

NOTE: You can fill this form out online by using your TabKey to move through fields. Use EnterKey for Checkboxes or Radio Buttons.

Today's Date: _____

FLORIDA DERMATOLOGY AND SKIN CANCER SPECIALISTS, PL

Patient Information

Name _____ Date of Birth ____/____/____ Gender M F

Address _____ City _____ State ____ Zip _____

Social Security Number ____-____-____ E-mail _____ Marital Status ____

Best phone number (____)____-____ Home Mobile Work
Alternate phone number (____)____-____ Home Mobile Work

Veteran Yes No Student Yes No Employment status Employed Retired Other

Pharmacy _____ Phone number _____ Address/Side Streets _____

Employer: _____ Full Time Part Time

Primary Language: English Spanish Other: _____

Ethnicity: Hispanic non-Hispanic Prefer Not to Disclose

Race: White Black/African-American Asian American Indian or Native Alaskan

Native Hawaiian/Pacific Islander Prefer Not to Disclose

Primary Care Physician _____ Referring Physician _____

Insurance Info (If your Insurance is Family Coverage, Complete This for the Primary Insured)

Name _____ Social Security Number ____-____-____

Address _____ City _____ State ____ Zip _____

Relationship to Patient _____ Date of Birth ____/____/____ Phone (____)____-____ Home Mobile Work

Primary Insurance: _____ Secondary Insurance: _____

Emergency Contact

Name _____ Relationship _____

Best phone number (____)____-____ Home Mobile Work
Alternate phone number (____)____-____ Home Mobile Work

Patient Name: _____

Insurance Authorization and Assignment Consent to Treat

I hereby authorize Florida Dermatology and Skin Cancer Specialists, PL to furnish information concerning this illness/accident to insurance carriers and/or audit/compliance agencies. I hereby irrevocably assign to Florida Dermatology and Skin Cancer Specialists, PL all payments for medical services rendered to dependents or myself. I understand that I am financially responsible for all charges whether or not covered by insurance. I also hereby request and consent to treatment and services reasonable and proper by today's standards provided by a physician or provider of Florida Dermatology and Skin Cancer Specialists, PL and any employee acting under my physicians' orders.

Patient (or Guardian) Signature: _____ Date _____

Acknowledgement of Florida Dermatology and Skin Cancer Specialists, PL Notice of Privacy Practices Authorization to Release Information

- I have reviewed or received or have been given the opportunity to receive a copy of Florida Dermatology and Skin Cancer Specialists, PL Notice of Privacy Practices.
- I agree that telephone messages regarding my: (Check all that apply)
 - Appointments
 - prescription renewals
 - lab results
 - other Personal Health Information (PHI)

may be left for me on my Home, Mobile, and/or Work voicemail system(s)

- I hereby authorize Florida Dermatology and Skin Cancer Specialists, PL, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.
- I authorize Florida Dermatology and Skin Cancer Specialists, PL, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.
- I further authorize Florida Dermatology and Skin Cancer Specialists, PL to contact, discuss my personal health information with:

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Patient Name: _____

Pathology services – I authorize Florida Dermatology and Skin Cancer Specialists, PL to send my tissue or other specimens to the Laboratory for microscopic slide processing and interpretation.

Medical Photography – I understand that photographs may be taken and added to my medical record. I understand that if I request release of my medical records these photographs may be included. I understand that these photographs may be used for the following purposes: education, training, medical or scientific publication, in which case my identity will be protected.

Financial policy – The physicians and staff at Florida Dermatology and Skin Cancer Specialists, PL appreciate the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

- Payment is due in full at the time of service for any copays, unmet deductibles, co-insurances, self-pay patients, and cosmetic procedures.
- Patients must provide proof of insurance ID number at the time of visit. If the patient’s insurance card is not presented at the initial visit or when there is a change in coverage, the patient will be responsible for full payment of service.
- Please provide at least 24 hours advance notice if you need to reschedule or cancel your appointment.
- FDSCS, PL accepts cash, checks, CareCredit and all major credit cards. If a check payment is returned by the bank, a \$30.00 fee will be applied to the patient’s account. Patients who have a returned check must use cash or credit card only for all future payments.

Patient or Responsible Party Signature

Print Name

____/____/____
Date

*We request that at least **24 hour** advance notice be given to the office if you will be unable to keep your scheduled appointment. Our practice is very busy, and if you are unable to keep your appointment, we would like to offer that slot to another patient.*

**Thank you for completing our Patient Form.
Please print this form and bring it with you to your appointment.**