name: _____

Date of Birth: _____

Consent for Treatment and Fee Responsibility

This is to certify that I (or my authorized agent) consent to the performing of any surgical or medical procedure or examination as required. I (or my authorized agent) assume financial responsibility for any services rendered.

→Signature: _____ Name: _____ Date: _____
Patient Parent Legal Guardian

Authorization and Release for the Use and/or Disclosure of Protected Health Information for Marketing and**Authorization and Release for the Use and/or Disclosure of Protected Health Information for Marketing and Communications****We may use your health information and/or records to:**

- ❖ Plan for your care and help your health care providers communicate and work together for your medical benefit
- ❖ Submit bills for reimbursement for the care provided to you
- ❖ Help health care payers or medical insurance companies verify that services were provided to you
- ❖ Help improve the quality of your health care
- ❖ Disclose information to certain officials or organizations as requested by law.

Check the boxes below if you do not wish to authorize:

- The release of my medical information to my immediate family upon their request. I DO NOT AUTHORIZE
- The Use of my non-medical Information (name, address, date of birth) to receive information such as appointment reminders, birthday cards, medical information.. I DO NOT AUTHORIZE

We will NEVER disclose your Health Information to any 3rd party marketing company

Everyone at Abrams Dermatology is bound by law to uphold to all privacy standards. We encourage you to read the Notice of Privacy Practices and ask us any questions.

This authorization may be revoked at any time to the extent that use or disclosure has not already occurred prior to your request. To update or revoke the authorization, notify Abrams Dermatology Privacy Officer in writing or call (941)-926-2300.

By signing below, you confirm that you have read and understand your rights to privacy, and that you have been given access to all information pertaining to those rights.

→Signature: _____ Name: _____ Date: _____
Patient Parent Legal Guardian

Abrams Dermatology will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The Protected Health Information disclosed as a result of this authorization may be redisclosed by the entity receiving it, and thus is no longer protected by the federal privacy regulations. This Authorization is given without promise of compensation. The parent/legal guardian and the patient release to Abrams Dermatology's any right, titles and /or interest of any kind they may have in the information produced.

The above statements must be signed and dated to be valid. If the patient is an emancipated minor or 18 years of age, he/she is required to sign the Authorization. If Abrams Dermatology requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided to the individual completing this form.

Receipt of Notice of Privacy of your Health Information

Your privacy is important to us. The information that we record about you and your medical history is to help us provide quality medical care. We are committed to protecting this information. The Notice of Privacy Practice describes your rights with regards to your health information and our responsibility to protect that information. **A complete copy of our Notice of Privacy Practices is available for you in our lobby. Additional copies are available in the folder for you to take home.**

Your rights include:

- ❖ The right to amend your health information
- ❖ The right to request restrictions on what information we use or know we disclose your health information
- ❖ The right to see an account of certain disclosures we have made of your health information
- ❖ The right to obtain access to your health information with limited exceptions (written request, advance notice and a cost-based fee for expenses delineated by law)
- ❖ The right to receive a paper copy of our Notice of Privacy Practices

These rights do have certain restrictions and you may obtain detailed disclosure of these restrictions at any time.

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Personal Health Information. *Copy provided upon request

→Signature: _____ Name: _____ Date: _____
Patient Parent Legal Guardian

PATIENT BILLING CONSENT FORM

If you are a minor, uninsured, insured with a non-participating insurance (including non-QMB Medicaid patients), have an outstanding balance or had a past delinquent account, please fill out the form below.

Patient Name: _____ Date of Birth _____

IF PATIENT IS UNABLE TO CONSENT, GUARDIAN/PARENT MUST COMPLETE THE FOLLOWING:

Patient is unable to consent because: _____ I hereby consent on his/her behalf and in his/her stead.
I am responsible for any medical expenses incurred by this patient YES NO.

Name: _____ Relationship to patient: _____

_____ _____ _____
First Name Middle Last Name

Date of Birth: ____ / ____ / ____ Social Security Number: _____ Primary Phone Number: _____
Month Date Year

Billing Address: _____ City / State: _____ Zip code: _____

Please present your photo ID to the receptionist. *Used for identification purposes and for protection of your Private Health Information.*

Signature: _____ **Date:** _____

Name on Card if Different: _____

Card Number: _____ Exp. Date: _____ Security Code: _____

Card Holder's Billing Address for Monthly Card Statements:

_____ _____ _____ _____
Street City State Zip Code

I authorize Abrams Dermatology to charge my Credit card for professional services as follows:

- Full Fee for Service \$ _____
- Co-pay Amount or Fees towards Insurance Deductible \$ _____
- Outstanding Balance \$ _____
- Other \$ _____ - Description: _____

Special Note: _____

Please be aware that unless an agreement is negotiated with the above provider all outstanding balances not paid within 30 days, after a bill is sent or the insurance company has notified you or this office of your balance, will be charged to your credit card.

Card Holder's Signature: _____ Date: _____

Please note that all information will be kept confidential and that information will only be used to obtain payment for services.