Dermatology & MOHS Surgery New Patient Paperwork

Patient Information:

Patient Name: _____
Date of Birth: ____/____/____ SSN: _____-_____-_____
Parent's Name (if a minor): _____
Mailing Address: _____
Street

_____
City State Zip

Home Phone: _____
Alt Phone: _____
Cell Phone: _____

Primary Care Physician: _____
Address:_____
City:_____ State:_____ Zip:_____ Phone Number: _____

Pharmacy Name: _____
Address:_____
City:_____ State:_____ Zip:_____
Phone #:_____

Marital Status: Single _____ Married _____ Divorce _____ Widow _____ Other _____

Notify in case of an emergency:

Name: _____
Relationship: _____
Phone Number: _____

Insurance Information:
If you are not a self pay patient, please give the receptionist your driver's license or state identification card and your insurance card so we can copy this information in your file.

If you are a SELF PAY patient, payment is due at the time of service. Please give your payment to the receptionist, along with your Driver's License or state identification card so we can copy this information in your file.

Insured (Policyholder) Information—Primary

Ins Co Name:_____
Policy #:_____ Group #:_____
Address:_____
City:_____ State:_____ Zip:_____
Patient Relation to Insured: Self_____ Spouse_____ Child_____ Other_____
Policy Holder Name:_____
Policy Holder Date of Birth:____/____/____ SSN: _____-_____-_____
Address:_____
City:_____ State:_____ Zip:_____
Phone Number:_____

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Consent for Treatment: I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examinations, and treatments. I understand it may be necessary to perform a procedures, examinations, and treatments. I understand it may be necessary to perform a procedure during my visit(s) with this office to necessitate a diagnosis and/or treatment, the necessity and any possible complications (to include bu not limited to: scarring, bleeding and/or infection). I understand an outside laboratory (GLOBAL PATHOLOGY/AURORA DIAGNOSTICS) will be utilized for all skin biopsy specimens obtained, and that it is my responsibility to follow up on tests which are performed or ordered by this office, and it is my financial responsibility for any costs that may occur with this pathologist. I understand Dermatology & Mohs Surgery is not responsible for any charges from the pathology centers or Quest Diagnostics.

Physician Assistant(s)/Advanced Nurse Practitioner(s): This office employs Board Certified Physician Assistants, and board Certified Advanced Nurse Practitioners that are trained in Dermatology by Dr. Johnny Gurgen, DO. During your visit, you will encompass evaluation/treatment by our Physician Assistant(s) and/or Advanced Nurse Practitioner(s). Our Physician Assistant(s) and Advanced Nurse Practitioner(s) work closely with our physician, and is supervised by our physician in all aspects of your care.

Financial Policy: We are dedicated to providing the best possible care and service to you. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. If you have any questions about the following financial policy, please do not hesitate in discussing them with us. **Your Insurance:** We make every effort to follow the guidelines required by your insurance company. However, every insurance contract is unique. If you do not inform us of any special requirements in your plan and we subsequently perform a service or test that is denied, we have no choice but to bill you directly for those charges. Every effort is made to file claims on your behalf with your insurance plan. Unfortunately, if we are unable to collect from your insurance company, you will be held financially responsible. Therefore, we encourage our patients to be pro-active ensuring that claims are paid. If your insurance coverage changes, it is your responsibility to notify our office before your next visit. Failure to do so may result in you being fully liable for your claim if we do not have updated insurance information. **Your insurance card and driver's license or state identification card will be required at check in.** It is your responsibility to inform our office of any address or telephone number changes. Your account is to be kept current-accordingly, all self pay or insurance co-payments, co-insurances and deductibles will be collected at the time of service payable by cash, check or credit/debit cards. You are responsible for your office visit fees if you have not met your deductible for the year. If your insurance policy requires a referral from your Primary Care Physician, it is your responsibility to have that referral faxed to our office prior to your appointment. You are responsible for any non-covered charges not payable by your insurance policy.

I have read and understand the "Consent for treatment", "Physician Assistant(s)/Advanced Nurse Practitionet(s)", and "Financial Policy" of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by practice.

Patient or Authorized Representative Signature:_____

Date:_____ **Relationship to Patient:**_____

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Medical History

Reason for Today's Visit: _____

Current Medications:

Do you have any allergies to any medications? Yes No * Allergies to Latex? Yes No

Allergies to Adhesives? Yes No * Allergies to Lidocaine or Epinephrine? Yes No

Please list any medications or other allergies that you might have: _____

_____

Please list any past surgical history: _____

_____

Have you ever been told you have any of the following? (please circle all that apply)

Asthma COPD Emphysema Heart Problems High Blood Pressure Hepatitis
High Cholesterol Psoriasis Eczema Skin Cancer HIV/AIDS
Lupus Communicable Diseases Anemia Thyroidism
Liver Disease Gastro Disease Pacemaker/Defibrillator
History of Melanoma Other Medical Problems

Please list any other medical history that is not listed above: _____

_____

Do you have a history of lymphoma or leukemia? Yes No
Have you ever had an organ transplant, radiation/chemotherapy treatments? Yes No
Are you on any immunosuppressants such as Humira, Enbrel, or Methotrexate? Yes No
If you answered yes to any of those questions, please explain: _____

_____

Do you have a family history of skin cancer or Melanoma? Yes No
Do you Smoke? _____ Now _____ Never _____ Former

- How many packs a day? _____

Do you drink alcohol? _____ No _____ Social _____ Moderate _____ Heavy
Have you had the flu vaccine in the past year? _____ Yes _____ No
Have you ever had the pneumonia vaccine? _____ Yes _____ No
Do you have a history of psoriasis? _____ Yes _____ No

- Do you have regular TB Screenings? _____ Yes _____ No

Dermatology and MOHS Surgery

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. THIS NOTICE IS REQUIRED UNDER FEDERAL MANDATE OF HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA).

Use and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by our physicians and medical staff.

Payment. Your health information may be used to seek payment from your health plan, or from other sources of coverage such as an automobile insurer. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of Dermatology and MOHS Surgery. For example, information on the services you receive may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Appointment Reminders. Your health information may be used or disclosed to provide a reminder to you about an upcoming appointment.

Treatment Options. Your health information may be used to send you information regarding new treatment or management options for your medical conditions.

Workers compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to workers compensation.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information (Dermatology and MOHS Surgery is not required to honor, and withholds the right to deny, any such request).
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information

- The right to receive an accounting of how and to whom your protected health information has been disclosed (such an accounting will not include disclosures for treatment, payment, health care operations and disclosures made based upon an authorization).
- The right to receive a printed copy of this notice

Dermatology and MOHS Surgery Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our front office staff or our privacy officer. We may charge you a reasonable fee for copying and mailing of protected health information.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Dr. Johnny Gurgen, DO
1340 Citizens Boulevard
Leesburg, Florida 34748
(352) 435-7695

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also send a written complaint to the U.S. Secretary of the Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The Name and address of the person you can contact for further information concerning our privacy practices is:

Dr. Johnny Gurgen, DO
1340 Citizens Boulevard
Leesburg, Florida 34748
(352) 435-7695

Effective Date: April 24, 2017 (Updated and Revised) - AC

Dermatology and MOHS Surgery

HIPAA Notice of Privacy Practices Acknowledgement and Authorization

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices which provides a more complete description of such uses and disclosures. I also understands that his practice has the right to change its Notice of Privacy Practices at any time. A revised notice or privacy practices may be obtained by forwarding a written request to Dermatology and MOHS Surgery at 1340 Citizens Boulevard Leesburg Florida 34748.

Please answer the following:

1. May we call your home or other alternative location and leave a message in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to your clinical care, including laboratory results among other?
   _____ Yes / _____ No (If yes, what is the alternate numbers to be called: _____)
2. May we phone you at work and leave a message to call our office back?
   _____ Yes / _____ No
3. May we mail to your home or alternate location regarding appointment reminders/patient statements?
   _____ Yes / _____ No
   **our office will mail benign results to the patient. These results are in the form of a postcard, addressed to the patient. Unless told otherwise, these results will be mailed to your home address. Please notify our office if you want these results mailed to an alternate address.*
4. Do we have your permission to talk to family members or other individuals?
   _____ Yes / _____ No
   If yes, please provide the names, phone number, and relationship to you:
   Name: _____ Phone Number: _____
   Relationship to Patient: _____

   Name: _____ Phone Number: _____
   Relationship to Patient: _____

By signing this form, I hereby give my consent for Dermatology and MOHS Surgery to use and disclose **protected health information** (PHI) about me to carry out **treatment, payment, and healthcare operations.** I acknowledge that I have received or have been given the opportunity to receive a copy of the 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 may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If i do not sign this consent, or later revoke it, Dermatology and MOHS Surgery amy decline to provide treatment to me.

PRINT PATIENT NAME: _____

SIGNATURE: _____ **DATE:** _____

Note: This form does not authorize use to release actual medical records to your or your representative(s). An authorization for the release of medical records is available upon request. A signed authorization must be updated every 12 months.