Florida Specialty Medical Services LLC
Dermatology Division
Patient Packet

"Proving Compassionate Dermatology Care with the Focus on Patient and Family"

Florida Specialty Medical Services
Dermatology Division
17427-B Bridge Hill Court Suite J Tampa, Florida 33647
Telephone: (813) 765-0688 Fax (888) 731-3365

Patient, Surrogate and Power of Attorney Contact Information

Facility:___________________

Patient Name:___________________________ Medicare Part B # _______________________

Date of Birth:____________________________ Secondary Ins._______________________________

Social Security #_________________________ (or provide copy of card)

Address:_______________________________ Phone:_______________________

Surrogate or Power of Attorney Information

1. Name:___________________________
   Address:__________________________
   Work #:____________________________
   Home:_____________________________
   Cell:_______________________________
   Email:______________________________
   Relationship to patient_____________________

2. Name:___________________________
   Address:__________________________
   Work #:____________________________
   Home:_____________________________
   Cell:_______________________________
   Email:______________________________
   Relationship to Patient_______________________

3. Name:___________________________
   Address:__________________________
   Work #:____________________________
   Home:_____________________________
   Cell:_______________________________
   Email:______________________________
   Relationship to Patient_______________________

Other important info:____
____
____

Important: Please submit copies of all insurance cards, patient, surrogate and power of attorney contact information to be submitted prior to patient visit. Failure to provide information will result in cancellation of visit.

Consent for Treatment

It is understood by Patient (or Patient's authorized representative under a power of attorney) that during the physical examination and course of care and treatment of Patient by dermatologic health care practitioners from Florida Specialty Medical Services LLC. (FSMS), unforeseen conditions may occur that necessitates cryotherapy or skin biopsy(s) to be taken by shave, punch, and/or excision for which permission and consent is hereby granted. In addition, permission and consent is also hereby granted for Patient to have minor procedures and any subsequent treatments as deemed necessary by the health care practitioner. Procedure risks include, but are not limited to, scarring, bleeding, swelling, pain, deformity, infection, and/or ulceration. Patient (or Patient's authorized representative under a power of attorney) will inform the FSMS dermatologic health care practitioner of any possible known medical conditions or medications taken by the Patient that could be contradictions to a dermatologic procedure, including without limitation, medications such as anticoagulants, aspirin, cardiac, infectious, or psychotropic drugs. It is understood by the Patient (or Patient's authorized representative under a power of attorney) that the FSMS dermatologic health care practitioner will also review and rely on the information and documentation in the Patient's medical record maintained at the extended care facility in which the Patient is a resident in connection with any care and treatment provided.

It is recognized and acknowledged by Patient (or Patient's authorized representative under a power of attorney) that every surgical procedure involves uncertainty and no result can be guaranteed. It is also recognizes and acknowledged by Patient (or Patient's authorized representative) that the FSMS dermatologic health care practitioner is not responsible for natural complications that may occur. If any postoperative complications do occur, it is the responsibility of the Patient (or the Patient's authorized representative under a power of attorney) to contact the FSMS dermatologic health care practitioner as soon as possible or to promptly notify the health care providers at the facility where Patient is a resident.

To document and follow the course of Patient's treatment, permission and consent is hereby given by Patient (or Patient's authorized representative under a power of attorney) to have photographs taken by the FSMS dermatologic health care practitioner, and any such photographs will become part of the Patient's medical record and are confidential in nature. Patient (or Patient's authorized representative under a power of attorney) also grants permission for the reasonable limited use of any photographs of Patient for medical education purposes if Patient's identity is withheld.

Patient (or Patient's authorized representative under a power of attorney) also hereby grants permission and consents to have any tissue removed from Patient by a FSMS dermatologic health care practitioner during a medical procedure sent for histologic examination, and hereby grants permission and consent for the disposal of any such removed tissue in accordance with accustomed practice and procedure.

The patient, surrogate, or power of attorney is responsible for any failure to consent to any treatment plan or follow up care recommended by FSMS. I understand that I do not hold FSMS providers professionally or personally responsible for any follow up care or refusal of treatment of any skin condition or skin cancer.

Due to the nature of residence change or discharge of an extended care patient from a facility contracted with FSMS, it is important for the patient, family and health care surrogate or power of attorney to understand that it is their responsibility to seek follow-up care by a dermatology provider within one month of treatment. Recommended follow up will be determined by the new dermatology

provider. FSMS assumes no responsibility of patient's care or follow up after being discharged from the contracted facility and assumes no responsibility for the new dermatology provider's treatment or recommended follow up visits.

You consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made with your prior Consent. FSMS provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Protected health information may be disclosed or used for treatment, payment, or health care operations. Please contact FSMS for our Notice of Privacy Practices.

Patient (or Patient's authorized representative under a power of attorney) understands that any controversy or claim arising out of or related to the Patient's medical care and treatment provided by a FSMS health care practitioner will be resolved through mandatory binding arbitration under the rules of the Florida Arbitration Code.

Signed:____

Printed Name:____

A copy of the most current Power-of-Attorney from Patient is on file in Patient's Medical Record at the Facility for the Authorized Representative signing on behalf of Patient

Relationship to Patient (if signing under Power-of-Attorney):______________________________

Telephone:_______________________ Date:_____________________

HIPAA AUTHORIZATION FORM

Patient's Full Name	**Patient's Social Security Number**
Address	**Patient's Date of Birth**
City, State Zip Code	**Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:
   ____
2. The following person (or class of persons) may receive disclosure of protected health information about me:

   His/her/its Name

   Address

   City, State Zip Code
3. The specific information that should be disclosed is (please give dates of service if possible):

   ____

   ____

   UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
   YES, DISCLOSE THIS INFORMATION *______________________
   NO, **DO NOT** DISCLOSE THIS INFORMATION * ______________________
4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying Florida Specialty Medical Services in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for
   ____ .
7. This authorization expires on _____________, 200___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me:
   _____________________________________.

Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth or Social Security Number**

OR, if applicable –

Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**