# Patient Registration Form

☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

SS#: _____-_____-_____ DOB: _____/_____/_____ Age: _____ Sex: ☐ M ☐ F

_____ ☐ Jr ☐ Sr
First Middle Last

E-Mail address: _____
Is it okay to email you about upcoming cosmetic promotions and events (your e-mail will not be shared with any outside parties)? **Yes** or **No**

**Primary address:** _____

_____
City State Zip Code

Home #: (_____) _____ Work #: (_____) _____ Cell #: (_____) _____

**Secondary address:** _____

_____
City State Zip Code
Home #: (_____) _____

**Insurance Information:** Do you have health insurance? ☐ Yes ☐ No (if yes, please complete below)

**Primary Insurance Carrier:** _____ Policy type: ☐ PPO ☐ HMO
Address: _____
Name of Insured (Guarantor): _____ Guarantor Date of Birth: _____/_____/_____
SS#: _____-_____-_____ Policy #: _____
Relationship to Insured: _____

**Secondary Insurance Carrier:** _____Policy type: ☐ PPO ☐ HMO
Address: _____
Name of Insured (Guarantor): _____ Guarantor Date of Birth: _____/_____/_____
SS#: _____-_____-_____ Policy #: _____
Relationship to Insured: _____

**Emergency Contact (In Case of Emergency)**

Name of Spouse/Close Relative or Friend: _____
Home #: (_____) _____ Cell #: (_____) _____

Name of Spouse/Close Relative or Friend: _____
Home #: (_____) _____ Cell #: (_____) _____

**Please present your insurance card(s) and your photo ID to the receptionist along with this completed form. The receptionist will make a copy and return them to you promptly. Thank You.**

**- OVER -**

# PLEASE READ AND SIGN

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient signature: _____ Date: _____/_____/_____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a pre-paid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. In the event that your account must be turned over to collections, a $10.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient signature: _____ Date: _____/_____/_____

# Dermatology Medical History

Patient: _____ DOB: ____/____/____ Today's Date:_____/_____/_____
Reason for today's visit: _____
Are you allergic to any medications: □ Yes □ No if yes, list below:
1. _____ 2. _____ 3. _____
Have you ever had dental anesthesia (Novocain)? □ Yes □ No Any bad reaction? □ Yes □ No
List all medications you are currently taking (including prescriptions, over-the counter meds., vitamins, and herbals): 1._____ 3. _____ 5. _____
2._____ 4. _____ 6. _____
Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

| **Lungs:** | **Yes** | **No** |
|---|---|---|
| Bronchitis | □ | □ |
| Emphysema | □ | □ |
| Asthma | □ | □ |
| Chronic Cough | □ | □ |
| Morning Cough | □ | □ |
| Shortness of Breath | □ | □ |

| **Cardiovascular:** | **Yes** | **No** |
|---|---|---|
| High Blood Pressure | □ | □ |
| Chest Pain | □ | □ |
| Heart Attack | □ | □ |
| Heart Murmur | □ | □ |
| Irregular Heartbeat | □ | □ |
| Phlebitis | □ | □ |
| Inflammation of vein | □ | □ |
| Blood clots | □ | □ |
| **Pacemaker** | □ | □ |
| **Liver problems** | □ | □ |
| Hepatitis | □ | □ |

| **Other Systemic:** | **Yes** | **No** |
|---|---|---|
| Diabetes | □ | □ |
| Excessive thirst/hunger | □ | □ |
| Amputation | □ | □ |
| Thyroid | □ | □ |
| Kidney | □ | □ |
| Dialysis | □ | □ |
| Bladder | □ | □ |
| Frequency/burning | □ | □ |
| Gastrointestinal | | |
| Stomach absorptive disorder | □ | □ |
| Nausea, vomiting, diarrhea when taking antibiotics | □ | □ |
| Yeast infection when taking antibiotics | □ | □ |
| Arthritis/Joint Deformity | □ | □ |
| Arthralgia | □ | □ |
| Limited motion | □ | □ |
| **Artificial joint** | □ | □ |
| Convulsions, Epilepsy or Seizures | □ | □ |
| Fainting | □ | □ |

List any other diseases or conditions: _____
List surgical procedures you have had in the last 6 months: _____
**Skin:** Have you ever had skin cancer? □ Yes □ No
Has anyone in your family had skin cancer? □ Yes □ No if yes, who?_____
Have you ever had a melanoma? □ Yes □ No
Has anyone in your family had a melanoma? □ Yes □ No if yes, who?_____
Do you have a history of any specific skin diseases? □ Yes □ No if yes, _____
Do you have problems with healing? □ Yes □ No
Do you develop keloids (scars) after surgery? □ Yes □ No
Do you bleed easily? □ Yes □ No
Do you develop skin rashes in reaction to: □ Medications □ Food □Environment □ Bandages
□ Topical Neosporin □ Other _____
**Social History:** Do you drink alcohol? □ Yes □ No if yes _____ drinks per day
Do you use IV drugs? □ Yes □ No if yes, what? _____ How often? _____
Do you smoke? □ Yes □ No if yes, how much: _____
Have you had or have you been exposed to HIV (AIDS)? □ Yes □ No
**(Women) Are you pregnant?** □ Yes □ No Due Date: ____/____/____
What is your occupation? _____ Hobbies? _____

Completed by: □ Patient Signed by Patient _____ Date:_____/_____/_____
Initials _____□ MA □ Nurse Reviewed by _____ Date:_____/_____/_____

# HIPAA
# Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

## Acknowledgement of Notice of Privacy Practices

My signature below verifies that I, _____, have received
(Print Name)
a copy of the Notice of Privacy Practices from Romagosa Dermatology Group, LLC

Signature of Recipient _____ Date: _____/_____/_____

## Protected Health Information Authorization (optional)

Do you give our office permission to discuss your medical information with family members or significant others?

☐ Yes ☐ No If yes, please provide their name and phone number.

Name: _____ Phone #: _____-_____-_____
Relationship : _____

My signature below authorizes Romagosa Dermatology Group, LLC to discuss my PHI with my spouse or personal representative named above.

Signature of Patient _____ Date: _____/_____/_____

Date of Last Revision: 08/01/05
Effective: Immediately

Romagosa Dermatology Group, LLC
2220 SE Ocean Blvd., Suite 301
Stuart, FL 34996
(772) 220-3339

# Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY HAVE ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
THIS NOTICE APPLIES TO ALL OF THE RECORDS OF YOUR CARE GENERATED BY THE PRACTICE, WHETHER MADE BY THE PRACTICE OR AN ASSOCIATED FACILITY.

This notice describes our practice's policies, which extend to:

- Any health care professional authorized to enter information into your chart (including physicians, PAs, RNs, etc.);
- All areas of the practice (front desk, administration, billing and collection, etc.);
- All employee, staff and other personnel that work for or with our practice;
- Our business associates (including a billing service, or facilities to which we refer patients, on-call physicians, and so on.

The practice provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

OUR THOUGHTS ABOUT YOUR PROTECTED HEALTH INFORMATION:

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create paper and electronic medical records about your health, our care for you, and the services and/or items we provide to you as our patient. We need this record to provide for your care and to comply with certain legal requirements.

We are required by law to:

- make sure that the protected health information about you is kept private;
- provide you with Notice of our Privacy Practices and your legal rights with respect to protected health information about you; and
- follow the conditions of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose protected health information that we have and share with others. Each category of uses or disclosures provides and general explanation and provides some examples of uses. Not every use or disclosure in a category is either listed or actually in place. The explanation is provides for your general information only.

- Medical Treatment. We use previously given medical information about you to provide you with current or prospective medical treatment or services. Therefore we may, and most likely will, disclose medical information about you to doctors, nurses, technicians, medical students, or hospital personnel who are involved in taking care of you. For example, a doctor to whom we refer you for ongoing or further care may need your medical record. Different areas of the Practice also may share medical information about you including you record(s), prescriptions, requests of lab work and x-rays. We may also discuss your medical information with you to recommend possible treatment options or alternatives that may be of interest to you. We also may disclose medical information about you to people outside the Practice who may be involved in your medical care after you leave the Practice; this may include your family members, or others we use or to whom we refer you to provide services that are part of your care. Unless clearly instructed to the contrary, we may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to some one who helps to pay or pays for your care.
- Payment. We may use and disclose medical information about you for services and procedures so they may be billed and collected from you, an insurance company, or any other third party. For example, we may need to give your health care information, about treatment you received at the Practice, to obtain payment or reimbursement for the care. We may also tell your health plan and/or referring physician about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment, to facilitate payment of a referring physician, or the like.
- Operational Uses. We may use and disclose medical information about you so that we can run our Practice more efficiently and make sure that all of our patients receive quality care. These uses may include reviewing our treatment and services to evaluate the performance of our staff, deciding what additional services to offer and where, deciding what services is not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. We may also combine the medical information we have with medical information from other Practices to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are. We may also use or disclose information about you for internal or external utilization review and/or quality assurance, to business associates for purposes of helping us to comply with our legal requirements, to auditors to verify our records, to billing companies to aid us in this process and the like. We shall endeavor, in all times when business associates are used, to advise them of their continued obligation to maintain the privacy of your medical records.
- Appointment and Patient Recall Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care with the Practice or that you are due to receive periodic care from the Practice. This contact may be by phone, in writing, e-mail, or otherwise which could (potentially) be picked up by others.
- Others Involved in Your Care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
- Research. Under certain circumstances, we may use and disclose medical information about you for research purposes regarding medications, efficiency of treatment protocols and the like. All research projects are subject to an approval process, which evaluates a proposed research project and its use of medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the Practice. We will attempt to make the information non-identifiable to a specific patient but we cannot guarantee that we can always do this. We will endeavor to (but cannot guarantee we will) seek your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care with the Practice; provide, however that we will obtain your specific authorization if required by law.
- Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.
- To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- Public Health Risks. Law or public policy may require us to disclose medical information about you for public health activities. These activities generally include the following:
    - to prevent or control disease, injury or disability;
    - to report births and deaths;
    - to report child abuse or neglect;
    - to report reactions to medications or problems with products;
    - to notify people of recalls of products they may be using;
    - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
    - to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- Investigation and Government Activities. We may disclose medical information to a local, state or federal agency for activities authorized by law. Those oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the payor, the government and other regulatory agencies to monitor the health care system, government programs, and compliance with civil rights laws.
- Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. This is particularly true if you make your health an issue. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We shall attempt in these cases to tell you about the request so that you may obtain an order protecting the information requested if you so desire. We may also use such information to defend ourselves or any member of our practice in any actual or threatened action.
- Law Enforcement. We may release medical information if asked to do so by a law enforcement official:
    - In response to a court order, subpoena, warrant, summons or similar process;
    - To identify or locate a suspect, fugitive, material witness, or missing person;
    - About the victim or a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
    - About a death we believe may be the result of criminal conduct;
    - About criminal conduct at the Practice; and
    - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
- Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Practice to funeral directors as necessary to carry out their duties.
- Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (a) for the institution to provide you with health care (b) to protect your health and safety or the health and safety of others; or (c) for the safety and security of the correctional institution.

CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we may receive from you in the future. We will post a copy of the current notice in the Practice. The notice will contain on the first page, in the top right-hand corner, the date of last revision and effective date. In addition, each time you visit the Practice for treatment or health care services you may request a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with Practice, contact our office manager, who will direct you on how to file an office complaint. All complaints must be submitted in writing, and all complaints shall be investigated, without repercussion to you. YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission, unless those uses can be reasonably inferred from the intended uses above. If you have provided us with your permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with you permission, and that we are required to retain our records of the care that we provide to you.

PATIENT RIGHTS

You have the following rights regarding medical information we maintain about you:

- Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes your own medical and billing records, but does not include psychotherapy notes. Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed. To inspect and copy your medical record, you must submit your request in writing to our Office Manager. If you request a copy of the information, we may charge a fee for the copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request a review of our denial. Another licensed health care professional chosen by the Practice will review your request and the denial.
- Right to Amend. If you feel that the medical information we have about you in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as the Practice maintains your medical record. To request an amendment, your request must be submitted in writing, along with your intended amendment and a reason that supports your request to amend. We may deny your request for an amendment if :(a) was not created by us, unless the person or entity that created the information is not longer available to make the amendment; (b) is not part of the medical information kept by or for the Practice; (c) is not part of the information which you would be permitted to inspect and copy; or (d) is inaccurate and incomplete.
- Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you, to others for purposes other than treatment, payment or healthcare operations. To request this list, you must submit your request in writing. Your request must state a time period no longer than six (6) years back and may not include dates before April 14, 2003. The first list you request within a twelve (12) month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you to someone who is involved in your care or the payment for your care. To request restrictions, you must make you request in writing. In your request, you must indicate; (a) what information you want to limit; (b) whether you want to limit our use, disclosure or both; and (c) to whom you want the limits to apply.
- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will attempt to accommodate all reasonable requests. Your request must specify how or where you wish us to contact you.
- Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To Our Patients:

As you know if you have ever checked into a hotel or rental car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share. At the time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This will not compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays due at the time of the visit will, of course, still be due at the time of the visit.

If you have any questions about this payment method, do not hesitate to ask.

Sincerely yours,

Romagosa Dermatology Group, LLC

I authorize Romagosa Dermatology Group, LLC to charge outstanding balances on my account to the following credit card:

Visa MasterCard American Express Discover Other: _____

Account number: _____ Expiration Date: _____

Name on card (please print):_____

Signature: _____ Date: _____