Associates in Dermatology

Caring for Southwest Florida for over 40 years

Communication Consent Form

CHART # _____

In order to comply with HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations, we ask that our clients review and sign this Communication Consent Form.

I, _____ authorize Associates in Dermatology to contact me and/or named authorized person(s) by the following methods for confirmation of appointments as well as any communications regarding appointments and assume responsibility to notify Associates in Dermatology whenever this information changes:

E-mail: _____@_____ ____Yes ____No

Telephone: _____ ____Yes ____No

SMS Text Message: _____ ____Yes ____No

If you choose not to receive notifications through SMS text message or e-mail, we will continue to contact you via telephone for all appointment confirmations.

Patient Signature: _____ Date: _____

A copy of this document will be provided to you upon request.

Diplomates, American Board of Dermatology

8381 Riverwalk Park Blvd #101 & Ste. #202 Fort Myers, FL 33919 (239) 936-5425 – Fax (239) 936-3591
14 North Del Prado Blvd Ste. #301 Cape Coral, FL 33909 (239) 772-1909 – Fax (239) 772-9742
3665 Tamiami Trail Ste. #104 & #105 Punta Gorda, FL 33950 (941) 621-8991 Fax (941) 347-7959

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Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of Associates in Dermatology's Notice of Privacy Practices.

Further, 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 medical assignment of benefits apply.

May we mail to your home or other designated location any items that assist the practice in carrying treatment/healthcare operations, such as appointment reminders, insurance items, and lab results?

YES NO

May we leave a message with a **member of your household** regarding appointments, lab results, and insurance?

YES NO

If yes, whom: _____ Relationship_____

If yes, whom: _____ Relationship_____

May we leave a message on an **answering machine/voice message** regarding appointments, lab results, and insurance?

YES NO

If employed, may we contact you at your work place?

YES NO

I understand the contents of this Notice.

_____

Patient or Legal Guardian Signature (If under 18 parent/legal guardian/relation to patient) Date

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MEDICAL HISTORY

Name _____ **Chart #** _____ **Date** _____

Reason for today's visit: _____

List Current Medications: _____

_____

Pharmacy: _____ Telephone: _____

Do you have a Heart Pacemaker or Defibrillator? □ **Yes** □ **No**

Blood Thinners	□ Aspirin	□ Advil / Ibuprofen	□ Aggrenox	□ Brilenta
	□ Eliquis	□ Pradaxa	□ Plavix	□ Coumadin/Warfarin
	□ Xarelto	□ Fish oil	□ Ginko	□ Vitamin E

Other: _____

Medicine Allergies	□ Lidocaine	□ Novocaine	□ Epinephrine	□ Keflex
	□ Penicillin	□ Tetracycline	□ Sulfa	□ Erythromycin
	□ Aspirin	□ Neosporin	□ Polysporin	

Others: _____

Current and Past Medical Conditions	□ Arthritis	□ Asthma	□ Alzheimer/Dementia	
□ Bronchitis	□ Convulsions	□ Diabetes	□ Easy Bleeding	□ Emphysema
□ Eczema	□ Epilepsy	□ Fainting	□ Heart Attack	□ Heart Valve Replace
□ Hepatitis	□ High Blood Pressure	□ HIV (AIDS)	□ Stroke	□ Irregular Heart Beat
□ IV Drug Use	□ Joint Replacements	□ Liver Disease	□ MVP (Mitral Valve Prolapse)	
□ Phlebitis	□ Stomach Ulcers	□ Thyroid Disease	□ Tuberculosis	

□ Skin Cancer, what type? _____ □ Cancer, what type? _____

Others: _____

Are you pregnant? □ **Yes** □ **No** If yes, _____Months

Has a blood relative had Skin Cancer? If yes, who and what kind? _____

_____ If not patient, please indicate relationship: _____

Signature of Patient or Legal Representative

Physician Signature: _____ **Date:** _____

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Patient Registration Chart #_____

Name: _____ DOB: _____
Last Name MI First Name

Address: _____City: _____State _____Zip_____

Home# _____Other #_____SS#_____

Marital Status: M W D S Sex: F M Student: FT PT Employment Status: F P R N/A

Spouse's Name _____ Patient's employer name: _____

Primary / Referring Physician: _____

Insurance Information (from your insurance card)

Primary Insurance Name: _____

Claims Address: _____ City _____ State _____ Zip_____

Insurance ID#_____Group#_____

Subscriber Name _____ SS# _____ Subscriber DOB _____

Subscriber Employer_____

Patient Relationship to Subscriber: Spouse _____ Child _____ Other_____

Secondary Insurance Name: _____

Claims Address: _____ City _____ State _____ Zip_____

Insurance ID# _____ Group#_____

Subscriber Name _____ SS# _____ Subscriber DOB _____

Subscriber Employer_____

Patient Relationship to Subscriber: Spouse _____ Child _____ Other_____

Medicare Patients

I authorize Associates in Dermatology to release to the Social Security Administration and Health Care Finance, or its intermediaries, any information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to Associate in Dermatology. Release of Information

I authorize the release of medical information to my primary care or referring physician, and as necessary to insurance companies to process insurance claims, insurance applications and prescriptions.

I understand that I am ultimately responsible for any/all services rendered to me at the time of service.

_____ Date _____

Patient or Legal Guardian Signature (If under 18 parent/legal guardian/relation to patient)

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