DERMATOLOGY SURGERY CENTER

**Scott L. Beals, DO, FAAD**
www.dermsurgctr.com
**Fax: 850- 897-7547**

4566 Hwy 20 E, Suite 101
Niceville, FL 32578
(850) 897-7546

## PATIENT INFORMATION: Complete with PATIENT Information

First Name: _____ Last: _____ M.I.: _____

Social Security Number: _____-_____-_____ DOB: _____/_____/_____ Age: _____

Gender: M ( ) F ( ) Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated

Race: White ( ) Black or African American ( ) Asian ( ) Other Race ( ) / Ethnic Group: Unknown ( ) Hispanic or Latino ( ) Not-Hispanic or Latino ( ) / Preferred Language: English ( ) Spanish ( ) Other ( )

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (____) _____

E-Mail Address: _____

Emergency Contact Name: _____ Phone: (____) _____

Guarantor's Name (if patient is a minor) _____ Relationship: _____

Can we leave a detailed voicemail message? ☐ Yes ☐ No

Preferred Pharmacy: _____

Who may we thank for referring you to us? _____

## INSURANCE INFORMATION: This information is REQUIRED

**Primary Insurance**

Relationship to Patient: ( ) Self ( ) Parent ( ) Spouse ( ) Employer ( ) Other: _____

Insurance Company: _____ Policy ID/Member ID #: _____

*Primary Policy Holder(If not self):*

Primary Insured Name: _____ Gender: M ( ) F ( ) Primary Insured's Date of Birth: ___/___/___

**Secondary Insurance**

Relationship to Patient: ( ) Self ( ) Parent ( ) Spouse ( ) Employer ( ) Other: _____

Insurance Company: _____ Policy ID/Member ID #: _____

*Primary Policy Holder(If not self):*

Primary Insured Name: _____ Gender: M ( ) F ( ) Primary Insured's Date of Birth: ___/___/___

**Tricare/Tricare for Life:**

Sponsor's Date of Birth: ____/____/____ Social Security Number: _____-_____-_____Status: _____

The contents of DERMATOLOGY SURGERY CENTER PRACTICE POLICIES have been fully reviewed by me and I have been given the opportunity to ask questions. Any questions which I have asked have been answered to my satisfaction. I certify that I understand the contents of that form.
(A copy of DERMATOLOGY SURGERY CENTER PRACTICE POLICIES or HIPAA PRIVACY GUIDELINES is available for you to keep upon request.)

_____
Printed Patient (and Authorized Representative) Name

_____ _____
Signature of Patient or Authorized Representative Date

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# HISTORY AND INTAKE FORM

**Name:** _____ **DOB:** _____/_____/_____

**Language:** English Other:_____ **Gender:** **M** **F** **Race:** _____

**Preferred Pharmacy:** _____ **Pharmacy Phone:**_____

**Pharmacy Address:**_____

**Primary Care Provider & Phone:** _____

**Past Medical History:** (Please circle all that apply)

| | | |
|---|---|---|
| Anxiety | Depression | Leukemia |
| Arthritis | Diabetes | Lung Cancer |
| Artificial Joints | End Stage Renal Disease | Lymphoma |
| Asthma | GERD | Pacemaker |
| Atrial Fibrillation | Hearing Loss | Prostate Cancer |
| BPH | Hepatitis | Radiation Treatment |
| Bone Marrow Transplantation | Hypertension | Seizures |
| Breast Cancer | HIV / AIDS | Stroke |
| Colon Cancer | Hypercholesterolemia | Valve Replacement |
| COPD | Hyperthyroidism | None |
| Coronary Artery Disease | Hypothyroidism | |

Other: _____

**Past Surgical History:** (Please circle all that apply)

| | |
|---|---|
| Appendix Removed | Kidney Biopsy |
| Bladder Removed | Kidney Removed (Right, Left) |
| Mastectomy (Right, Left, Bilateral) | Kidney Stone Removal |
| Lumpectomy (Right, Left, Bilateral) | Kidney Transplant |
| Breast Biopsy (Right, Left, Bilateral) | Ovaries Removed: Endometriosis |
| Breast Reduction | Ovaries Removed: Cyst |
| Breast Implants | Ovaries Removed: Ovarian Cancer |
| Colectomy: Colon Cancer Resection | Prostate Removed: Prostate Cancer |
| Colectomy: Diverticulitis | Prostate Biopsy |
| Colectomy: IBD | TURP |
| Gallbladder Removed | Skin Biopsy |
| Coronary Artery Bypass | Basal Cell Cancer Surgery |
| PTCA | Squamous Cell Carcinoma Surgery |
| Mechanical Valve Replacement | Melanoma Surgery |
| Biological Valve Replacement | Spleen Removed |
| Heart Transplant | Testicles Removed (Right, Left, Bilateral) |
| Joint Replacement, Knee (Right, Left, Bilateral) | Hysterectomy: Fibroids |
| Joint Replacement, Hip (Right, Left, Bilateral) | Hysterectomy: Uterine Cancer |
| Joint Replacement within the last 2 years | None |

Other: _____

**Skin Disease History:** (please circle all that apply)

| | | |
|---|---|---|
| Acne | Dry Skin | Poison Ivy |
| Actinic Keratoses | Eczema | Precancerous Moles |
| Asthma | Flaking or Itchy Scalp | Psoriasis |
| Basal Cell Skin Cancer | Hay Fever/ Allergies | Squamous Cell Skin Cancer |
| Blistering Sunburns | Melanoma | None |

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Other: _____

Do you wear Sunscreen? Yes No What SPF? _____

Do you have a family history of melanoma? Yes No If yes, which relative(s)? _____

Do you tan in a tanning salon? Yes No

**Medications:** (Please list all current medications & strength)

_____

_____

**Allergies:** _____

**Social History:** (Please circle all that apply)
Current Smoker Former Smoker Never Smoked Type of Tobacco Used_____

What is your current occupation? _____

**Review of Systems:** Are you currently experiencing any of the following? (please circle all that apply)

| | | | |
|---|---|---|---|
| Abdominal Pain | Changing Mole | Hay Fever | Seizures |
| Anxiety | Chest Pain | Joint Aches | Shortness of Breath |
| Bleeding Problems | Cough | Muscle Weakness | Sore Throat |
| Bloody Stool | Depression | Neck Stiffness | Thyroid Problems |
| Bloody Urine | Fever or Chills | Night Sweats | Unintentional Weight Loss |
| Blurry Vision | Headaches | Rash | Wheezing |

Other Symptoms: _____

**Surgical Precautions:** (Please write Y for Yes or N for No in the blanks below)

Have you ever had difficulty stopping bleeding? _____
Do you require antibiotics prior to a surgical procedure? _____
Have you had an artificial joint replacement? _____
If yes, when and what body locations? _____
Have you had an artificial heart valve? _____
Do you have a pacemaker? _____
Do you have a defibrillator? _____
Are you pregnant or currently trying to get pregnant? _____

**Reason for visit:** _____

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# Patient Responsibility Notification

## Please Initial Each Statement

*Dermatology Surgery Center strives to offer the highest quality of care to our patients. Due to the numerous changes in Healthcare during this present time, we are informed by insurance companies that no benefits are guaranteed. In order to provide quality care to our patients, we file their insurance as a courtesy, but the following procedures must be in place in order to do so. Please INITIAL next to each statement, then sign and date below, to acknowledge that you have read and understand your patient responsibility. Thank you!*

1. **Appointment time:** Arrive 15 minutes prior to your appointment. _____
2. **Patient is responsible for confirming Dermatology Center is on their Insurance Provider List.**
3. **Co-payment, Coinsurance and Deductibles:** Must be paid at time of service. _____
4. **Patient's with No insurance or Out of Network benefits are responsible for full payment of services the day services are rendered.**
5. **Delayed payment:** If your outstanding balance is over 60 days past due, then it is your responsibility to contact your carrier to assess the reason for delay. _____
6. **Outstanding bill:** If your insurance carrier does not reconcile complete payment by 90 days, then the remaining balance is your responsibility. _____
7. **Same day cancellation or No show appointment:** Unless related to an emergency, this will result in an unfilled appointment. There is a $50 fee for Office Visit or $200 fee for Surgical or Cosmetics visits, if you fail to provide 24 hour notice of cancellation or reschedule. _____
8. **Prescription Refills:** Please contact our office directly for prescription refills. No refill requests will be accepted by the pharmacy that sends us a fax. Allow 3 to 5 business days for all refill requests to be processed. _____
9. **Communication:** I grant permission for Dermatology Surgery Center to communicate via phone, voicemail, text or email in regard to my health information, care, and appointments. _____

## ACKNOWLEDGEMENT OF FINANCIAL AND PATIENT CARE POLICIES

## SIGNATURE REQUIRED TO BE SEEN

**I understand that insurance coverage IS NOT A GUARANTEE of payment for any services claimed by myself or Dermatology Surgery Center. Further I understand that I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES incurred, regardless of insurance coverage or payment of copays or deductibles due and collected at time of service. I understand that if I do not provide all required identification information for insurance claims filing to Dermatology Surgery Center, and insurance fails to pay, I will be held responsible for total costs of services as well as administration fees to process that claim.**

**By signing below, I acknowledge that I have read the Dermatology Surgery Center Financial and Patient Care Policies. I certify that I understand these Policies and will comply with them.**

_____ _____ _____

**Patient Name (Please Print)** **Patient/ Guardian Signature** **Date**

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# PATIENT CARE POLICIES

## Medical Records

- ALL PATIENTS NOW HAVE FREE ACCESS TO THEIR RECORDS THROUGH OUR ONLINE PATIENT PORTAL. Ask the front desk if you have not received this information. Any records that you would like to have printed or faxed to another facility by our office will have an ADMINISTRATION FEE:
    - These fees are based on Florida law, Statutes 395.3025. Fees are:
        - $1.00 per page for the first 25 pages
        - $0.25 per page for each additional page.
- To comply with government regulated HIPPA Privacy Laws, we need you to SIGN A RECORDS RELEASE FORM. You can sign this form in the office or download it from our website. Please bring a signed copy by the office or send by fax or mail.
- PLEASE ALLOW 2 WEEKS FOR RECORDS TO BE PROCESSED. After records are pulled from our electronic software, medical providers review your records before we release them. Records will be reviewed on a first come first served basis outside of patient service hours.

## Prescription Refills

- You must come to the office for an examination and evaluation by a Dermatology Surgery Center provider bi-annually to receive a prescription refill.
- Please contact our office directly for prescription refills. No refill requests will be accepted by the pharmacy that sends us a fax. Refill requests will be handled after patient service hours. Allow 3 to 5 business days for all refill requests to be processed.

## Call Back Policy

- Please allow 3 to 5 business days to receive a return phone call. If you would like to schedule a time to visit with the provider, please schedule an appointment so that we may address your concerns.

# FINANCIAL POLICIES

Complete understanding of and cooperation with our practice financial policy is an essential element of your care and treatment. For your convenience, we accept cash, check and major credit cards. 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 do not hesitate to ask or call our office. Our friendly staff is ready to help and provide any information.

## No-Shows or Failure to Cancel

- 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 by you to avoid any cancellation fees.
- **PATIENTS WHO NO SHOW OR FAIL TO CANCEL THEIR SCHEDULED APPOINTMENT WITHIN 24 HOURS OF THEIR APPOINTMENT TIME WILL BE CHARGED A FEE OF $50.00 FOR EVALUATIONS OR A FEE OF $200 FOR SURGICAL PROCEDURES.**
- Cosmetic procedures must be paid two days prior to the procedure to avoid a $100.00 charge FOR NO-SHOW or FAIL TO CANCEL their scheduled appointments.

## Insurance Policy

- Dermatology Surgery Center is a participating provider with most major insurance companies.
- If you Do Not have insurance or your insurance policy is Out of Network, full payment is due the day services are rendered.
- Insurance coverage is verified prior to being seen at each appointment as a courtesy to our patients. It is your responsibility to provide us with the correct information to bill your insurance. Insurance verification is not a guarantee of benefits or coverage.
- Your insurance is a contract between you, your employer, and the insurance company. We are not a part of that contract. It is very important that you understand the provisions of your policy. The patient is solely responsible for understanding their own contracted benefits. We cannot guarantee your insurance company will pay 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.
- If you are covered by one of our participating plans, your predetermined portion of charges set by your insurance plan (co-pay and/or co-insurance and deductible) will be collected at the time of service.
- If you are not covered by one of our participating plans, we will file your insurance claim for you as a courtesy. You will be expected to make payment in full at the time service is rendered.
- After we submit a claim for payment to your insurance company for services provided at your office visit, they will determine what charges they will and will not pay. Your company should send you an Explanation of Benefits form, explaining their payment and what you may still owe based on your policy agreement.
- Your insurance company will pay Dermatology Surgery Center their portion of your charges and notify us of any remaining balance that may be owed by you.
- Any balance owed by you will be charged to your account and you will receive a bill.
- If your insurance company denies our charges or does not pay us in a timely manner, we will charge that balance to your account.
- Delayed payments: If your complete bill (insurance and co-pays) is over 60 days past due, then it is your responsibility to contact your insurance carrier to assess the reason for delay.

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- Outstanding bill: If your insurance carrier does not reconcile complete payment by 90 days, then the entire bill is your responsibility. 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.
- Administration (SBO-Small Business Operations) fees may be charged to patient account for continued refiling of claims, processing of claim denials or collections processing to cover the cost quality measures mandated by Obamacare not covered by insurance.
- You may take advantage of our credit card policy and avoid having multiple bills mailed.

# DERMATOLOGY SURGERY CENTER PRACTICE POLICIES

**ASSIGNMENT OF INSURANCE BENEFITS**

The undersigned hereby authorizes the release or any information in relation to all claims, including Medicare for benefits submitted on my behalf and/or my dependents. I further agree and acknowledge that my signature of this document authorizes my physician to submit claims for benefits, for services rendered or to be rendered, without obtaining my signature on each claim form to be submitted for myself and or dependents, and that I will be bound by this signature as though the undersigned had personally signed each claim. I hereby authorize my insurance carrier to pay and assign all medical and/or surgery benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Scott L. Beals, D.O. I authorize the release of any medical records for treatment, payment or healthcare operations.

**INSURANCE COVERAGE IS NOT A GUARANTEE OF PAYMENT FOR ANY CLAIM, FURTHER I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED REGARDLESS OF INSURANCE COVERAGE. COPAYS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE.**

**RELEASE OF PATIENT INFORMATION**

I acknowledge that records concerning the patient are the property of Dermatology Surgery Center and are maintained for the use and benefit of Dermatology Surgery Center and its staff in providing care and treatment to the patient. I hereby authorize Dermatology Surgery Center to disclose all or any part of my patient records to my admitting physician, consulting physician(s), hospital-based physicians. I further authorize Dermatology Surgery Center and providing physicians to disclose all or any part of my patient record to any person or corporation which is or may be liable under contract to Dermatology Surgery Center or to me or a family member of mine, for all part of Dermatology Surgery Center's charges, including but not limited to, hospital or medical service companies, insurance companies, Worker's Compensation carriers, welfare agencies, or my employer, provided such release of information shall be in accordance with state and federal laws and regulations.

**FINANCIAL AGREEMENT**

For and in consideration of services rendered, each of the undersigned agrees to pay Dermatology Surgery Center for all charges not covered by insurance and any insurance administrative/ payment processing fees incurred by Dermatology Surgery Center as statements are rendered. Further, should it become necessary to enforce collection of any unpaid balance for medical services rendered, each of the undersigned agrees to pay all collection and legal expenses incurred by Dermatology Surgery Center including reasonable attorney's fees which shall include but not be limited to such fees incurred prior to institution of litigation, or in litigation, including trial and appellate reviews, and in arbitration, bankruptcy, or other administrative or judicial proceedings. Pursuant to Florida Statues 222.111, the undersigned patient and/or responsible party waives his or her exemption to have disposable earnings of the head of the family which are greater than $500 per week garnished.

**PLEASE NOTE: PATIENTS WHO NO SHOW OR FAIL TO CANCEL THEIR SCHEDULED APPOINTMENT WITHIN 24 HOURS OF THEIR APPOINTMENT TIME WILL BE CHARGED A FEE OF $50.00 FOR EVALUATIONS OR A FEE OF $200 FOR SURGICAL PROCEDURES.**

- **Cosmetic procedures must be paid two days prior to the procedure to avoid a $100.00 charge FOR NO-SHOW or FAIL TO CANCEL their scheduled appointments.**

**ACKNOWLEDGEMENT OF HEALTH INFORMATION PRACTICES** (HIPAA Privacy Guidelines)

The Dermatology Surgery Center Notice of Health Information provides information about how health information about patients may be used and disclosed. I have been offered an opportunity to review the Notice before signing this consent. I understand the terms of this Notice may change and that a copy of the revised Notice will be posted. By signing this form, I acknowledge that I have been offered and/or received the Dermatology Surgery Center Notice of Health Information Practices.

**COMMUNICATION**

I grant permission for Dermatology Surgery Center to communicate via phone, voicemail, text or email in regard to my health information, care, and appointments. I acknowledge that by supplying my phone number, mobile number, email address, and any other personal contact information, I authorize my healthcare provider to employ a third-party automated outreach and messaging system to use my personal information to correspond with me in regard to appointments, medical updates, lab results, billing issues, upcoming events and clinic notifications.

**AUTHORIZATION FOR MEDICAL CARE AND TREATMENT**

I understand that insurance coverage IS NOT A GUARANTEE of payment for any services claimed by myself or Dermatology Surgery Center. Further I understand that I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES incurred, regardless of insurance coverage or payment of copays or deductibles due and collected at time of service. I understand that if I do not provide all required identification information for insurance claims filing to Dermatology Surgery Center, and insurance fails to pay, I will be held responsible for total costs of services as well as administration (SBO) fees to process that claim.By signing below, I acknowledge that I have read the Dermatology Surgery Center Financial and Patient Care Policies. I certify that I understand these Policies and will comply with them.

| _____ | _____ | _____ |
|---|---|---|
| Patient Printed Name | Signature | Date |

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# Authorization to Release Protected Health Information

*In accordance with HIPAA regulations, we will not share your information with anyone without your permission. This form is to authorize the release or use of your individually identifiable medical health information (protected health information or PHI) by Dermatology Surgery Center and staff to carry out treatment, payment, or health care operations. If you would like your information to be shared with a friend, family member or caregiver; please read, and complete the form below.*

*You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.*

*We reserve the right to change the terms of the Notice of Privacy Practices at any time. If we do makes changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.*

I hereby authorize Dermatology Surgery Center to use and/or disclose Protected Health Information (PHI) about myself via phone, work number, text, email, Patient Portal or in person to the contact(s) listed below:

NAME: _____ PHONE: _____ RELATION: _____

NAME: _____ PHONE: _____ RELATION: _____

NAME: _____ PHONE: _____ RELATION: _____

- I would like the above-named person(s) to pick up medical items, including prescriptions, from the office if I am unable to: YES _____ NO _____
- This authorization permits the practice to use and/or disclose the following identifiable health information about me:
  - All medical documentations or care needs YES _____ NO _____
  - In the event of emergency only YES _____ NO _____
  - Other
    If other, specifically describe the information to be used or disclosed; such as specific date(s) of service or level of detail to be released:
    _____
    _____

## Patient Acknowledgement

**By signing this form below, I authorize Dermatology Surgery Center and its staff to release my PHI (Protected Health Information) to the above-mentioned contact(s) via phone, work number, text, email, Patient Portal or in person:**

_____ _____

**Patient/Guardian Signature**

**Patient Name (please print)***
***If parent or guardian is signing for minors, Please print the minor's name.**

_____

**Date**

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# Credit Card Authorization Form

**All copays, coinsurances and deductibles paid at time of service are only estimates based on the rates provided by your insurance carrier. We do our best to collect as close as possible but sometimes insurance carriers do not cover all costs of services. To ensure you only pay the amounts required by your insurance plan, we will be happy to charge your credit card when the exact amount is provided by your insurance company after claims are processed.**

**Your credit card information will be kept confidential and secure. Charges to your credit card will only be made after the insurance company pays its portion. We will first mail a statement for any amount not covered by your insurance, to give you the opportunity to pay with our many other payment methods before contacting you to charge your card for any balances due.**

**Please complete the form below:**

**I authorize Dermatology Surgery Center to charge the portion of my bill that is my responsibility to the following credit card:**

**Patient Name (Print): _____ Date: _____**

**Patient Signature: _____**

**Credit Card Type: ❒ VISA ❒ MasterCard ❒ AMX ❒** Discover

**Credit Card Number _____Expiration Date _____**

**CVS Code _____**

**Cardholder Name _____**

**Cardholder Signature _____**

**Billing Address _____**

**City _____ State_____ Zip _____**