MEDICAL HISTORY **Pt Acct #:_____**

Patient Name: _____ **Height:**
Weight:

Reason for Visit:_____

Do you have any allergies to any medications or latex? □ Yes □ No if yes, please list:
_____

Please list all medications
_____
_____

Social History: Have you received the PNEUMONIA vaccination? □ Yes □ No Influenza Vaccine □ Yes □ No
Do you drink alcohol? □ Yes (# per week ____) □ No Do you sunbathe? □ Yes □ No
Do you use tobacco products? □ Yes (____packs per day) □ No Do you use a tanning bed? □ Yes □ No

Skin History:
Have you ever had skin cancer? □ Yes □ No
Have you ever had Melanoma? □ Yes □ No
Do you bleed easily? □ Yes □ No
Do you develop keloids? □ Yes □ No

Family Skin History:
Has anyone in your family had skin cancer? □ Yes □ No
Has anyone in your family had Melanoma? □ Yes □ No
Has anyone in your family had skin disease? □ Yes □ No

Do you have a history of any specific skin diseases? □ Yes □ No If yes,_____
Do you have an Advance Care Plan (Health Care Surrogate and/or Living will) □ Yes □ No
Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	Yes	No
• Chronic Bronchitis/Emphysema	□	□
• Asthma/ Wheezing	□	□
Cardiovascular:		
• High Blood Pressure	□	□
• High Cholesterol	□	□
• Chest Pain	□	□
• Heart Attack	□	□
• Heart Murmur	□	□
• Irregular Heartbeat	□	□
• Pacemaker/AICD	□	□
• Artificial Heart Valve	□	□
Vascular:		
○ Phlebitis	□	□
○ Blood clots	□	□
○ Stroke	□	□
Other:		
• Parkinson's Disease	□	□
• Multiple Sclerosis	□	□
• Arthritis/Joint Deformity	□	□
Convulsions, Epilepsy, Seizures	□	□

Other systemic:	Yes	No
• Diabetes	□	□
• Thyroid Disease	□	□
• Depression/Anxiety	□	□
• Kidney	□	□
• Immunosuppressed	□	□
○ Lupus	□	□
○ On chemotherapy	□	□
○ On steroids (i.e. Prednisone)	□	□
• Infectious Disease	□	□
○ Hepatitis A, B, C	□	□
○ TB exposure	□	□
○ HIV/AIDS	□	□
• Artificial Joint	□	□
If yes please list location:_____		
Amputation	□	□
• Fainting	□	□

Do you have to take antibiotics before surgical procedures? □ Yes □ No

Please explain any yes answers: _____

Please describe any recent hospitalization, surgeries or other conditions: _____
_____

Which pharmacy do you use? _____Location:_____

_____ **_____**
Patient Signature **Date**

PROCEDURE CONSENT

Patient Name: _____Pt Acct #_____

My signature permits Dr's. Kirkpatrick, Sequeira, and Miner, Nurse Practitioner Brookelynn Kendrick and Physician Assistants Makesha Holbrook Curd, Allison Raco, Cheryl Young, Kristine Hertzog, Fonda Schreiber, Elizabeth Meredith, Mark Snavely, Susan Hammerling and Cindy Bassford to examine me for the purpose of making a diagnosis and providing treatment. I further permit and request that they perform the test and procedures they deem necessary and I agree are appropriate for my medical care.

Biopsy
A biopsy entails obtaining a small piece of skin using local anesthesia in order to determine or verify a diagnosis and to plan a future course of therapy. The biopsy site may bleed, become irritated and infected. A small scar will form. If cancerous or precancerous changes are found on the biopsy specimen further treatment will be required even though the growth may appear to be gone.

Cryosurgical Therapy
Cryosurgical Therapy entails using liquid nitrogen to locally destroy skin cells. It is routinely used to treat pre-cancers, benign lesions, such as warts, and occasionally some small skin cancers. Following cryosurgical therapy, a small blister will form which can crust and slough off within two weeks. You may experience inflammation at the site and rarely infections. Complications may include scarring and pigmentary changes.

Dermatopathology is a critical part of giving you excellent care. We recommend that you use our preferred laboratories because of diagnostic accuracy, timeliness, and the ability of our providers to correlate clinical findings with pathology. If you request to have your biopsy sent elsewhere we will respect those wishes.

Brevard Skin and Cancer Center Laboratory (preferred) ____

Other laboratory request (specify) _____

The Patient is responsible for any laboratory charges outside of this office

Signed: _____ Date: _____
Patient or person authorized for this patient

Provider Witness: _____

Brevard Skin & Cancer Center Patient Registration Form **Patient acct# _____**

Patients Last Name		First Middle Initial	
Date of Birth	Age	Gender	Social Security Number
/ /		Female ____ Male ____	

Marital Status (circle one)	What is your preferred Language
Single / Married / Divorced / Widow	

Race (circle one)	Ethnicity (circle one)
American Indian or Alaska Native / Asian / Black or African American Native Hawaiian or Other Pacific Islander / White / Decline to state / Other	Hispanic-Latino Non-Hispanic or Latino / Other

Due to Government Program Hitech Act (Health Information Technology for Economic and Clinical Health Act), we are required to collect and report data on race and ethnicity.
You may refuse to provide this information by circling "Declined to state" above.

Personal information

Address (Number, Street, Apartment #)	City	State	Zip Code
Other Address	**E-Mail Address**		

Are you currently employed? YES NO	Have you served in the Military? YES NO	Is your spouse employed? YES NO	Are you covered under any other health care plan? YES NO

Phone Options	Phone Number	Okay to leave detailed msg	Call this number (circle one)
Home	( )	Yes ____ No ____	1st 2nd 3rd choice
Cell	( )	Yes ____ No ____	1st 2nd 3rd choice
Work	( )	Yes ____ No ____	1st 2nd 3rd choice

Primary Care Physician	Referred by	Are you new to our practice
		Yes _____ No _____
Employer	Employer phone number	Occupation
	( )	

Emergency Contact

Emergency Contact Name	Relationship to patient	Phone number	Other phone number
		( )	( )
Other family seen in practice			

Insurance Information

Subscriber Name (Ins. Holder)	Date of Birth	Relationship to patient	Subscriber Phone Number
	/ /		( )
Health Plan Information	Primary Health Plan	Secondary Health Plan	Other
Health Plan Name			
Health Plan Address			
Phone Number	( )	( )	( )
Insurance ID Number			

Signature of Patient or Guardian _____ Date _____

Patient acct #_____ **PAYMENT POLICY 2021**

Payment or insurance information is due at time of service. To ensure compliance of Federal Laws, Co-pays, Deductibles, and Co-insurance balances will be collected. Insurance coverage is not a guarantee of payment and you are responsible at the time of service for co-payment, co-insurance, or deductibles that may apply. Brevard Skin & Cancer Centers will bill your insurance. If your insurance policy has provisions such as deductibles, co-insurance or co-payments please note that these provisions that have been agreed to between you and your carrier. We cannot legally discount fees after their submission on your behalf to your carrier. If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined with your carrier. Writing off patient responsibility balances could jeopardize our contract with your carrier. If a portion of your fees are applied to an annual out of pocket maximum and we do not collect that fee, your out-of-pocket maximum has not been correctly calculated. If we are not participating with your insurance, you will be responsible for 100% of the out-of-network amounts. Contract discounts will not apply. In the event any insurance company does not render payment to Brevard Skin & Cancer Centers in a timely manner (within 60 days of filing) then you agree to be responsible for any unpaid claim(s). Any previous balances, or any known copay's will be collected upon arrival to your appointment.

- **Medicare:** We are participating providers of Medicare & most replacement plans. We will accept assignment on all Medicare claims. Patients are responsible for meeting and keeping track of their **annual $203.00 deductible** and paying the 20% co-payment at time of service unless you have a secondary supplemental insurance. As a courtesy to you we will file your secondary/supplemental insurance. <u>However, in the event the secondary does not pay within 60 days, you will be billed and be responsible for payment.</u>
- **Contracted HMO, PPO, or Other managed care:** If we are contracted participating provider of your insurance carrier, we will file your claims, however, <u>you are responsible for paying and keeping track of your annual deductible, co-pays, and co-insurance</u>. You will be responsible for all non-covered services (e.g., cosmetic surgery). Payment on all services is due at time of service.
- **Commercial, Non-contracted:** If you are covered by private, commercial insurance or any other plan in which our physicians are not contracted participating providers, you will be responsible for payment at time of service. We will provide you with all the necessary paperwork so you will be able to file with your insurance provider.
- **Marketplace Plans:** Plans through the Marketplace are given a Grace Period for their premium payments. During that Grace period, your insurance coverage is not inactive. However, during that time, full allowable rates must be paid if your insurance company does not pay or recoups their payments. Any necessary refunds will be provided once the insurance company processes that claim.
- **Authorization/Referrals:** With any insurance policy that requires prior authorization, it is the patient's responsibility to obtain an active authorization prior to their appointment. For policies that fall under the Florida Statue 627.6472, patients are allowed 5 visits to a Dermatologist in the state of Florida, without prior authorization, with-in a calendar year. It is the patient's responsibility to inform Brevard Skin and Cancer Center of any previous visits to another Dermatologist in Florida, as these will count towards those allowed visits.

In the event an account is forwarded to a collection agency, you agree that you will be responsible for the full amount owed to Brevard Skin & Cancer Centers plus any collection agency fees to Gulf Coast Collection Agency. For payment of services rendered, we accept cash, checks, MasterCard/Visa/Discover, and Care Credit® **<u>all checks returned unpaid will be charged a $30.00 administrative fee in addition to the amount of the returned check.</u>**

Patient/Responsible Party Signature: _____ Date: _____

<u>MEDICARE Patients Only:</u> This office is required to keep your signature on file authorizing us to file claims to Medicare for you and release information to the payer if they require it for proper consideration of a claim. Please read and sign the following statement: " I authorize any holder of medical or other information about me be released to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare benefits apply."

Signature for Medicare Patients: _____Date: _____

MEDIGAP PATIENTS: If you have a supplemental policy and it's a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file: "I authorize MEDIGAP benefits to me made on my behalf for any services furnished to me. I authorize the holder of information to release to the above MEDIGAP carrier information to determine these benefits payable for related services.

Signature as it appears on your MEDIGAP Card: _____Date: _____

Brevard Skin and Cancer Center

Patient: _____

Effective January 2nd, 2008 our billing department is asking for a credit card number and expiration date on which any outstanding balances will be billed, or **credits refunded**.

You will only be charged the portion of the insurer determined amount not paid by the Insurer for the services provided which they determine to be your share of cost and is not to exceed $200.00 unless approved by you. In the past you would have received a statement requesting your share of cost. If you would like us to charge your credit card on file for any balance, you can contact the billing office at 321-636-0109.

This policy will be no different than what most businesses such as hotels and airlines already implement. This information will be confidential and protected just as your medical record is.

As with any other transaction, as a cardholder you have the right to challenge any charges against your account.

If you have any questions about this payment method, do not hesitate to ask. You may also choose to decline this payment method and receive a statement in the mail by simply circling "declined: with your signature.

I authorize Brevard Skin and Cancer Center to charge outstanding patient portion balances for me and my dependents to the following credit card:

Visa MasterCard Discover Care Credit **or Declined (Please circle one)**

Account number: _____

Expiration date: _____ Billing zip code: _____

Full name on card (please print): _____

Signature: _____

Acknowledgment of
Notice of Privacy Practice

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and professional certification and licensures.

I have received, read, and understand the HIPAA Notice of Privacy Practices containing a more complete description of the uses and disclosures of my personal health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at the address below to obtain a current copy of the practices.

I understand that I may request, in writing, that Brevard Skin and Cancer Center restricts how my Private Health Information (PHI) is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that Brevard Skin and Cancer Center is not required to agree to my request for restrictions, but if they do, they agree to be bound by such restrictions.

Your Individual Rights to: In order to receive copies of your medical record a request must be made in writing at a charge of $1.00 per page. (Postage added, if copies are mailed to you).
Please allow 72 business hours notice for processing of records, at that time you will be informed of the cost to copy your records. Payment for copies will need to be rendered prior to picking up or sending documents to you.
There is no charge for documents that are forwarded for continuation of medical care to other providers that you designate in writing. These records may be mailed or faxed to the representative you have chosen.

Release of Information

"I authorize the release of medical information to my primary care or referring physician and to consultants as necessary to process insurance claims, insurance applications, and prescriptions as so noted on my patient registration form. I also authorize payment of medical payments to the providers at Brevard Skin & Cancer Center". If any of the information changes, I will notify the office of changes with written notification. I have received the Privacy Practices Acknowledgment and I have been provided an opportunity to review it.

You have the right to choose to whom we may release your health information to in regards to your family members.

_____ Spouse Only _____ All Family Members _____ Other: _____
(Please indicate which)

Print Patient Name: _____

Signature: _____

Date: _____ Account #: _____