



**BRACCIANO**  
DERMATOLOGY

Bracciano Dermatology  
8430 Cooper Creek Blvd | Suite 102 | University Park, FL | 34201  
Tel: 941-360-2255 | Fax: 941-487-1777

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Home Phone # \_\_\_\_\_

\_\_\_\_\_ Social Security # \_\_\_\_\_

May we contact you at work? Y/N Tel: (\_\_\_\_\_) \_\_\_\_\_ OK to leave voice mail? Y/N

May we contact you via cell phone? Y/N Tel: (\_\_\_\_\_) \_\_\_\_\_ OK to leave voice mail? Y/N

Name of nearest relative \_\_\_\_\_ Phone # \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

Would you like to authorize an individual to receive any of your personal information? If yes, indicate name and telephone number below:

\_\_\_\_\_

Snow Bird? Please provide us with your out-of-state address and phone number:

\_\_\_\_\_ Phone # \_\_\_\_\_

\_\_\_\_\_

**Has Dr. Bracciano seen you as a dermatology patient within the last three years in Ellenton at The Eye Associates? Y/N**

Name of primary care physician: \_\_\_\_\_

**Were you referred by a physician to see Dr. Bracciano? If so, whom?** \_\_\_\_\_

If not, how did you hear about our office? \_\_\_\_\_

**Is your insurance in another person's name (spouse, parent, etc.)? If so, whom?**

Policyholder's Name: \_\_\_\_\_ Policyholder's Date of Birth: \_\_\_\_\_

Policyholder's Social Security Number: \_\_\_\_\_

**Patient HIPAA Acknowledgement**

**I understand that I am responsible for determining which laboratories participate with my insurance plan in regards to pathology specimens, cultures, and blood work. Bracciano Dermatology has provided me with a copy of my rights as a patient under the HIPAA act. I have been provided the opportunity to read and understand my rights and ask questions regarding my rights and receive answers to my satisfaction.**

**Privacy Protection Agreement**

I consent that photographs may be taken of me or parts of my body, under the following conditions:

The photographs may be taken only with the consent of my provider and under such conditions and at such times as may be approved by him or her. The photographs shall be taken by my provider or by a photographer approved by my provider. The photographs shall be used for medical records and in the opinion of my provider medical research, education, or science will benefit from their use. Such photographs and information relating to my case may be published and republished either separately or in connection with each other in professional journals or medical books, or used for any purpose which my provider may deem proper in the interest of medical education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name, and reasonable steps shall be taken to preserve my identity. The aforementioned photographs may be modified or retouched in any way that my provider, in his/her discretion, may consider desirable.

**Bracciano Dermatology Financial Policy Acknowledgement**

I hereby authorize my current insurance carrier to forward all medical payment(s) on my behalf to Bracciano Dermatology for any services furnished to me by the physician(s) of this practice. I further authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. This authorization will not be cancelled until further written notice, as this is a lifetime signature of Patient/Guardian. I understand that any amount not covered by my insurance company for ANY reason is my responsibility, and I, being the patient/guarantor, am solely responsible for the payment of any balance on my account. I further understand that if my account should be turned over for collection and/or legal action, I agree to pay for all collection fees including, but not limited to, postage, court costs, collection agency fees, attorney's fees, and interest from the date of service in the amount of 18% per annum (1.5% per month).

**Consent for Self-Pay Procedures and Exams**

If you do not have insurance and have requested a procedure or treatment that will be billed directly to you and not an insurance company, please be aware that most dermatology procedures including excisions and biopsies involve two separate components – the actual procedure performed by the dermatologist, and examination of the tissue removed by a pathologist. You will receive two bills for the procedure – one from Bracciano Dermatology, and one from the pathologist.

I understand that the treatment, procedure, or exam that I will have performed today is my financial responsibility. I understand that any tissue that I have removed will be sent for pathologic examination. I also understand that the pathologist/pathology corporation will bill me separately for their pathology services, and that I am responsible for any charges related to this service.

**Your signature below signifies that you have read and understand our financial policy and your responsibility regarding charges incurred in this office.**

\_\_\_\_\_  
**Patient/Guardian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Staff Initials (Witness)**