American Institute of Dermatology, P.A.

PATIENT ID #

PATIENT INFORMATION

DATE

Last Name	First Name	M.I.	Home Phone # ( )
Cellular # ( )	Pager #/ Out of State Phone # ( )	Email:	
Mailing Address	City	State	Zip Code
Physical Address (if different)	City	State	Zip Code
Out of State Address	City	State	Zip Code

Age	Gender	Date of Birth	Social Security Number	Marital Status

Retired Yes ____ No ____ If yes, from where? _____

Occupation	Employer / School Name	Work / School Phone # ( )
Employer / School Address	City / State / Zip Code	

PRIMARY INSURANCE INFORMATION

Insurance Name	Policyholder Last Name	Policyholder First Name	M.I.
Policyholder Employer / Ex-employer Name	Policyholder Date of Birth	Policyholder Work Phone # ( )	
Patient's Relationship to Policyholder	**Self ___ Wife ___ Husband ___ Child ___ Parent ___ Other _____**		

SECONDARY INSURANCE INFORMATION

Insurance Name	Policyholder Last Name	Policyholder First Name	M.I.
Policyholder Employer / Ex-employer Name	Policyholder Date of Birth	Policyholder Work Phone # ( )	
Patient's Relationship to Policyholder	**Self ___ Wife ___ Husband ___ Child ___ Parent ___ Other _____**		

LEGAL GUARDIAN

Last Name	First Name	M.I.	Home Phone # ( )
Date of Birth / Gender	Social Security Number		
Mailing Address	City / State / Zip Code		
Physical Address (if different)	City / State / Zip Code		
Employer	Work Phone # ( )	Cellular # ( )	
Patient's Relationship to this person	**Self ___ Wife ___ Husband ___ Child ___ Parent ___ Other _____**		

EMERGENCY CONTACT INFORMATION – NOT IN THE SAME HOUSEHOLD

Last Name	First Name	M.I.	Phone # ( )

REFERRAL INFORMATION

How did you hear about us?

PRIMARY CARE PHYSICIAN INFORMATION

Name	Address	Phone # ( )

American Institute of Dermatology, P.A.

LIFETIME MEDICARE PART B – SIGNATURE AUTHORIZATION

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of the American Institute of Dermatology, P.A. any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand this is a lifetime signature authorization.

Print Name _____ Relationship to Patient _____

Signature _____ Date _____ Witness_____

COMMERCIAL INSURANCE RELEASE AND ASSIGNMENT

I hereby authorize the American Institute of Dermatology, P.A. to release to my company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical or Surgical care.

I also authorize and request my company to pay directly American Institute of Dermatology, P.A. the amount due me in my pending claim for Medical or Surgical treatment or services, by reason of such treatment or services rendered to me.

Print Name _____ Relationship to Patient _____

Signature _____ Date _____ Witness_____

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

American Institute of Dermatology, P.A. may use and disclose PHI (including records for treatment of HIV or AIDS, Mental Health Notes and treatment notes for Alcohol/Drug Dependency) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to American Institute of Dermatology, P.A 's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I had the opportunity to review the Notice of Privacy Practices prior to signing this consent. American Institute of Dermatology, P.A. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to American Institute of Dermatology, P.A.'s Privacy Officer.

American Institute of Dermatology, P.A. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. American Institute of Dermatology, P.A. may mail or e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

In addition, I authorize disclosure of my PHI for treatment, payment and healthcare operations with the following individuals:

Print Name _____ Relationship to Patient _____

Phone # _____ Email: _____

Print Name _____ Relationship to Patient _____

Phone # _____ Email: _____

I have the right to request that American Institute of Dermatology, P.A. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to American Institute of Dermatology, P.A.'s use and disclosure of my PHI to carry out TPO. 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, American Institute of Dermatology, P.A. may decline to provide treatment to me.

Print Name _____ Relationship to Patient _____

Signature _____ Date _____ Witness_____

Please understand that email is an unsecured medium of transmission and is potentially accessible by others. We reserve the right to require you to send us an email authorizing transmission of your healthcare information to you by unsecured email.

American Institute of Dermatology, P.A.

FINANCIAL POLICY

American Institute of Dermatology P.A. (Provider) holds contracts with Medicare and many other managed care plans. I understand that if my insurance plan is one of those with which a contract between the Provider is in place, the Provider will file a claim for medically necessary services rendered and the amount for which I am responsible (deductibles, copays, percentages or non-covered services) is in some instances required at the time of service or after my insurance claim is processed. However, I understand that in the case that my insurance plan is not contracted with the Provider or furthermore, if I am not covered by an insurance plan, the total cost of my visit is required at the time of service.

If for any reason any portion of my balance becomes overdue and it is turned into a recovery agent, I understand that I will be responsible in full for all outstanding charges and will reimburse American Institute of Dermatology, P.A. the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

Print Name _____ Relationship to Patient _____

Signature _____ Date _____

NO SHOW AND CANCELLATION POLICY

I understand that, to prevent scheduling issues and to ensure that all patients' medical needs are being met accordingly, it is the policy of American Institute of Dermatology, P.A. to charge for missed appointments or late cancellations at their discretion. American Institute of Dermatology, P.A. requires 24 hours advanced notice of all cancellations, which means that if I have an appointment Monday morning they must be notified by 12:00 pm the previous Friday. Appointment cancellations and no shows will be charged according to the time allotted to each patient. I understand that most insurance carriers do not reimburse for no show or late cancellation charges and that if I incur a charge in violation of this policy I will be fully responsible, may be billed directly and will pay it in full.

Print Name _____ Relationship to Patient _____

Signature _____ Date _____ Witness_____

LABORATORY AND DIAGNOSTIC EXAMS POLICY

Laboratory and diagnostics tests are an important part of modern health care. Through the examination of body fluids and skin tissue, laboratory tests may reveal important information about a patient's medical condition and aid in the early detection and prevention of skin disease. I understand that in some cases it may be necessary for American Institute of Dermatology, P.A. to perform laboratory and diagnostic exams in their facility and/or to collect body fluids and/or skin tissue samples to refer them to an outside laboratory facility for further analysis that will assist in the diagnosis of my condition. In the case that this additional testing is necessary, I understand that I may be billed separately from American Institute of Dermatology, P.A. and/or from another outside facility for their diagnostic services. I understand that American Institute of Dermatology, P.A. is not responsible for the billing practices of these facilities; however, upon my request I will be provided with their contact information to inquire about their services.

Print Name _____ Relationship to Patient _____

Signature _____ Date _____ Witness_____

ADVANCE CARE PLAN (FOR PATIENTS 65 YEARS AND OLDER)

An advance care plan allows you to make decisions about the care you would want to receive if you happen to become unable to make decisions for yourself. Please check one of the following:

_____ In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I have designated as my surrogate decision maker:

Surrogate Name _____ Address _____

Phone # _____ Email: _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

Do you have a living will? Yes: _____ No: _____

Which statement best reflects your wishes on advanced care recommendations:

- Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
- Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life.
- Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made

_____ The need for an advance care plan has been communicated with me; however, I do not wish or I am unable to name a surrogate decision maker, establish or provide an advance care plan at this time.

Print Name _____ Relationship to Patient _____

Signature _____ Date _____ Witness_____