Welcome to Bracciano 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

Bracciano Dermatology, 8430 Cooper Creek Blvd., University Park, FL 34201 Fax: (941) 487-1777

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#:***	❑***Male*** ❑***Female***	***Birthday*** *(mm/dd/yy)*

Address:	*Name of Responsible Party (patient, parent, guardian, POA) Circle one*
City/ State/Zip	*Mailing / Secondary/ Billing/Guardian/POA address (circle one)*
Northern Address: 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?
❑Website/Internet ❑Newspaper ❑Yellow Pages
❑ Friend/Family ❑Mailer ❑Doctor
❑Insurance Plan ❑Window sign ❑ Other _____

Primary Language: ❑English ❑Spanish ❑Other_____
Hispanic or Latino:? ❑Yes ❑No
Ethnicity: ❑White ❑Black/African American ❑Asian
❑American Indian/Alaska ❑ Hawaiian/Pacific Islander

How would you like us to contact you for future appointments: Phone # _____
Test message # _____ Email: _____

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 # _____

What is your occupation?	**What is your weight?**
Marital Status ❑Single ❑Married ❑Widowed ❑Other	**What is your height?**

Do you drink alcohol? ❑Yes ❑No	**Do you smoke Cigarettes/Cigars**?	**Do you use illicit drugs**? ❑Yes ❑No
If yes,❑LESS or ❑MORE than 7 glass/week ❑LESS or ❑MORE than 14 glass/week	❑Never smoked ❑Yes, ___ cig/day ❑I quit,____ ❑day ❑mth ❑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 _____

PATIENT INITIALS

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) U***se 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*

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation _____
- ❑ Bone Marrow Transplantation _____
- ❑ BPH (prostate enlargement) _____
- ❑ Breast Cancer _____
- ❑ Colon Cancer _____
- ❑ Chronic Obstructive Pulmonary disease
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal Disease
- ❑ GERD (acid reflux, heartburn)
- ❑ Hearing Loss
- ❑ Hepatitis _____
- ❑ Hypertension
- ❑ HIV/AIDS _____
- ❑ Hypercholesterolemia _____
- ❑ Hyperthyroidism _____
- ❑ Hypothyroidism _____
- ❑ Leukemia _____
- ❑ Lung Cancer _____
- ❑ Lymphoma _____
- ❑ Prostate Cancer _____
- ❑ Radiation Treatment _____
- ❑ Seizures _____
- ❑ Stroke _____
- ❑ OTHER: _____

Skin Disease History

- ❑ Acne
- ❑ Actinic Keratoses
- ❑ Asthma
- ❑ Basal Cell Skin Cancer_____
- ❑ Blistering Sunburn (s)
- ❑ Dry Skin
- ❑ Eczema
- ❑ Flaking or Itchy Scalp
- ❑ Hay Fever/Allergies
- ❑ Melanoma _____
- ❑ Poison Ivy _____
- ❑ Precancerous Moles _____
- ❑ Psoriasis _____
- ❑ Squamous Cell Skin Cancer_____
- ❑ OTHER: _____

Medical conditions or recent surgery (within last 6 months):

_____
_____
_____
_____

Past Surgical History *Area/Year*

- ❑ Appendix Removed _____
- ❑ Bladder Removed _____
- ❑ Breast Biopsy (Right, Left, Both) _____
- ❑Lumpectomy (R, L, B) _____
- ❑ Mastectomy (R, L, B) _____
- ❑ Colon Cancer Resection _____
- ❑ Colectomy: Diverticulitis
- ❑ Inflammatory Bowel Disease _____
- ❑ Gallbladder Removed _____
- ❑ Biological Valve Replacement _____
- ❑ Coronary Artery Bypass Surgery _____
- ❑ Heart transplant _____
- ❑ Mechanical Valve Replacement _____
- ❑ Heart: PTCA _____
- ❑ Hip Joint Replacement (R, L, B) _____
- ❑ Knee Joint Replacement (R,L,B) _____
- ❑ Kidney Biopsy
- ❑ Kidney Transplant _____
- ❑ Kidney: Nephrectomy _____
- ❑ Liver: Hepatectomy _____
- ❑ Liver Transplant _____
- ❑ Liver Shunt _____
- ❑ Ovaries Removed _____
- ❑ Ovarian Cancer Removed _____
- ❑ Ovarian Cyst Removed _____
- ❑ Tubal Ligation _____
- ❑ Pancreas: Pancreatectomy _____
- ❑ Prostate Biopsy
- ❑ Prostate Cancer _____
- ❑ Prostate: TURP _____
- ❑ Rectum: APR _____
- ❑ Skin: Basal Cell _____
- ❑ Skin: Melanoma _____
- ❑ Skin Biopsy _____
- ❑ Skin: Squamous Cell _____
- ❑ Spleen Removal _____
- ❑ Testicles Removal _____
- ❑ Hysterectomy: Fibroids _____
- ❑ Hysterectomy Uterine Cancer _____
- ❑ Hysterectomy Cervical Cancer_____
- ❑ OTHER: _____

Current Influenza Immunization: ❑Yes ❑No

We recommend yearly immunization

Vaccinated for Pneumonia: ❑Yes ❑No

Do you were sunscreen? ❑ Yes: SPF___ ❑No

Do you go to tanning salon? ❑ Yes ❑ No

Are you pregnant? ❑Yes:_____ ❑No ❑Maybe
Due date

Review of Systems (current symptoms)

- ❑ Fever or chills
- ❑ Unintentional weight loss
- ❑ Night sweats
- ❑ Immunosuppression (low immune system)
- ❑ Enlarged lymph nodes
- ❑ Problem with bleeding
- ❑ Problem with healing
- ❑ Problem with scarring (keloids)
- ❑ Rash
- ❑ New or Changing mole
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Cough
- ❑ Wheezing
- ❑ Sore throat
- ❑ Blurry Vision
- ❑ Thyroid problems
- ❑ Abdominal pain
- ❑ Bloody stool
- ❑ Bloody urine
- ❑ Joint aches
- ❑ Muscle weakness
- ❑ Neck stiffness
- ❑ Headaches
- ❑ Seizures
- ❑ Anxiety
- ❑ Depression

ALERTS

- ❑ Pacemaker
- ❑ Defibrillator
- ❑ Premedication before procedures
- ❑ Artificial heart valve
- ❑ Artificial joints within the past 6 months
- ❑ Allergy to lidocaine (Xylocaine)
- ❑ Rapid heartbeat with epinephrine
- ❑ Allergy to adhesive/tape
- ❑ Allergy to topical antibiotic ointments
- ❑ Blood thinners
- ❑ MRSA (staph infection)
- ❑ Pregnancy or planning pregnancy
- ❑ Hospice
- ❑ OTHER: _____

Do you know any "blood relative" who has/had melanoma? ❑ Yes ❑ No

Type & whom?_____
_____

Allergies: ❑ NONE (or list all Allergies)

_____
_____
_____

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

Form Completed by: ❑ **Patient** ❑ **Nurse/MA - Initials:**

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 check-in 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 will result in further collection efforts and a collection fee may 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. Product returns are limited to company policy.

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 at your request.**

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 Bracciano 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 ONLY 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 Bracciano 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 Bracciano Dermatology Privacy Officer in writing or call (941)-364-8220.

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

Bracciano 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 BraccianoDermatology 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 Bracciano 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

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:** _____

Financial Self Pay Agreement

I, the undersigned, understand that if I am a minor, uninsured, insured with a non- participating insurance (including non-QMB Medicaid patients), have an outstanding balance or had a past delinquent account that:

As such, I am obligated to pay for my services at the time they are rendered.

I agree that I will pay at the time of service in the following manner: cash, check or credit card

_____
Signature of Patient or Guardian

PREMIER DERMATOLOGY

Bracciano Dermatology is a division of Premier Dermatology LLC. Your financial statements and billing related correspondence will come from Premier Dermatology LLC. If at any time you have questions regarding your bill for services performed at Bracciano Dermatology or by our pathology laboratory, please contact our Central Billing Office at (941) 312-5027 for assistance.