Welcome to Venice Avenue Dermatology!

Please fill out the information below. You may complete this information online at our patient portal, http://www.premierdermdocs.ema.md. You may call us at **(941) 486-1404**, at any time and we will provide you with your personal access information. You can also mail or fax your completed forms to:
Venice Avenue Dermatology, 897 East Venice Avenue, Suite A., Venice, FL 34285 – Fax: (941) 486-4146

NOTE: If you have an HMO plan, you are responsible for obtaining an Authorization from your primary care physician prior to your visit or we may have to reschedule your appointment.

PATIENT INFORMATION

Patient Name: *(First/Middle/Last)*	**Date of Birth:** *(mm/dd/yy)* / **Gender:** ☐ Male ☐ Female / **Social Security #:**
Preferred Name:____________________ *(ex: John, Johnny, Mr. Smith, Dr. Smith)*	**Ethnicity:** ☐White ☐Black/African American ☐Asian ☐Other ☐American Indian/Alaskan ☐Hawaiian/Pacific Islander
Local Address:	**Email:**
City/State/Zip:	**Home Phone #:** / **Mobile Phone #:**
Alternate Address: *(If applicable)*	**Emergency Contact:**
City/State/Zip:	
Primary Care Physician:	**Relationship:** / **Phone #:**
Did a Healthcare Provider refer you to us? ☐Yes ☐No **If yes, Name:**	**How did you hear about us?** ☐Website/Internet ☐Newspaper ☐Doctor ☐Friend/Family ☐Insurance Plan ☐Other __________

Receipt of Notice of Privacy Practices

Your privacy is important to us. The information that we record about you and your medical history is to help us provide quality medical care. We are committed to protecting this information. The Notice of Privacy Practice describes your rights with regards to your health information and our responsibility to protect that information. **A complete copy of our Notice of Privacy Practices is available for you in our lobby. Additional copies are available for you to take home**.

Your Rights Include:

- ➩ The right to amend your health information
- ➩ The right to request restrictions on what information we use or know we disclose your health information
- ➩ The right to see an account of certain disclosures we have made of your health information
- ➩ The right to obtain access to your health information with limited exceptions (written request, advance notice and a cost-based fee for expenses delineated by law)
- ➩ The right to receive a paper copy of our Notice of Privacy Practices

These rights do have certain restrictions and you may obtain detailed disclosure of these restrictions at any time. My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Personal Health Information. **Copy provided upon request.*

Signature: ____________________ **Name:**____________________ **Date:**__________

Venice Avenue Dermatology - Patient Medical History

Patient Name: *(First/Middle/Last)*

Date of Birth: *(mm/dd/yy)*

Primary Care Physician:

Known Drug Allergies:

Current Prescriptions AND Over The Counter Medications:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________
8. ____________________

Select any of the following medical conditions you currently have:

☐ Anxiety/Depression
☐ Arthritis
☐ Asthma/COPD
☐ Atrial Fibrillation (Irregular Heartbeat)
☐ Bone Marrow Transplantation
☐ BPH (Prostate)/Prostate Cancer
☐ Cancer: Breast, Colon, Kidney, Lung
☐ Coronary Artery Disease
☐ Diabetes
☐ End Stage Renal Disease
☐ GERD
☐ Hearing Loss
☐ Hepatitis
☐ High Blood Pressure (Hypertension)
☐ HIV/AIDS
☐High Cholesterol (Hypercholesterolemia)
☐ Hyper/Hypothyroidism
☐ Leukemia/Lymphoma
☐ Radiation Treatment: ☐Current ☐ Past
☐ Seizures
☐ Stroke
☐ Other ____________________

Have you had any of the following surgeries?:

☐ Appendix (Appendectomy)
☐ Bladder (Cystectomy)
☐ Breast: Biopsy/Lumpectomy/Mastectomy
☐ Colon (Colectomy): Colon Cancer Resection
☐ Colon: Inflamatory Bowel Disease/Colostomy
☐ Gallbladder (Cholecystectomy)
☐ Heart: Bypass Surgery/Valve Replacement
☐ Joint Replacement: Knee (☐Left/☐ Right)
☐ Joint Replacement: Hip (☐Left/☐ Right)
☐ Kidney: Kidney Biopsy/Nephrectomy
☐ Ovaries: Endometriosis/Cysts/Cancer
☐ Ovaries: tubal LIgation/Hysterectomy
☐ Prostate: Biopsy/TURP
☐ Spleen (Splenectomy)
☐ Transplant: Heart/Kidney/Liver/Lung
☐ Testicles (Orchiectomy)
☐ Uterus: Uterine or Cervical Cancer
☐ Other ____________________

Do you currently, or have formerly suffered(ed) from any of the following skin conditions?:

☐ Acne
☐ Actinic Keratoses (Pre Cancers)
☐ Basal Cell/ ☐ Squamous Cell Skin Cancer
☐ Blistering Sunburns
☐ Eczema/ ☐ Psoriasis
☐ Flaking or Itchy Scalp
☐ Hay Fever/Allergies
☐ Melanoma
☐ Precancerous Moles
☐ Other ____________________

Do you have any of the following? (Please check all that apply):

☐ Allergy to lidocaine/Epinephrine
☐ Allergy to topical antibiotic ointments
☐ Artificial joints within past 2 years
☐ Defibrillator/ ☐ Pacemaker
☐ Pregnancy or planning a pregnancy
☐ Allergy to adhesive or latex
☐ Artificial heart valve
☐ Blood thinners
☐ Premedication prior to procedures

Social History Details:

Do you currently smoke cigarrettes?
☐ YES ☐ NO

Have you ever smoked cigarrettes?
☐ YES ☐ NO

Do you drink alcohol?
☐ YES ☐ NO

Number of drinks per day:
____

Family History:

Positive family history of MELANOMA?
☐ YES ☐ NO

If yes, which relative(s)?
____

Do you tan in a tanning salon?
☐ **YES** ☐ **NO**

Do you wear sunscreen?
☐ **YES** ☐ **NO**

Pharmacy Name and location:
____

Occupation/Hobbies:
____
____

NPP2

Venice Avenue Dermatology - PHI Consent

Patient Consent for Release of Personal Protected Health Information

I hereby give consent for **Venice Avenue Dermatology** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). **Venice Avenue Dermatology's** Notice of Privacy Practices provides a more complete description of such uses and disclosures.

WITH THIS CONSENT, Venice Avenue Dermatology, MAY DISCUSS TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS WITH THE FOLLOWING PERSON(S):

IF YES, PLEASE PROVIDE THE NAMES, PHONE NUMBERS, AND RELATION TO YOU

Name:______________________________ **Phone**________________________ **Relation:** ______________

Name:______________________________ **Phone**________________________ **Relation:** ______________

Name:______________________________ **Phone**________________________ **Relation:** ______________

Name:______________________________ **Phone**________________________ **Relation:** ______________

Name:______________________________ **Phone**________________________ **Relation:** ______________

☐ **NO ONE OTHER THAN MYSELF IS PERMITTED TO HAVE MY INFORMATION**

I understand that **Venice Avenue Dermatology** cannot share my health information with a family member, including my spouse, child, caregiver or other person unless they are listed above. I also understand that this release of information will remain in effect unless I revoke my consent in writing, except to the extent the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Venice Avenue Dermatology** may decline to provide treatment to me.

By signing this form, I am consenting to **Venice Avenue Dermatology's** use and disclosure of my PHI to carry out TPO.

_____________________________ _____________________________ ____________

Signature of Patient or Legal Guardian | Print Name of Patient or Legal Guardian | Date

Venice Avenue Dermatology

Consent for Treatment, Exposure policy, and Fee Responsibility

This is to certify that I (or my authorized agent) consent to the performing of any surgical or medical procedure or examination as required. I (or my authorized agent) assume financial responsibility for any services rendered.

If another person is exposed to my blood or bodily fluids, I consent to have my blood drawn and tested and to the disclosure of my results to Venice Avenue Dermatology and the exposed person for the purposes of treatment of the exposed person.

We may use your health information and/or records to:

- Plan for your care and help your health care providers communicate and work together for your medical benefit
- Submit bills for reimbursement for the care provided to you
- Help health care payers or medical insurance companies verify that services were provided to you
- Help improve the quality of your health care
- Disclose information to certain officials or organizations as requested by law

Everyone at Venice Avenue Dermatology is bound by law to uphold all privacy standards. We encourage you to read the Notice of Privacy Practices and ask us any questions. This authorization may be revoked at any time to the extent that use or disclosure has not already occurred prior to your request. To update or revoke the authorization, notify the Venice Avenue Dermatology Privacy Officer in writing or call (941)-486-1404.

By signing below, you confirm that you have read and understand your rights to privacy, and that you have been given access to all information pertaining to those rights.

Signature: ______________________ Name: ____________________ Date: ____________________

() Patient () Parent () Legal Guardian

Venice Avenue Dermatology will not condition treatment, payment, enrollment, or eligibility for benefits on the execution of this Authorization. The Protected Health Information disclosed as a result of this authorization may be redisclosed by the entity receiving it, and thus is no longer protected by the federal privacy regulations. This Authorization is given without promise of compensation. The patient and, if applicable, parent/legal guardian release to Venice Avenue Dermatology any right, titles and/or interest of any kind they may have in the information produced.
The above statements must be signed and dated to be valid. If the patient is an emancipated minor or 18 years of age, he/she is required to sign the Authorization. If Venice Avenue Dermatology requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided to the individual completing this form.

Venice Avenue Dermatology is a division of Premier Dermatology LLC. Your financial statements and billing related correspondence will come from Premier Dermatology LLC. If at any time you have questions regarding your bill for services performed at Venice Avenue Dermatology or by our pathology laboratory, please contact our Central Billing Office at (941) 312-5027 for assistance.

Insurance Information – If Card(s) Are Not Available	
Primary Insurance:	**Secondary Insurance:**
Member ID #: **Group #:**	**Member ID #:** **Group #:**
Subscriber's Name:	**Subscriber's Name:**
Subscriber's DOB: **SS #:**	**Subscriber's DOB:** **SS #:**
Subscriber Relationship to patient:	**Subscriber Relationship to patient:**

Financial Policy, Notice of Privacy Practices, Authorization, and Payment Terms

We ask that you read and sign the following form to acknowledge your financial responsibility for the medical services provided here as well as our policy on the protection of your private health information. We will be happy to provide further clarification if necessary. In order to avoid any misunderstanding regarding our payment policies, please review our Financial Policy below.

Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments, deductibles, and co-insurance will be collected at the time of service.

We accept payment via cash, check, debit cards, Master Card, Visa, Discover, and American Express.

We may request a payment authorization form to be filled out at the time of check-in for patients who are minor, uninsured or with an outstanding balance, as well as patients with a non-participating insurance (including non-QMB Medicaid patients). Any outstanding balance from your visit will be mailed to your primary address. If there is any discrepancy or if you are unable to pay the balance in full, we ask that you contact our office immediately. Failure to settle your balance will result in further collection efforts and a collection fee may be assessed to your account.

Please note that you may be billed separately for laboratory analysis if we are required to send specimens (such as a biopsy) to an external laboratory. Ask us if any specimen was submitted to an external laboratory at time of checkout.

Participating Insurance: We are a provider for a variety of commercial insurance carriers and we bill them as a courtesy to you. Prior to your visit, you will be informed whether or not we are a provider for your insurance plan. We accept payment for covered services from these insurance plans in accordance with our contracts. It is your responsibility to know and understand the guidelines of your insurance plan. You should attempt to seek medical care with physicians participating in your plan when possible. Insurance may not cover all fees. To be fully aware of your benefit limitations, please read your insurance policy or talk with your insurance representative. **You are responsible for co-insurance, deductible amounts, and payment for services not covered by your insurance at the time of service.**

Medicare Patients: We bill Medicare directly for you. However, you are responsible for charges applied to your deductible, any co-insurance, or charges not covered by Medicare. **We do not bill supplemental insurance carriers**. If your secondary insurance does not crossover with Medicare, you are responsible for that portion of your charges at the time of service (normally 20% of the covered charges).

Medicaid Patients: We are not a Medicaid provider. If you are not a Qualified Medicare Beneficiary you are responsible for payment of all charges non-covered by Medicare at the time of service.

Uninsured & Non-participating Insurance: If we are not a provider for your insurance you are responsible for payment of all charges at the time of service. For non-participating insurance, we will provide you with a receipt for reimbursement.

Refund Policy: We do not offer refunds for medical and cosmetic procedures. Product returns are limited to company policy.

I voluntarily consent to care treatment by Venice Avenue Dermatology including diagnostic procedures, labs and medical treatment ordered by the attending physician/ARNP/PA-C. I understand that I have financial responsibility for payment of medical services provided and hereby assume payment of all expenses incurred during my office visit. Should legal action be required to secure payment of this account, I agree to pay the legal expenses incurred by this office. Additionally, in the event of non-payment, the undersigned guarantees payment of all costs of collections, including reasonable late fees and attorney's fees.

I have read and understand this financial policy and notice of privacy practices and agree to accept responsibility as described.

Patient/POA/Guardian: Signature:____________________ **Date:** ____________

Printed Name (if not patient):________________ **Relationship (if not patient):**____________

Patient Name: ____________________ Date of Birth: ____________