BAY DERMATOLOGY
AND COSMETIC SURGERY, P.A.

PATIENT NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be disclosed. Please review it carefully.

Bay Dermatology & Cosmetic Surgery, P.A. will use your medical information for the following:

1. TREATMENT: Including providing your medical records to consulting clinicians and insurance companies.

2. PAYMENT: We will file necessary claims to insurance companies in your name to obtain payment. They may request part or all of your medical record to pay the claim.

3. HEALTH CARE OPERATIONS: Any others involved in your healthcare.

The entire PRIVATE POLICY NOTICE of Bay Dermatology & Cosmetic Surgery, P.A. is posted in the waiting room for your perusal.

QUESTIONS #1, 2 AND 3 MUST BE COMPLETED

In conjunction with these privacy practices you will need to provide us with the following information:

1. **Name of person(s) we may speak to regarding your health (i.e. spouse, child, etc. including phone number.)**

   ____
   ____
   ____

2. **Emergency Contact: (relative or person not living with you)**

   Name: ___________________________

   Address: _________________________

   Phone Number: __________________

3. **May we leave a message regarding your health or an upcoming appointment on your answering machine?**

   YES:__________ **NO:**__________

Signature of Patient or Legal Guardian	Relationship to Patient
Print Patient's Name or Legal Guardian	Patient's Date of Birth
Witness	Date

BAY DERMATOLOGY AND COSMETIC SURGERY, P.A.

Patient Financial Policy

Welcome to Bay Dermatology and Cosmetic Surgery, P.A. We are dedicated to providing you with the highest level of medical care in a compassionate and proficient manner. All patients are expected to complete a patient financial responsibility form annually. You will need to read carefully the Financial Policies as described below.

Your co-payment will be collected on the date of service. Any deductible, co-insurance, or full payment is due at the time services are rendered. We cannot waive co-payments, deductibles, co-insurance or non-covered service amounts defined as patient responsibility under the terms of our contract with various health plans.

For your convenience we accept cash, personal checks, most major credit and debit cards, Quick Pay and CareCredit as an extended payment option. If you cannot provide a current medical insurance card, full payment must be made at the time services are rendered.

It is your obligation to make certain that this office is a participating provider of your policy and that referral information and authorization has been obtained in advance of your appointment. We will file your insurance claims for you if all necessary information is received at the time of your visit. It is also your responsibility to inform our office of changes in insurance coverage and/or personal contact information.

If payment is not received from your insurance company within 45 days, you will be billed for the services rendered. You will also be billed for any services not covered by your insurance company. An account for which no payment is received within 60 days and for which no payment arrangements are made may be sent to a collection agency. The balance will accrue a monthly interest fee and an additional fee for the expenses related to collections. Checks returned to our office for non-sufficient funds (NSF) will incur a $30 service charge.

Patients are seen by appointment. If you cannot keep your appointment it is your responsibility to call at least 24 hours in advance. We do understand that occasionally it will be necessary to change or cancel an appointment in less than 24 hours; however, if two (2) appointments are missed without notice there will be a $25 fee charge. Appointments set for cosmetic or aesthetician services not cancelled 24 hours in advance will automatically be charged $25. Three missed appointments are subject to dismissal from the practice. Families (three or more), who miss their same-day scheduled appointments and fail to provide a minimum of 24 hours notice, unduly inconvenience the practice and will incur a mandatory $250 service charge.

We try to utilize contracted laboratories for biopsies. When skin growths are biopsied or removed, there are two separate charges. First there is a charge for the actual biopsy/removal performed. Second, there is a lab charge for preparing and examining specimen slides under a microscope. Lab charges occur on a different date. If the specimen slides require a second opinion or special stain, an independent lab (not owned by our practice) will bill your insurance carrier for additional fees. If you have questions about these additional lab fees, please contact the lab directly as these fees are not charged by our office.

Unaccompanied minors must have a consent signed by a parent or guardian. Non-emergency treatment will be denied unless non-covered charges and co-pays have been paid and insurance billing is approved under the insured's policy. Co-pays and other charges can be paid via telephone by credit card.

Should you request copies of your medical records, there is a fee charged as allowed by current Florida statutes. There is also a cost associated with your request for physician "narrative reports" and/or letters not related to our insurance claims. These fees would be based on the complexity and amount of time involved.

Our staff will be happy to answer any questions you may have about our policies. Thank you for allowing us to serve you.
I have read and understand the terms of this Financial Policy. I understand and agree that such terms may be amended from time to time by the practice. I agree to assign insurance benefits to Bay Dermatology and Cosmetic Surgery, P.A. I authorize the release of medical information to my primary care or referring physician, and/or consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.

X____ ________________
Signature of Patient or Responsible Party **Date**

NAME: ______________________ DATE: ______________________
BP: ______________________
PULSE: ______________________

MEDICATIONS:

____

____

Are you taking: ASPIRIN YES NO / BLOOD THINNER YES NO / ASPIRIN LIKE PRODUCTS YES NO
SMOKER YES NO / ALCOHOL YES NO / RECREATIONAL DRUGS YES NO
Birth Control Pills .... YES NO
Birth Control Implant: .... YES NO

ALLERGIES TO: MEDICATIONS: TOPICALS: FOODS:

____
____
____

Allergy to Neomycin .... YES NO
Allergy to Xylocaine .... YES NO
Allergy to Lidocaine .... YES NO
Allergy to Latex .... YES NO
Allergy to Epinephrine .... YES NO

PAST SURGERY HISTORY:
Artificial Hip / Knee .... YES NO
Artificial Heart Valve / History of Mitral Valve Prolapse .... YES NO

PAST MEDICAL HISTORY:
Diabetes: .... YES NO
Gastro Disease / Ulcer: .... YES NO
Thyroid Disease: .... YES NO
Liver Disease: .... YES NO
High Blood Pressure: .... YES NO
Communicable Disease / Hepatitis / TB / Syphilis / HIV: .... YES NO
Glaucoma: .... YES NO

PAST DERMATOLOGIC HISTORY:
Skin Cancer: .... YES NO
Type: ______________________
Skin Disease or Condition: ______________________
Family History of Skin Cancer / Melanoma: .... YES NO
Type of Relation: ______________________

Pregnant: .... YES NO
Breast Feeding: .... YES NO
Language Spoken: ______________________
Hobbies: ______________________
Referred by: ______________________

PATIENT INFORMATION

❑ New Patient ❑ Name Change ❑ Address Change ❑ Insurance Change

ALL SECTIONS MUST BE COMPLETED FOR ALL PATIENTS: Today's Date_____/_____/_____

Patient Name: ____
Last First Middle Initial

Date of Birth: _____/_____/_____ Age: _____ Social Security #: ______________________ Sex: ❑ Male ❑ Female

ADDRESS:

Mailing Address: ____
Street City State Zip

Secondary Address: ____
Street City State Zip

Home Phone: ( ) ______________ Work Phone: ( ) ______________ Cell Phone: ( ) ______________

Emergency Contact Phone: ( ) ______________ Email Address: ______________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Occupation: ____

Primary Care Physician: ______________________ Referred by: ______________________

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name: ____
Last First Middle Initial

Address: ____
Street City State Zip

Home Phone: ( ) ______________ Work Phone: ( ) ______________ Cell Phone: ( ) ______________

Date of Birth: _____/_____/_____ Age: ______ Social Security #: ______________________ Sex: ❑ Male ❑ Female

INSURANCE COVERAGE – PRIMARY HOLDER INFORMATION

Insurance Co. Name: ______________________ Phone: ( ) ______________ Ext: ______

Address of Claim Center: ____

City, State, Zip: ____

Policy Type: ❑ HMO ❑ PPO Policy #: ______________________ Group Name or #:______________________

Name Policy Holder (Insured): ______________________ Date of Birth: ____/_____/____ Social Security #: ______________

Address: ____
Street City State Zip

Check relationship: ❑ Mother ❑ Father ❑ Other______________________ Sex: ❑ Male ❑ Female
Identify

INSURANCE COVERAGE – SECONDARY

Insurance Co. Name: ______________________ Phone: ( ) ______________ Ext: ______

Address of Claim Center: ____

City, State, Zip: ____

Policy Type: ❑ HMO ❑ PPO Policy #: ______________________ Group Name or #: ______________________

Policy Holder (Insured): ______________________ Date of Birth: ____/____/____ Social Security #: ______________

Address: ____
Street City State Zip

ATTACH A COPY OF PATIENT'S INSURANCE CARD (BOTH SIDES)