Dermatology & MOHS Surgery

New Patient Paperwork

Patient Information:

Patient Name:_____ Marital Status: Married / Single / Widowed / Divorced / Other

Parent's Name (if minor): _____

Date of Birth: _____/_____/_____ Social Security Number:_____-_____-_____

Mailing Address:_____

Street

_____

City State Zip

Do you reside in FLORIDA more than 10 months out of the year? YES _____ NO _____

If no, please list alternative address : _____

Street

_____

City State Zip

Home Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____

Alt Phone: (_____) _____-_____

Work: (_____) _____ -_____

Email Address: _____

Referring Physician: _____

Phone Number: (_____) _____-_____

Primary Care Physician: _____

Phone Number: (_____) _____-_____

Pharmacy Name: _____

Address:_____

City:_____ State:_____ Zip:_____ Phone Number:_____

Notify In Case of Emergency:

Name:_____

Relationship:_____ Home Number: (_____) _____-_____

Cell Number: (_____) _____-_____

Insurance Information:

Company: :_____ Policy#:_____

Group #:_____

Relationship to Policyholder: ⬜ Self ⬜ Spouse ⬜ Child ⬜ Other: _____

Policy Holder Name: _____ D.O.B: _____ SSN: _____

Policy Holder Address: _____

Company: :_____ Policy#:_____

Group #:_____

Relationship to Policyholder: ⬜ Self ⬜ Spouse ⬜ Child ⬜ Other: _____

Policy Holder Name: _____ D.O.B: _____ SSN: _____

Policy Holder Address: _____

*** SELF PAY - PAYMENT DUE AT TIME OF SERVICE ***

*** Please fill out the front and back of both pages ***

Dermatology & MOHS Surgery
Consent for Treatment & Financial Policy

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 procedure, examination, and/or 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, but not limited to: scarring, bleeding and/or infection). I understand an outside laboratory (Global Pathology/Aurora Diagnostics/Carepath/Quest Diagnostics) will be utilized for 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 charged from the pathology centers or Quest Diagnostics.

Physician Assistant(s)/Advanced Nurse Practitioner(s): This office employs Board Certified Physician Assistants, and/or 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 card(s) and driver's license or state identification card will be required at check in.** if 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 copayments, coinsurance and deductibles will be collected at the time of service payable by cash, check or credit/debit card. You are responsible for your office visit fees if you haven't 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 faced 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 Practitioner(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: _____

Relationship to patient:_____ **Date:**_____

Dermatology and MOHS Surgery - Medical History Form

Patient Name: _____ **Date:** _____
Date of Birth: _____ **Height:** _____ **Weight:** _____
Reason for today's visit? _____

Were you referred to our office? ❑ Yes ❑ No : If yes, by who? _____
Do you have any allergies to medications, lidocaine, or epinephrine? ❑ Yes ❑ No
Do you have any allergies to latex or adhesives? ❑ Yes ❑ No
If answered "yes" to any questions listed above, please list: _____

Do you currently take any medications? ❑ Yes ❑ No - If yes, please list below:

Current Medication and Strength:	Dosing:

Have you had any surgeries? ❑ Yes ❑ No : If yes, please list:
_____
_____

Do you have any of the conditions listed below:

Pacemaker/Defibrillator	Asthma	Lupus	Thyroid Issues
High Cholesterol	HIV/AIDS	Liver Disease	Communicable Diseases
High Blood Pressure	Hepatitis	Emphysema	History of Basal Cell Carcinoma
Gastro Disease	Anemia	Psoriasis	History of Squamous Cell Carcinoma
Heart Problems	COPD	Eczema	History of Malignant Melanoma

Please list any other personal medical conditions: _____
_____
Any personal history of lymphoma? ❑ Yes ❑ No
Have you had an organ transplant, radiation, or chemotherapy? ❑ Yes ❑ No
Are you on any immunosuppressants? ❑ Yes ❑ No
Is there any family history of malignant melanoma? ❑ Yes ❑ No

- If Yes, what family member: _____

Have you had a flu vaccine? ❑ Yes ❑ No
For 65 & older, have you had a pneumonia vaccine? ❑ Yes ❑ No
Do you get regular TB screenings? ❑ Yes ❑ No
Do you smoke? ❑ current smoker ❑ former smoker. Quit in _____ ❑ never smoker

Do you drink alcohol? ❑ No ❑ Moderate ❑ Heavy ❑ Social

Dermatology & MOHS Surgery

HIPPA 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 understand that this practice has the right to change its Notice of Privacy Practices at any time. A revised notice of 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:

- 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 others?
  _____ Yes / _____ No (if yes, what is the alternate number(s) to be called:_____
- May we phone you at work and leave a message to call our office back?
  _____ Yes / _____ No
- May we mail to your home or alternative location regarding appointment reminders/patient statements?
  _____ 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, 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 the opportunity to ask questions. A copy of this consent will be included in my chart for future references.

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 may decline to provide treatment to me.

PATIENT NAME (Print): _____

SIGNATURE: _____ **DATE:**_____/_____/_____

Dermatology & MOHS Surgery
Johnny Gurgen, DO FAOCD
Michael Gurgen, ARNP
John Kelly, PA-C
Jeren Kowalewski, PA-C
Leesburg: 1340 Citizens Blvd Leesburg, FL 34748
Lady Lake: 920 Rolling Acres Rd Suite 203, Lady Lake, FL 32159
Phone:352-435-7695 Fax: 352-435-7453

Authorization for Medical Records Release

Patient Name: _____ Date of Birth: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____

I _____ **authorize** / _____ **DO NOT authorize** the release of the following protected health information:

_____ Office Notes _____ Pathology Reports _____ Laboratory Reports
_____ Photos _____ All Records Other: _____

Please check the following for the purpose of the authorization of release of medical records:
____ Please release all my medical records to/from the following physician(s) continuation of care:
(Name, Address, Phone Number and Fax Number)
_____
_____
_____
_____
_____

_____ Please release all requested medical records listed above to ***Dermatology & MOHS Surgery*** for continuation of care.
Please forward all records via fax to 352-435-7453.

I understand that:

1. By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
2. I may refuse to sign this authorization, which will not affect my treatment for health care.
3. I understand that I may revoke this authorization at any time.
4. I understand that a copy of this form will be kept in my medical record.
5. This authorization expires on: _____

_____ _____
Patient/Representative Signature **Date**

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____
Print Name **Relationship to Patient**

DERMATOLOGY & MOHS SURGERY
OFFICE FINANCIAL POLICY

It is the policy of Dermatology & MOHS Surgery to file insurance as a courtesy to our patients; however, deductibles, co-payments and co-insurance are expected to be paid at the time of service. We do not accept responsibility for communications of collections from your insurance company. If we do not receive payment from your insurance company within 60 days of date of service, the responsibility for that payment will transfer to the patient and payment in full will be expected at that time.

1) We will collect your co-payment and non-covered services prior to seeing the doctor
.
2) There is a $40.00 charge on all returned checks and a $25.00 charge for scheduled appointments canceled without a 24 hour notice or a no show appointment. Payments can be made by cash, credit card or money order.

3) Please be thorough with your insurance information if you expect us to file for you. Bring your insurance card with you and any authorizations you may have. You will be responsible for any unpaid balance due to lack of information.

4) As a courtesy, we will submit your claim to your insurance company. It is your responsibility to make sure that we receive prompt payment from them. It is useful to maintain frequent contact with your insurance carrier to make sure they are paying, as expected.

5) After your claim has been submitted your insurance company will send you an Explanation of Benefits (EOB) that explains what they have paid or not paid to our office. This is a record that you must keep on file. If you do not agree with their payment policy, please contact the insurance company directly.

6) If your insurance denies payment on your account, you will be asked to pay by cash, check or credit card. Remember, you and/or your employer pay the monthly insurance premiums. Your insurance company is accountable to you, and should respond quickly to your complaint. Do not hesitate to contact them if you disagree with their payment or to find out the status of your claims.

7) TO ALL MEDICARE PATIENTS: At this time, we will continue to participate as

Medicare providers. We will bill Medicare as well as most secondary insurance for you, but if payment is not received from your secondary insurance within a 60 day time period, you will be notified and must pay our office the balance due. You then should contact your secondary insurance company and request the balance owed to be mailed directly to you.

8) SELF-PAY PATIENTS: Payment for services rendered is expected at time of service, unless other arrangements have been made with our Office Manager or Billing Specialist prior to appointment date and time.

9) Laboratory tests and associated charges done by outside laboratories are not affiliated with, nor the responsibility of this office. By having the test performed you become the responsible party for these charges.

If you have a question you should contact the laboratories directly, not our office. We do not have information regarding outside laboratory charges.

_____ _____

Patient or Representative Signature Date