DERMATOLOGY
Associates of Central Florida
David Yrastorza, MD
Hannah Vaughn, PA-C

New Patient Registration

Patient name: ______________________________ Birthdate: __________ Sex: M F

Address: ______________________ City: ________________ State: ____ Zip: ______

Home phone: ____________ Cell: ____________ Work: ____________

Best number to confirm appointments: __________

Email address: ______________________________________

Parent/Guardian name (minors): ______________________________ Birthdate: __________

Address: (if different) ______________________ City: ____________ State: _____ Zip: _____

Marital status: single married divorced widowed Spouse name: ____________________

Emergency Contact: ______________________________ Phone: ____________________

How did you hear about us? ____

Do you have a Seasonal address? ________ (if Yes, please provide)

Address: ______________________________ City: ______________ State: ____ Zip: _____

Insurance Information

(must be completed for all dependents and/or secondary insurance)

Primary Insurance:

Name: ______________________

Insurance Holder: ______________________

Relationship to Insured: ______________________

Insured's Date of Birth: ______________________

Secondary Insurance:

Name: ______________________

Insurance Holder: ______________________

Relationship to Insured: ______________________

Insured's Date of Birth: ______________________

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Past Medical History

Anxiety Arthritis
Thyroid Arrhythmia
Seizures Transplant
Hepatitis Joint Replacement
Lupus Cold Sores
Seasonal Allergies

Cancer (type/date) ____________________
Immunosuppression ____________________
Implants (type) ____________________
Require premedication before surgery **Y N**

Have you had:

Skin Cancer? Y N Date of most recent ____________ Location/Type ____________
Melanoma? Y N Date of most recent ____________ Location/Depth ____________
Abnormal Mole? Y N Date of most recent ____________ Location ____________

Blistering Sunburn Y N Use/Have Used Tanning Bed ____________
Sun Protection Y N Outside Activities

Medications ____________________

Allergies ____________________

Reason for Visit ____________________

Smoking? Y N Alcohol Frequency ____________________
Blood Thinners? Y N History of Fainting ____________________

If you are here for a rash:

a. **How long has it been going on? ____________ Does it itch? ____________**
b. **What are you putting on it? ____________________**
c. **What makes it better? ____________ Worse? ____________**
d. **What do you associate with onset? ____________________**
e. **Any new medications? ____________________**
f. **Ever had this rash before? ____________________**

Cosmetic Concerns:

Botox Wrinkles Warty Moles Skin Tags/growths
Brown Spots Tired Eyes Scarring Hyperpigmentation

Print Name: ____________________ Signature: ____________________ Date: ____________

Dermatology Associates of Central Florida, 3670 Innovation Drive Lakeland, FL 33812
Annual Financial & Privacy Agreement

Name: ______________________________

Date of Birth: ____________

<u>Financial Policy</u>: Payment in full is required at the time services are rendered, unless you are currently enrolled and eligible under one of the Insurance plans that lists this office as a participating network provider. Please check with your insurance company to verify this information. Please understand health plans have different copays, deductibles and rules and regulations regarding allowed visits for certain services. If our office participates with your health plan, we will honor the applicable fee schedules and discounts. <u>You will be responsible for your co-payments, any co-insurances and applicable deductible amounts</u>.

If our office does not participate with your health plan, payment in full is due at the time you exit our office for the services rendered to you.

Our office accepts payment by: cash, check, money order, debit card, Visa, MasterCard, or Discover. <u>There will be a $25.00 fee assessed on all returned checks</u>. As a courtesy to you, a claim is submitted to your insurance plan on your behalf. Once your insurance company considers your claim, if you still owe a balance after their decision, a statement will be sent to you. Our billing office will send three statements and one delinquency notice to you.

<u>If you neglect to pay your bill, or you refuse to make payment arrangements, your account will be forwarded to a collection agency.</u>

I acknowledge that it is the policy of this office that payment is required at the time of service. An insurance claim submission on my behalf is a courtesy extended to me, or the party I represent, unless mandated by the health plan. I am financially responsible for all services not covered by my health plan.

<u>Patient Payment Authorization</u>:

I hereby authorize my insurance company (or Medicare) to send all payments for medical services rendered to me (or my dependents) directly to: Dermatology Associates of Central Florida. With my signature, I confirm the above demographic and insurance information is true and correct, and for any future services this authorization applies to. If the information is found to be inaccurate, I agree to be personally responsible for payment in full for the services provided. I further authorize the release of any information (including medical information) to my insurance company in order to determine the insurance benefits for which I may be entitled to.

<u>Laboratory/Biopsy Services:</u>

We provide the professional services portions for these procedures. If a specimen is sent to an outside source to confirm a diagnosis, you will be billed separately by the laboratory that provides the service.

<u>NOTICE OF PRIVACY PRACTICES/ RELEASE OF MEDICAL INFORMATION</u>: Our HIPAA Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a patient rights section describing your rights under the law.

You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this consent, you specifically authorize our use and disclosure of protected health information about you for treatment, payment or health care operations, and as otherwise explained in the Notice of Privacy Practices. You specifically authorize the use and release of all of your health care information including, but not limited to mental health, HIV/AIDS, genetic testing, venereal disease, substance abuse, and tuberculosis information for treatment, payment, health care operations, and as otherwise permitted by law. Your information may be exchanged electronically.

I acknowledge that I have reviewed:

<u>Financial Policy</u>
<u>Patient Payment Authorization</u>
<u>Laboratory/Biopsy Services</u>
<u>Notice of Privacy Practices/Release of Medical Information</u>
for Dermatology Associates of Central Florida.
(Copy of Privacy Practice is available upon request)

X ______________________________
Patient Signature (or representative)

__/__/____ ______________________________
Date Relationship if not patient

<u>Authorization to disclose Protected Health Information (PHI):</u>

Name: ______________________________

Phone#: ______________________________

Relationship: ______________________________

<u>Office Use Only:</u>

____
Staff Signature Date

____
Printed Staff Name

Insurance Verified/Current Card On File __________
Initial

Dermatology Associates of Central Florida
3670 Innovation Drive Lakeland, FL 33812
Phone: (863) 686-2282
Fax: (863) 686-2370

Biannual Intake Form

Patient Name: ____

Date of Birth: ____________________ Date of Visit: ______________

1. **Occupation** – current ***or retired from***: ____

2. Do you have a Living Will?
   ____ **YES** ____ **NO**

3. Tobacco smoker?
   ____ **YES** ____ **NO**

5. Have you received the flu vaccine for the current flu season: (Jan – March and/or Oct – Dec)
   ____ **YES** ____ **NO**

6. Have you received the Pneumonia Vaccine (65 years and older)
   ____ **YES** ____ **NO** (if NO, was this for medical reasons?) _____ **YES** _____ **NO**

7. **Pharmacy Information**:

   Name of Pharmacy: ____ Phone: ____________________

   Pharmacy address or cross streets: ____

8. ***Who is your Primary Care Physician*** (name please) ____

   Location: ____

____ ____________________________

Patient Signature (or guardian if Minor) Date

Staff entered: _________

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Cancellation Policy

As is the case with many dermatologic practices, our office is busy and there are a number of patients who are eager to get in for an office visit or move up their appointment/surgery time. Our staff works hard to accommodate patients in a timely fashion. Part of that process is the ability to work patients into the schedule in the event of a cancellation. It is not fair to patients waiting to get in for an appointment to wait any longer than necessary. The policy below helps all patients.

Office Visit

Please be advised that our office requires 24 hours' notice if cancelling an appointment. It is the responsibility of the patient to inform the office if they are unable to keep their appointment. If we do not receive proper notice, you may be charged $20.00 for a missed appointment fee. Your signature below indicates your willingness to adhere to this policy.

___________________________ ___________

Signature *Date*

Surgical Appointment

Please be advised that our office requires 24 hours' notice if cancelling a surgical appointment. It is the responsibility of the patient to inform the office if they are unable to keep their surgical appointment. If we do not receive proper notice, you may be charged $100.00 for a missed surgical appointment fee. Your signature below indicates your willingness to adhere to this policy.

___________________________ ___________

Signature *Date*

Feel free to speak with our office manager if you have any questions regarding this policy.