COASTAL SKIN SURGERY & DERMATOLOGY

DEMOGRAPHIC INFORMATION

Last Name:____________________________________ First:_____________________________ Middle:______________________

Date of Birth:______________________ Age:_________ Sex: **M F** Marital Status: _______________ SSN: __________________

Race: _______________ Ethnicity: __Hispanic or Latino __Not Hispanic or Latino Language:________________________

Mailing Address:____

Street apt/unit# City State Zip

Home Phone:__________________________ Cell Phone: _________________________ Work Phone: ______________________

E-Mail:____ Employer: ____

Emergency Contact Name: ____ Phone: ____________________________

Primary Physician: _______________________________ Location: ________________________ Phone: ____________________

RESPONSIBLE PARTY

Responsible Party: _________________________________ Relationship to Patient: _______________________________________

Responsible Party Phone: ____________________________________ Alternate Number: __________________________________

INSURANCE INFORMATION

Primary Insurance: _________________________________ Name of Policy Holder: ____

Date of Birth: _________________Relation: ______________ (Tricare Patients) Sponsors SS #:______________________________

Policy No.____Group No.____

Secondary Insurance: _______________________________ Name of Policy Holder: ____

Date of Birth: _________________Relation: ______________ (Tricare Patients) Sponsors SS #:______________________________

Policy No.____Group No.____

REFERRAL INFORMATION: "HOW DID YOU HEAR ABOUT US?"

Referring Physician: ____________________________________ Other Referral: ____

PHARMACY INFORMATION

Primary Pharmacy: ______________________________ Address: ______________________________ Phone: __________________

Coastal Skin Surgery & Dermatology, PL is proud to offer electronic prescription services to conveniently order new prescriptions and to refill most existing prescriptions at many participating pharmacies, including some mail order services. To enable electronic prescriptions to your pharmacy, you must grant Coastal Skin Surgery & Dermatology, PL permission to view current and past prescription information.

I authorize Coastal Skin Surgery & Dermatology, PL to e-prescribe on my behalf: **YES** **NO**

COASTAL SKIN SURGERY & DERMATOLOGY

PERSONAL MEDICAL INFORMATION

CURRENT MEDICATIONS (may also provide a list):

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

REVIEW OF SYSTEMS (Current or Past Problems)

Major Surgeries/Hospitalizations: ____

HISTORY of Skin Cancer?

Personal: □Basal Cell □Squamous Cell □Melanoma – Details (Location, Date)________________________________

Family: □Basal Cell □Squamous Cell □Melanoma - Details____

Personal History	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
Heart Attack	Y	N	Stroke	Y	N	Cancer (non-skin)	Y	N
Heart Disease	Y	N	Autoimmune Disease	Y	N	What kind? ____________		
Kidney Disease	Y	N	Diabetes (Sugar)	Y	N	Blood/Bleeding Disorder	Y	N
Liver Disease	Y	N	High Blood Pressure	Y	N	Infectious Disease (TB, HIV, Hepatitis)	Y	N
Lung Disease	Y	N	Thyroid Disease	Y	N	What Kind?____________		

OTHER:________________________

	YES	**NO**		**YES**	**NO**
Do you have a Pacemaker/Defibrillator?	Y	N	Do you have an artificial joint/heart valve?	Y	N
Do you take antibiotics prior to procedures?	Y	N	Do you form keloids or thick scars?	Y	N

↑

ALLERGIES (Medication/Drug/Food):____

	YES	**NO**		**YES**	**NO**
Allergic to Iodine?	Y	N	Allergic to X-Ray/IVP Dye?	Y	N
Allergic to Latex?	Y	N	Allergic to Nickel/Metal Allergy?	Y	N
Allergic to Adhesive?	Y	N			

SOCIAL HISTORY

Do you smoke?	NO	FORMER: Quit: ______	YES: How much?_______
Do you drink alcohol?	NO	SOCIALLY/OCCASSIONALLY	HEAVILY
Do you use tanning beds?	NO	IN THE PAST	YES

Occupation? ____

____ ________________________

Signature of Patient **Date**

COASTAL SKIN SURGERY & DERMATOLOGY

Coastal Skin Surgery & Dermatology Financial Policy

Thank you for choosing Coastal Skin Surgery and Dermatology. Our policies are listed below for your careful review. These policies are intended to make your office visit as pleasant as possible, and enable our Medical Staff provide the highest quality of care that you are accustom to.

Please read all information and acknowledge by signing below.

1. We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance.
2. If you have a change of address or telephone number(s), please notify our office immediately.
3. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. It is very important that you understand the provisions of your policy. We cannot guarantee payment of all claims. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, their policy holder.
4. We will collect your deductible, co-payment, or charge for a non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. We accept cash, checks, and all major credit cards.
5. If we do not participate with your insurance company, you will be expected to make payment in full at the time service is rendered.
6. If your insurance denies our charges, or does not pay us in a timely manner, or if your account becomes delinquent we reserve the right to refer your account to a collection agency and to be reported to the credit bureau.
7. All cosmetic services are not covered by insurance. You will be expected to pay half of the service fee to make an appointment and to pay the remainder of balance when services are rendered.
8. **No show or missed appointments** – We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel an appointment within 48 hours by you. If **two** appointments are missed without cancellation, you will be charged a $50.00 fee. If **three** appointments are missed, you will be dismissed from the practice for non-compliance.
9. Any balances on your account need to be paid in full before you will be seen again unless a payment arrangement has been made with billing personnel.
10. Return checks will be subject to a Non-Sufficient Fund Fee of $25.00.
11. **PLEASE BE ADVISED, THERE MAY BE ADDITIONAL COSTS FROM OUTSIDE LABORATORIES. OUR BIOPSIES ARE SENT TO OUR PREFERRED PATHOLOGIST/LABORATORY IN TALLAHASSEE, FL-KETCHUM, WOOD & BURGETT, IN PENSACOLA, FL-DERMPATH DIAGNOSTICS, AND IN BIRMINGHAM, AL-SKIN DX. IT IS THE PATIENT'S RESPONSIBILITY TO CONTACT THEIR INSURANCE COMPANY TO VERIFY THAT THESE LABS ARE IN THE NETWORK.**

Please remember, whether you have insurance or not, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our office.

Thank you very much for reading and adhering to our policies.

I have read and have a full understanding of the financial policy of Coastal Skin Surgery and Dermatology.

Signature: ____ **Date:** ____________________

COASTAL SKIN SURGERY & DERMATOLOGY

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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:

< Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
< Obtain payment from third-party payers
< Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. 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 any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name or Legal Guardian: ____

Signature: ____

Date: ______________________________

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason:

REQUEST FOR ELECTRONIC & CONFIDENTIAL COMMUNICATIONS

I request that the following communications from the practice be delivered to me by the provided electronic means. I understand that this form of communication may not be secure, creating a risk of improper disclosure to unauthorized individuals. I am willing to accept that risk, and will not hold the practice responsible should such incident occur.

Communications

_______Appointment reminders _______ Prescription refill reminders

_______ Other (list specifically): ______________________________________

Method

_______E-mail Address: ______________________________________

_______Text Phone Number: ______________________________________

Patient Name or Legal Guardian: ____

Signature: ______________________________________ Date: ________________________

COASTAL SKIN SURGERY & DERMATOLOGY

RELEASE OF MEDICAL INFORMATION

BY SIGNING BELOW, I AUTHORIZE COASTAL SKIN SURGERY & DERMATOLOGY TO RELEASE MY MEDICAL AND BILLING INFORMATION TO:

RELATIONSHIP		NAME OF DESIGNATED PERSON
SPOUSE	☐ YES ☐ NO	________________________________
CHILDREN	☐ YES ☐ NO	________________________________
PARENTS	☐ YES ☐ NO	_________________________________

OTHERS ____

Patient Name or Legal Guardian: ____

Signature: ____

Date: ____

We ask that if you have any change in this request, that you please inform the receptionist.

REQUEST FOR RESTRICTION OF PROTECTED HEALTH INFORMATION

PLEASE NOTE: THE PRACTICE IS NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS.

What PHI would you like restricted or limited? (Please be as specific as possible; e.g. biopsy results, medications, appointments, etc.)

____

____

How would you like your PHI restricted?

____

____

Patient Name or Legal Guardian: ____

Signature: ____

Date: ____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- Treatment: We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.
- Payment: We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- Health operations: We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.
- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain law suits and law enforcement.

Certain ways that your protected health information could be used disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.
- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are

obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.

- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Carlene Jarrett, Privacy Officer

Phone number: 850-654-3376

Fax number: 850-654-3320

Office for Civil Rights

http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We are required to abide by the policies stated in this Notice of Privacy Practices, which became effective on September 23, 2013