PATIENT INFORMATION FORM

Patient Name: ____ Date: ________________

Nickname: ______________________________________ D.O.B.: ______________________

Referred By:______________________________Primary Care Doctor: ____________________

Reason(s) for Visit: ____

Previous Dermatologist:__________________________________Date of last skin exam: _______________

PAST MEDICAL HISTORY: (Please circle if you have/had any of the following)

Anemia	Dementia	Leukemia/Lymphoma
Anxiety	Depression	Lung Cancer
Arthritis	Diabetes	Lupus
Asthma	End Stage Renal Disease	Osteoporosis
Bleeding Disorder	GERD	Pancreatitis
BPH (Enlarged Prostate)	Glaucoma	Prostate Cancer
Breast Cancer	Hearing Loss	Radiation Treatment
Colon Cancer	Hepatitis	Seizure Disorder
COPD	High Blood Pressure	Stroke
Coronary Artery Disease	High Cholesterol	Thyroid Disorder
Crohn's Disease/Ulcerative Colitis	HIV/AIDS	Tuberculosis
NONE OF THE ABOVE		

Other: ____

PAST SURGICAL HISTORY: (Please circle all that apply)

Amputation	Joint Replacement, Hip (Right, Left, Bilateral)
Appendix Removed	Joint Replacement, Knee (Right, Left, Bilateral)
Bladder Removed	Liver Removed
Breast Biopsy (Right, Left, Bilateral)	Lumpectomy (Right, Left, Bilateral)
Breast Implants	Mastectomy (Right, Left, Bilateral)
Breast Reduction	Organ Transplant(s):
Colectomy: Colon Cancer Resection	____
Colectomy: Diverticulitis/IBD	Ovaries Removed: Cyst
Coronary Artery Bypass	Ovaries Removed: Ovarian Cancer
Hysterectomy	Pancreas Removed
Gallbladder Removed	Testicles Removed (Right, Left, Bilateral)
Kidney Biopsy (Nephrectomy)	TURP (Prostate Removed)
Kidney Stone Removal	Spleen Removed
Kidney Removed	Valve Replacement
NONE OF THE ABOVE	

Other: ____

Do you have an advanced care plan or healthcare proxy? *Yes *No

If yes, (Name/Relationship)___________________________

Have you had the pneumonia vaccine? * Yes * No

PERSONAL SKIN DISEASE HISTORY: (Please circle all that apply)

Acne
Actinic Keratosis
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin/Eczema
NONE OF THE ABOVE
Flaking or Itching Scalp
Hives
Melanoma
Merkel Cell Cancer
Poison Ivy
Precancerous Moles
Psoriasis
Rosacea
Shingles
Squamous Cell Skin Cancer

Other:____

Do you wear Sunscreen? **YES NO** If yes, what SPF? __________

Do you or have you ever used a tanning salon? **YES NO**

FAMILY HISTORY OF SKIN DISEASE AND MEDICAL ILLNESS:

(Only first-degree relatives- Mother, Father, Brother, Sister and your children. Please specify which relative)

Eczema ____________________
Keloids ____________________
Melanoma ____________________
Diabetes ____________________
Cancer ____________________
Heart Disease ____________________
Other: ____________________
Psoriasis ____________________
Skin Cancer ____________________
Lupus____________________
High Blood Pressure ____________________
High Cholesterol ____________________
Stroke ____________________

SOCIAL HISTORY: (Please circle all that apply)

Cigarette Smoking:
Currently Smoke:_________pack(s) per day
Smoked in the past
Never smoked

Alcohol use:
None
Less than 1 drink per day (Socially)
1-2 drinks per day
3 or more drinks per day

Recreational Drug Use:
Currently using
Past Use
Never used

Occupation:____

REVIEW OF SYSTEMS: (Please circle if you are currently experiencing any of the following)

Problems with bleeding
Problems with scarring
Headaches
Unintentional weight loss
Fever or Chills
Irregular Menses
Problems with healing
Night sweats
Rash
Chest pain
Itch
Muscle weakness
Wheezing
Neck stiffness
Anxiety
Depression
Joint aches
Blurry vision
Abdominal pain
Shortness of breath
Cough
Hay fever
Sore throat
Decreased night vision

ALERTS: (Please circle all that apply)

Allergy to adhesive
Allergy to topical antibiotic ointments
Blood thinners
Artificial joints within the past 2 years
Pacemaker/Defibrillator
MRSA
Organ transplant
Hepatitis B/C
Allergy to anesthetic
Allergy to Betadine
History of melanoma
Artificial heart valve
CNS stimulator
Premedication prior to procedure
Genetic bleeding disorder
Pregnancy or planning pregnancy
Allergy to antibiotics
Allergy to latex
History of Merkel cell cancer
Rapid heartbeat with epinephrine
Cochlear implant
Immunosuppression
HIV/AIDS
Lactating/breastfeeding

INNOVATIVE DERMATOLOGY
AND MOHS SURGERY

MEDICATIONS

☐ **NONE** (Please include all current prescribed and over-the-counter medications)
☐ **SEE MEDICATION LIST ATTACHED**

MEDICATION NAME	DOSAGE	FREQUENCY

MEDICATION ALLERGIES

☐ **NONE** (Please list all medication allergies and reactions)

MEDICATION NAME	TYPE OF REACTION

PHARMACY INFORMATION

Pharmacy Name: ______________________________

Location Address: ______________________________

Phone: (______)______________________ Fax: (______) ______________________

Patient/Guardian Signature:______________________________Date: ____________

Provider Signature:______________________________Date: ____________

3507 LEE BLVD. SUITE#107, LEHIGH ACRES, FL 33971 8800 BERNWOOD PARKWAY UNIT#6, BONITA SPRINGS, FL 34135
P: 239-368-8071 F: 239-368-8074 P: 239-908-6444 F: 239-494-1433

INNOVATIVE DERMATOLOGY
AND MOHS SURGERY

COSMETIC INTEREST QUESTIONNAIRE

Patient Name:______________________________________Date of Birth: ________________________

1. **Do you think you look?**
   - ☐ **Younger than you are**
   - ☐ **Your age**
   - ☐ **Older than you are**
2. **Do you have any cosmetic or rejuvenation concerns (wrinkles, volume loss, texture changes, discoloration, etc.)? { } Yes { } No**
3. **Have you ever had a cosmetic or rejuvenation treatment in the past (Botox, fillers, lasers, chemical peels, etc.)? { } Yes { } No**

   If so, what was it?

   ____
4. **Are you interested in discussing any of these treatments we have to offer in our practice?**

   { } Yes { } No

INNOVATIVE DERMATOLOGY
AND MOHS SURGERY

PATIENT REFERRAL FORM

Patient Name: (Last, First)___________________________________Date of Service:_____/_____/______

Date of Birth:_____/____/_____Email address: ____

How did you hear about us?

☐ **Advertising (mark all that apply)**

- **Internet/Google Search/Webpage**
- **Magazine**
- **TV**
- **Billboard**
- **Building Signage**
- **Newspaper**
- **Phone Book**

☐ **Insurance Company**

☐ **Physician: _______________________________________**

☐ **Family or Friend: __________________________________**

☐ **Other: ____**

INNOVATIVE DERMATOLOGY AND MOHS SURGERY

PATIENT REGISTRATION FORM

Patient name: (Last, First, Middle Initial)____Date:________/_____/__________

Date of Birth: _____/____/_______ Social Security #:__________________________________ Gender: Male Female

Race: __________________ Ethnicity: __________________________________Preferred Language: ____________________

Mailing Address: Street ____

City:______________________________State:________________________________ZIP________________

Alternate Address: ____

City:______________________________State:________________________________ZIP________________

Home Phone: (_____)_________________ Work Phone: (____)____________________Cell: (_____)______________________

Email:____

Marital Status: Single Married Divorced Widowed Separated

Preferred Contact Method:_____Phone_____E-mail____Fax_____Letter_____Patient Portal_____Other____Declined

Parent, Spouse or Responsible Party (if different from patient or patient is a minor)

Name: (Last, First, Middle Initial) ____

Date of Birth: _____/____/_______ Social Security #:__________________________________ Gender: Male Female

Mailing Address: Street ____

City:______________________________State:________________________________ZIP ________________

Home Phone: (_____)______________________Work Phone: (______)________________Cell: (______)___________________

Email: ____

EMERGENCY CONTACT

Name of Friend or Relative: ____

Relationship to Patient: ____

Address: ____

Phone #: ____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of medical information to my primary care physician, referring physician and/or consultant, if needed, as a necessary process for insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the Innovative Dermatology and Mohs Surgery Physician/Provider if applicable.

Responsible Party Signature:____ **Date**: ______________________

FOR MEDICARE PATIENTS ONLY

Medicare Authorization

I request that payment for authorized Medicare benefits be made on my behalf to Innovative Dermatology and Mohs Surgery for any services furnished to me by providers of Innovative Dermatology and Mohs Surgery. I authorize Innovative Dermatology and Mohs Surgery to release to the CMS and its agents any information needed to determine these benefits payables for related services.

Medicare is not always the Primary insurance. Federal regulations REQUIRE that we obtain information to determine if another insurer may be primary to Medicare.

Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at the job? **YES NO**

Are you covered by an HMO/PPO which makes Medicare secondary? **YES NO**

Do you have medical coverage through Medicaid? **YES NO**

Are you currently under Hospice Care? **YES NO**

Are you a resident of a skilled nursing facility or nursing home? **YES NO**

Are you presently receiving Worker's Compensation? **YES NO**

Are you visiting the office due to disability coverage? **YES NO**

Is this illness/injury covered by the VA (Veterans Administration)? **YES NO**

Is this illness/ injury covered by the federal Black Lung or End Stage Renal Disease Program? **YES NO**

Is this illness/injury due to an automobile accident? **YES NO**

Is this illness/injury due to work related causes? **YES NO**

Patient Signature:____ **Date:** ________________________

MEDIGAP

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to my MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Patient Signature:____ **Date:** ________________________

OFFICE FINANCIAL POLICY

In order to establish and maintain a trusting and strong patient/practice relationship, it is important that you understand your financial responsibility. The following information regarding our financial policy will help you achieve this.

Payment at time of service: Payment is due in full at the time of service unless you are covered by Medicare or an insurance company with which we participate. We accept Visa, MasterCard, American Express, Discover, debit cards, CareCredit (an extended payment option), cash and personal checks as forms of payment. For any returned checks, you will be charged a $25.00 service fee in addition to the amount of the check returned for insufficient funds; no exceptions. This total must be paid by cash or credit card within 14 days.

Insurance: Patients will be asked to present a government issued photo ID and current, valid insurance card to the receptionist for copying upon check-in at the office. Please make it a point to bring your insurance card with you each time you are seen for medical services to verify your benefits. Claims not paid within 45 days by your insurance company will become your responsibility. You will receive a statement for these services and you will need to contact your insurance company for reimbursement.

For those patients covered by insurance plans with which we ARE participating providers, all co-payments, co-insurance, deductibles and/or non-covered services are due at the time of service rendered as required by your insurance carrier(s). Any deductibles or copays owed from your visit pursuant to your insurance policy will not be waived. You will be billed in full for any services that your health plan considers "not a benefit" or a "non-covered service". We will file the insurance claim to the insurance company. If your insurance coverage changes to a plan with which we ARE NOT participating providers, we will require payment in full at the time of service and we will file your claim to the insurance company as a courtesy. In the case of non-contracted secondary carriers, the balance will become your responsibility 30 days after that claim is filed. Any charges that are not paid by your insurance company are your responsibility. Your insurance policy is a contract between YOU and your insurance company. Recent shifts in the healthcare industry have resulted in insurance companies increasingly transferring costs to patients, you, the insured**.** It is your responsibility to know and understand the terms, guidelines, and limitations of your plan. It is also your responsibility to advise us of any changes in your insurance, address or employer. Any pre-certifications of procedures or testing are your responsibility. Please let us know in advance if your insurance company requires this.

Your insurance plan may require a prior authorization or referral to be completed before seeing a specialist. It is your responsibility to obtain the proper referral to be seen for your appointment. You can determine whether you need prior authorization or a referral by checking your insurance card or by calling your insurance company, using the telephone number on the back of your insurance card. Contact your Primary Care Provider if a prior authorization or referral is needed for your visit. This may involve calls to your primary care or referring physician. If either is required, it must be received by our office prior to your visit. If you do not have a referral for an office visit or procedure, you will be required to pay for your visit on the day of service or given the option to reschedule the appointment which may result in a missed appointment fee.

Uninsured patients: Self-pay or uninsured patients are responsible for payment at the time of service. The fee schedule is based upon the established Medicare fee schedule in place. All prices quoted prior to the completion of non-cosmetic dermatology office visits and procedures are only estimates and can change based on the complexity of the office visit, pathology/laboratory analysis and/or procedures performed during the date of service.

Medicaid: We are not contracted with any Medicaid plan. Medicaid patients seeking services are responsible for payment in full at the time of service.

Personal injury and Worker's Compensation: We do not bill for worker's compensation cases. In addition, we do not bill for auto accident or other liability or lawsuit-related cases due to personal injury. You are responsible for payment at the time of service. We do not accept liens.

Minors: A parent or legal guardian must accompany all patients under the age of 18 to authorize treatment and financial arrangements. If this is a custodial parent, we can submit the charges to another parent's insurance, however, the parent presenting the child for care will be billed for the balance not covered by the insurance. Any patient over the age of 18 will be held financially responsible for all charges incurred.

Health Care Surrogate: If you are under the guardianship of a health care surrogate, we must have a written durable power of attorney to provide for a copy of our records. Until we have a signed, written document by the surrogate allowing us to provide care, we will be unable to perform any services and you will be given the option to reschedule the appointment which may result in a missed appointment fee.

Electronic Health Record: Our practice uses an Electronic Medical Recording system. Occasionally, office notes may be in a preliminary state and awaiting final review from the provider when a patient checks out. In the event your billing status changes from the time of check out, a refund will be issued or you will be responsible for the balance. Only finalized notes that have been reviewed and signed by a provider are submitted to insurance companies.

Collections: Statements will be sent out monthly for patients with a personal balance. Payment is due upon receipt of the statement. If you are unable to pay the balance in full, please contact the office to discuss a payment plan. Please note, if payment is not received from either you or your insurance company within 90 days from the date of service(s), your account will be considered delinquent and subject to referral to an outside collection agency. In the event an account is turned over to an outside collection agency, you will be responsible for the fees of that collection agency, which may be based on a percentage of the debt, and all costs and expenses, including court and attorney fees, we incur in such collection efforts. We reserve the right to charge you these processing fees if payment is not received after our first attempt to collect payment. Furthermore, should your account be in a collection agency, you may be given a 30-day notice of dismissal from the practice, allowing only for emergency visits during that time. In the event this occurs, you will be provided the necessary information of other sources for continuation of care.

Medical Records/Forms: Patients requesting medical records to be released to themselves or other providers will be charged $1.00 per page for the first 25 pages, and $0.25 per page for any additional pages thereafter. No charges will be applied for records we request from another provider. We can process disability or other benefit forms that are related to your treatment and care. There will be a $10 per page or $25 (lesser of the two) processing fee (except for Social Security and Worker's Compensation). Please allow up to 5 business days for records release and/or forms to be completed.

INNOVATIVE DERMATOLOGY
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Cosmetic Services: Patients are financially responsible to pay in full for all cosmetic procedures at the time of service. We do not bill insurance companies for cosmetic procedures. Fees for in-office treatments such as Botox, dermal fillers, chemical peels, laser procedures and other similar procedures are priced either on a per treatment basis or as a treatment package. The fee for a new cosmetic consultation is $100 and is payable at the time of the consultation. The fee will be waived for established cosmetic patients. If, after your consultation, you have the procedure done within one (1) year, the consultation fee will be deducted from the total cost. We require a non-refundable, non-transferable deposit of 50% (half) of the cost of service collected at the time the appointment is scheduled, and the other 50% (half) collected seven days prior to the date of service. We require three business days' notice of cancellation; otherwise you will forfeit 50% (half) the cost of service. Treatments and series of treatments are non-refundable. Additionally, if complications should develop or surgical revisions are necessary, you may incur additional costs. For more detailed information, please see one of our representatives.

Skin Care and Retail Products: We accept returns on retail items within 7 days of product purchase **only** if there is dissatisfaction with the product after minimal use or a product reaction. Returns are applicable for **account credit only**. Unfortunately, due to the nature of the pharmaceutical preparations, we cannot accept returns on items requiring a prescription, e.g. Latisse, Hydroquinone.

I am able to read and understand English or translated to me by one who does and accept the contents of the above policy. I have had the opportunity to discuss this policy with the medical professional or office representative and have had all my questions answered to my satisfaction. By signing this document, I am agreeing to the terms of this Financial Policy.

____ ____________________________

PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

INFORMED PATIENT CONSENT

I grant permission for the medical provider(s) and staff of Innovative Dermatology and Mohs Surgery to examine and treat me, including any procedure(s) or biopsy by shave, punch and/or excision, as deemed necessary in the exercise of their professional judgment. I acknowledge that during the course of my treatment, unforeseen conditions may occur that may necessitate these procedures. I give permission to have minor surgical procedures, evaluations and any subsequent treatments as deemed necessary, as long as the risks and complications are discussed with me prior to the procedure.

I have been informed, to my satisfaction, regarding the nature and risks inherent to the performance of any medical and/or surgical procedure including, but not limited to, pain, redness, discoloration of skin, dehiscence (opening of wound), bleeding, infection, rash, reaction to anesthesia and/or the formation of thick or otherwise objectionable scars. I am aware that such, or any, natural complications may result from any procedure and I recognize that the medical provider(s) and staff are not responsible for any natural complications that may occur.

I recognize that the practice of medicine and surgery is not an exact science and that every procedure involves uncertainty. I acknowledge that no result of examinations, treatments or operations has been guaranteed. If any postoperative complications occur, it is my responsibility to contact the medical provider(s) and/or staff as soon as possible. If, for any reason, contact is not made, then I understand to call 911 or proceed to the emergency department immediately.

I understand that medical care requires my cooperation and will follow my medical provider's orders and prescriptions. If indicated, I will schedule and keep appointments for follow-up care and call the office to note any changes or concerns in my condition. I understand that several treatments may be required for full resolution of my issue. I am aware that prescription refills may take up to two (2) business days to process the request. I understand that an annual exam for refills may be required, but more frequent visits may be necessary depending upon the medical condition. I understand that policies are constantly changing, and that my health insurance policy may not cover periodic preventive skin cancer screenings, although they may be required by my provider. I am aware that I will contact my insurance company to see if they cover skin cancer screenings.

I give permission to have any tissue removed during the procedure(s) to be sent for slide processing and histologic examination by a pathologist. I understand that fees for this service are separate from the procedure performed by the medical provider. I understand that other laboratory services, such as blood tests and cultures, are also separate from services performed by the provider, and that I may be billed by the outside laboratory for analysis. I also consent to the disposal of any tissue which is removed in accordance with accustomed practice and procedure. I am aware that I will be financially responsible for the removal or treatment of benign (non-cancerous) skin lesions, unless they have met certain clinical criteria, including, but not limited to, change in color, quality, size, pain or bleeding. I understand that I may be billed by an outside laboratory for work that is performed in this office, if my insurance company does not have a contracted lab or facility, or if services are not covered by my insurance company. I am aware that if my insurance company requires the use of a specific laboratory, then it is my responsibility to provide that information prior to treatment. I understand that failure of this notification may result in additional out-of-pocket costs to me.

I am aware that when a laboratory test or specimen is submitted for analysis, results should be available within 7-10 business days. I understand that it is the policy of Innovative Dermatology and Mohs Surgery to make every effort to communicate all results and notify me if any further treatment is needed. I understand that no system is perfect, and if I have not been notified of my results within 3 weeks, either by phone or mail, I will attempt to immediately contact the office to verify the diagnosis. I understand that untreated malignancies (cancers) can be dangerous and lead to further complications with potentially life-threatening results. I will not hold the medical provider(s) or staff responsible for my decision to not treat my malignancy (cancer) should such complications occur.

INFORMED CONSENT CONTINUED

I authorize my medical provider(s) and staff of Innovative Dermatology and Mohs surgery to document and record medical and/or surgical procedure(s) during my appointments by using photographs, video recordings and/or other media. I understand that reproduction or publication of these photographs, recordings and/or other media will be used for the purpose of medical/scientific study, research, education, before and after surgical portfolios and/or documentation for my medical record. I understand that descriptive texts, photographs and recorded material may include appropriate portions of the body to demonstrate medical and/or surgical procedure(s) and that every possible effort will be made to protect my identity in those materials. I also grant permission for the judicious use for medical education purposes if my identity is withheld.

I understand that these photographs, video recordings and/or media may be used for marketing, advertising and/or social media. By initialing this box, I decline the use of these images/media for these purposes.

I further acknowledge that all photographed and recorded media obtained is the sole property of Innovative Dermatology and Mohs Surgery. I understand that I may refuse any photographs or recording media at any time, and that I will be asked in advance of taking or using such media.

I am aware that by providing my email address, I may receive emails regarding appointment reminders, promotional material, special offers, patient surveys, newsletters, etc. from Innovative Dermatology and Mohs Surgery. I also consent to receive automated appointment reminder phone calls and emails. I further understand that Innovative Dermatology and Mohs Surgery will not share my email address or email personal medical information, unless I grant permission to do otherwise. By initialing this box, I decline communication via email.

I understand and agree that I may receive communication for appointment reminders by text messaging. I authorize Innovative Dermatology and Mohs Surgery to send these text messages to me on my provided cell phone number and that I am legally responsible for use of the account. I am aware that I may reply with various comments to receive account information. I acknowledge that text charges from my cell phone carrier may apply. I understand that I may opt out of these text messages communications at any time. By initialing this box, I decline the text messaging service.

I authorize and request that my insurance company, in lieu of reimbursing me directly, pay to the medical provider(s) or group any benefits for services rendered.

I understand that my medical insurance carrier may pay less than the actual bill for services. I agree that I may be responsible for payment of all services rendered on my behalf or my dependents.

I authorize my medical provider(s) to release information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such medical care to other institutions or agencies accepting the patient for medical or institutional care, including, but not limited to, my referring provider, insurance companies, pathologists, laboratories, worker's compensation carriers and/or third party payers, including Medicare. I also consent to the release of medical information to my next of kin or my designee, if requested, in the event of my death.

I am able to read and understand English or translated to me by one who does and accept the contents of the above consent. I accept the risks and complications of the procedure. I have had the opportunity to discuss this policy with the medical professional or office representative and have had all my questions answered to my satisfaction.

PATIENT OR LEGAL GUARDIAN SIGNATURE

DATE

CANCELLATION POLICY

We value your time and thank you in advance for valuing ours. So that we can minimize your wait time and not overbook, we are enforcing this cancellation policy. You will be notified to confirm your appointment. We understand that certain situations may arise that may interfere with your scheduled appointment. If you are unable to make your office visit appointment, please call or email (idermandmohs.com) our office at least 24 hours prior to your scheduled appointment to cancel and reschedule; cosmetic and/or procedure/surgical appointments, at least 48 hours prior to your scheduled appointment. As missed appointments represent a cost to us, to you and other patients who could be seen in the time set aside for you, we reserve the right to assess a fee of $50 for each missed office visit appointment or $100 for each missed cosmetic/procedure/surgical appointment. Three or more missed appointments within a 6-month period will result in discharge from the practice and denied any future appointments. The fee is the responsibility of the patient and must be paid in full before the patient's next appointment. Unavoidable circumstances may cause you to cancel your appointment within 24 hours. If you reschedule within 24 hours, the assessed fee in this instance may be applied towards your service or completely waived, but only with management approval. We believe that a positive physician/patient relationship is established on good communication and understanding. If you have any questions, please do not hesitate to ask us. Thank you for your cooperation.

I am able to read and understand English or translated to me by one who does and accept the contents of the above policy. I have had the opportunity to discuss this policy with the medical professional or office representative and have had all my questions answered to my satisfaction. I understand that if I miss or do not cancel my appointment by calling or emailing the office with at least a 24 hours' notice, I am aware and agree to pay the assessed fee for the missed appointment.

____________________________________ __________________________

PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

INNOVATIVE DERMATOLOGY
AND MOHS SURGERY

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PRIVACY RULE OF PATIENT AUTHORIZATION AGREEMENT AND AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS (§164.508(A))

I understand that under the HIPAA, I have certain rights to privacy regarding my PHI and as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare; a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can approve treatment and verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided/given the opportunity to receive a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment, it may be necessary to provide my Protected Health Information to another covered entity. I also understand that my PHI may be used or disclosed without my authorization as required by law and that disclosures will be provided upon my request. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified above for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement
Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent.
- This facility reserves the right to change the notice and practices and, that prior to implementation, will mail a copy of any revised notice to the address I have provided if requested.
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility has already acted in reliance thereon.

It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

HIPAA NOTICE CONTINUED

To protect your privacy and confidentiality, we request authorization to whom and when PHI can be released. Please provide the necessary information below so that we may serve you best.

MAY WE CALL YOUR HOME AND LEAVE A MESSAGE TO CALL OUR OFFICE BACK? **YES** **NO**

MAY WE CALL YOU AT WORK AND LEAVE A MESSAGE TO CALL OUR OFFICE BACK? **YES** **NO**

DO WE HAVE YOUR PERMISSION TO TALK TO FAMILY MEMBERS OR OTHER INDIVIDUALS? **YES** **NO**

IF YES, PLEASE PROVIDE THE NAMES, PHONE NUMBER & RELATION TO YOU:

Name:________________________________Phone:___________________________Relation: _____________________

Name:________________________________Phone:___________________________Relation: _____________________

Name:________________________________Phone:___________________________Relation: _____________________

OUR OFFICE WILL NOTIFY YOU OF BIOPSY RESULTS. IF WE ARE UNABLE TO CONTACT YOU, THESE RESULTS WILL BE ADDRESSED TO THE AUTHORIZED INDIVIDUAL. UNLESS TOLD OTHERWISE, THESE RESULTS WILL BE MAILED TO YOUR HOME. PLEASE NOTIFY OUR OFFICE IF YOU WANT THESE RESULTS MAILED TO AN ALTERNATE ADDRESS.

By signing this form, I acknowledge that I have received or have been given the opportunity to receive a copy of the Innovative Dermatology and Mohs Surgery Notice of Privacy Practices and have also been given an opportunity to ask questions. A copy of this consent will be included in my chart for future reference.

I am able to read and understand English or translated to me by one who does and accept the contents of the above policy. I have had the opportunity to discuss this policy with the medical professional or office representative and have had all my questions answered to my satisfaction.

____ ____

PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

INNOVATIVE DERMATOLOGY
AND MOHS SURGERY

AUTHORIZATION TO OBTAIN/RELEASE HEALTHCARE INFORMATION

Patient's Name:____DOB:_____/_____/_____

Address: ____

Check **ONE** Option: ☐ Obtain my records **OR** ☐ Send my records

Information in the medical files concerning:

☐ **Office Note(s)** ☐ **Pathology Report(s)** ☐ **Laboratory Report(s)** ☐ **Operative Report(s)** ☐ **Cosmetic Note(s)**

☐**Complete Medical Record** ☐**Specific date(s) of service**: ___________ ☐**Specific treatment(s) for**: __________

For the purpose of patient care, I hereby request and authorize the following organization or individual to transfer my medical records**: Name of Organization or Individual, Address, Phone #, Fax #**

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If releasing to INNOVATIVE DERMATOLOGY AND MOHS SURGERY, LLC, please render information to:

INNOVATIVE DERMATOLOGY AND MOHS SURGERY

3507 Lee Blvd Suite #107
Lehigh Acres, Florida 33971
Phone: (239) 368-8071 Fax: (239) 368-8074

8800 Bernwood Parkway, Unit #6
Bonita Springs, Florida 34135
Phone: (239) 908-6444 Fax: (239) 494-1433

I authorize Andrew Kontos, M.D. and Innovative Dermatology and Mohs Surgery, LLC, to allow the medical records and other medical information to be copied or examined by other parties including, but not limited to, my insurance company and/or other third-party payers, billing agents, attorneys, and other agents of Andrew Kontos, M.D. and Innovative Dermatology and Mohs surgery, LLC. I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis. In executing this authorization, I hereby release all parties to this documentation from all legal responsibility or liability relating to the release, disclosure and examination of confidential medical information.

Pursuant to this release, authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA Privacy Rules, Andrew Kontos, M.D. and Innovative Dermatology and Mohs Surgery, LLC. You have the right to revoke this authorization at any time by notifying Innovative Dermatology and Mohs Surgery, LLC, in writing at the above address. Revocation of this authorization will not affect actions already taken in reliance on this authorization. If not revoked sooner, this authorization will expire 365 days after executed.

Patient/Guardian Signature: ____ Date: _____/____/_____

Witness Signature: ____ Date: _____/____/_____