DERMATOLOGY PATIENT REGISTRATION

ADERA & ADERA PA, BOARD CERTIFIED FAMILY MEDICINE

Rev. 2/2019

Patient Information

Name		Date of Birth	Sex ☐Male ☐Female
Address		City, State, Zip	
Home Phone	Mobile Phone	Work Phone	
Social Security Number		Drivers License	
Email Address		Employer Name & Phone	
Primary Care Doctor & Phone		Pharmacy Name & Phone	
Emergency Contact Name	Relationship	Emergency Contact Phone	

Primary Language	Ethnicity	Race	Marital Status of Patient
☐English ☐Spanish ☐Other (Please specify below)	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined	☐American Indian ☐Asian ☐Alaska Native ☐Black or African American ☐Native Hawaiian/Pacific Islander ☐White ☐Other ☐Declined	☐Married ☐Divorced ☐Single ☐Widowed ☐Declined

Responsible Party Information ☐ Check if same as patient and sign X below. If not, complete section and sign X below.

Name:		Date of Birth:
Address		City, State, Zip
Home Phone	Mobile Phone	Work Phone
Social Security Number		Drivers License
Relationship to Patient ☐Parent ☐Spouse ☐ Legal Guardian If Patient is under the age of 18, he/she **WILL NOT** be seen without a Parent/Guardian present.		Employer Name & Phone

I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event that my account is turned over to a collection agency, I agree to pay all late fees, costs of collection fees, and/or attorney's fees and all court costs, if any.

X_____Date_____

Insurance Information

Primary Carrier		Secondary Carrier	
Insurance Company Name	Insurance Phone	Insurance Company Name	Insurance Phone
Employer Name	Employer Phone	Employer Name	Employer Phone
Policy ID	Group Number	Policy ID	Group Number
Subscriber Name	Subscriber DOB	Subscriber Name	Subscriber DOB
Relationship to Patient ☐Parent ☐Spouse ☐ Legal Guardian		Relationship to Patient ☐Parent ☐Spouse ☐ Legal Guardian	

ASSIGNMENT OF BENEFITS I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment check(s) directly to Adera & Adera PA for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

X_____Date_____

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Communication of Health Information

Names of family members for whom we may disclose information regarding your health:

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

May we leave appointment related information on your voicemail / answering machine? ☐Yes ☐No

Medical Information

Latex Allergy? ☐No ☐Yes **Lidocaine Allergy?** ☐No ☐Yes

Please list all Medication Allergies and your reaction/side effect:

Current Medications

Current Medical Conditions ☐Diabetes ☐Hypertension ☐High Cholesterol ☐Cardiac disease ☐Hepatitis ☐HIV ☐Hypothyroid

Other:

Have you ever been treated for: ☐Basal Cell Carcinoma ☐Squamous Cell Carcinoma ☐Melanoma ☐Unknown type of skin cancer ☐Pre-cancer (actinic keratosis)

Which part of the body?_____Removed(date)_____Biopsied(date)_____.

Do you have any skin conditions? ☐None ☐Acne ☐Eczema ☐Psoriasis ☐Moles ☐Skin tags

Other:

Tobacco Use

☐Never Smoked

☐Every day smoker of _____packs per day for _____ years.

☐Former smoker. Quit date:_____.

Alcohol Use

☐Never ☐Social Drinker ☐Rarely

☐Daily(choose from below) ☐Recovering Alcoholic

☐Beer ☐Liquor ☐Wine

☐1-2 drinks ☐2-3 drinks ☐>3 drinks

Have you received a Flu vaccine this season?

☐Yes, date of vaccine:_____.

☐No. Reason: ☐Religious exemption ☐Patient decision

Have you received a Pneumonia vaccine?

☐Yes, date of vaccine:_____.

☐No. Reason: ☐Religious exemption ☐Patient decision

☐N/A (Not 65+ years of age)

If you are 50+ years old:

Last Colonoscopy:_____

☐Refused. Reason: ☐Religious exemption ☐Patient decision

Last Mammogram:_____.

☐Refused. Reason: ☐Religious exemption ☐Patient decision

Is the reason for your visit due to a fall, injury, accident, or work-related injury? ☐No ☐Yes

Would you like a free consultation today to discuss aesthetic or cosmetic services, i.e. Botox or Fillers? ☐No ☐Yes

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CONSENT TO TREATMENT AND AUTHORIZATION

Patient Name	Date of Birth

Consent to Treatment
I, the patient or authorized representative of the patient, does hereby consent to any and all medical treatments and diagnostic examination administered or offered by Adera & Adera PA, which treatments/examinations may be deemed advisable by the physician to diagnose and/or treat me/the patient during the period which I am a patient of Adera & Adera PA.

Authorization for Release of Confidential Information
I hereby authorize Adera & Adera PA to release medical, psychiatric, and substance abuse information, whether contained now or in the future, in my/the patient's records to the following: Insurance carriers(s) and/or employer(s) and/or organization(s) for the limited purpose of obtaining payment of all or part of charge for medical care rendered by Adera & Adera PA, which may include financial and medical record information to substantiate the need for the medical care rendered and the cost associated with the medical charges incurred. The Federal HIPAA Privacy Regulations authorize health care providers to share your medical information for treatment purposes, without your consent, including treatment received after you leave. Florida law, however, restricts (in some instances) the ability of Adera & Adera PA to share your medical information with health care providers for treatment purposes, if treatment is sought after your discharge. By signing this consent, you authorize the release of your records (current and historical) to health care providers with whom you or your treating physician(s) may consult for medical treatment. This consent will remain in force during the period that I/the patient is accepted as a patient at Adera & Adera PA. You may revoke this authorization at any time by notifying Adera & Adera PA, in writing, however, your revocation will not affect action taken by Adera & Adera PA, prior to receipt of notice of your revocation and had reasonable opportunity to act upon the revocation. Information disclosed pursuant to your authorization is from records whose confidentiality is protected by Federal or State law. Federal regulations or State law prohibit making any further disclosures of HIV antibody/substance abuse information without the specific written consent of the person to whom it pertains, or as otherwise permitted by Federal/State law.

Assignment of Insurance Benefits
I assign payment directly to Adera & Adera PA, all insurance benefits otherwise payable to me, for medical treatment rendered by Adera & Adera PA. I understand I am financially responsible for charges not paid by the assignment, and that I/the patient will assist in the collection of my/the patient's insurance should there be any delay in payment. If my/the patient's insurance has not remitted charges due within 45 days of receipt of treatment, I understand the entire balance may become due and that Adera & Adera PA may seek payment direct from me/the patient. THIS ASSIGNMENT OF BENEFITS IS IRREVOCABLE.

Medicare Patients: I request that payment of authorized Medicare benefits be made on my/the patient's behalf to Adera & Adera PA. I authorize any holder of medical information about me/the patient to release to the Health Care Financial Administration and its agents, any information to determine benefits payable for related services. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charges authorized by the Medicare carrier.

Patient/Guarantor Agreement
I/we understand that Adera & Adera PA is not in the business of extending credit and, therefore, the policy of Adera & Adera PA is to require **PAYMENT IN FULL AT THE TIME OF TREATMENT IS RENDERED**. If Adera & Adera PA must use the services of a collection agency or service to encourage prompt payment, a collection charge may be imposed. We may also choose to provide you with notice that you are being discharged as a patient of Adera & Adera PA.

Notice To Guarantor *You are entitled to an exact copy of the agreement you sign.*
The undersigned hereby acknowledges receipt of a copy of the above disclosure statement containing all information pertinent to this transaction. By signing this patient/guarantor agreement, the guarantor(s) agree(s) to guarantee payment of all charges incurred by the patient for services at Adera & Adera PA. This is an absolute guaranty and it shall continue as long as any balance is due and owing for medical care rendered by Adera & Adera PA. I understand I am financially responsible for my account with Adera & Adera PA, regardless of any insurance benefits.

By my signature below, I acknowledge reviewing the information contained in this document and that I have received the HIPAA Notice of Privacy Practices document at Adera & Adera PA.

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Staff Witness Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by State and Federal laws, including the HIPAA Rules, to safeguard general and health-related information about you. We have created a Notice of Privacy Practices that explains how your protected health information is handled. The Notice of Privacy Practices is provided to patients (and/or authorized representatives) when they first become our patient. We are asking you to sign this form to show that we offered you a copy of our Notice of Privacy Practices. By signing below, you are only acknowledging that you were offered or received a copy of the Notice of Privacy Practices. You are not making a statement about the content of the Notice of Privacy Practices or about your agreement or disagreement with any portion of it.

I acknowledge that Adera & Adera PA has offered or provided me with a copy of its Notice of Privacy Practices, which describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

PRIVACY CONTACT: Jeniffer Lofton 352-341-2800

I also understand that I am entitled to receive updates upon request if Adera & Adera PA amends or changes its Notice of Privacy Practices in a material way.

_____ _____

Printed Patient Name or Name of Representative | Signature of Patient or Representative

_____ _____

Relationship to Patient | Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices from the above-name patient or representative, but acknowledgment could not be obtained because:

☐ Individual refused to sign

☐Communication barriers prohibited obtaining acknowledgment

☐An emergency situation prevented us from obtaining acknowledgment

☐Other. Please specify

_____

_____