

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

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

Do you have a history of any specific skin diseases?  Yes  No If yes, \_\_\_\_\_

**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 now, or have you ever had diseases or conditions of: (Please check YES or NO)

	Yes	No	Other systemic:	Yes	No
<b>Lungs:</b>					
• Chronic Bronchitis/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	• Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
• Asthma/ Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	• Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cardiovascular:</b>			• Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
• High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	• Kidney	<input type="checkbox"/>	<input type="checkbox"/>
• High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	• Immunosuppressed	<input type="checkbox"/>	<input type="checkbox"/>
• Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	○ Lupus	<input type="checkbox"/>	<input type="checkbox"/>
• Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	○ On chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
• Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	○ On steroids (i.e. Prednisone)	<input type="checkbox"/>	<input type="checkbox"/>
• Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>			
• Pacemaker/AICD	<input type="checkbox"/>	<input type="checkbox"/>	• Infectious Disease	<input type="checkbox"/>	<input type="checkbox"/>
• Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	○ Hepatitis A, B, C	<input type="checkbox"/>	<input type="checkbox"/>
<b>Vascular:</b>			○ TB exposure	<input type="checkbox"/>	<input type="checkbox"/>
○ Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	○ HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
○ Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	• Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>
○ Stroke	<input type="checkbox"/>	<input type="checkbox"/>	If yes please list location: _____		
<b>Other:</b>			Amputation	<input type="checkbox"/>	<input type="checkbox"/>
• Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>	• Fainting	<input type="checkbox"/>	<input type="checkbox"/>
• Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>			
• Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>	Do you have to take antibiotics before surgical procedures? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Convulsions, Epilepsy, Seizures	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any yes answers: \_\_\_\_\_

Please describe any recent hospitalization, surgeries or other conditions: \_\_\_\_\_

\_\_\_\_\_

Which pharmacy do you use? \_\_\_\_\_ Location: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**Brevard Skin & Cancer Center Patient Registration Form**

**Patient acct#** \_\_\_\_\_

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

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 2019**

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 \$185.00 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. However, in the event the secondary does not pay within 60 days, you will be billed and be responsible for payment.
- **Contracted HMO, PPO or Other managed care:** If we are contracted participating provider of your insurance carrier, we will file your claims, however, you are responsible for paying and keeping track of your annual deductible, co-pays, and co-insurance. 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 particular 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 in the event that 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® **all checks returned unpaid will be charged a \$30.00 administrative fee in addition to the amount of the returned check.**

**Patient/Responsible Party Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**MEDICARE Patients Only :** 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 as it appears on your Medicare Card:** \_\_\_\_\_ **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:** \_\_\_\_\_



## 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 #: \_\_\_\_\_



## 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 Snavelly, 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:** \_\_\_\_\_