Patient Information **Date:** _____

*How were you referred to our practice?*_____

Name:_____ Date of Birth:_____

Age:_____ Social Security #:_____ Sex: Male / Female

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____Alternate Phone:_____

Alternate Address:_____

City:_____ **State**:_____ **Zip Code**:_____

Primary Care Doctor: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

Insurance Information:

Primary Policy:_____ Secondary Policy:_____

Identification #:_____ Identification #:_____

Group #:_____ Group #:_____

Name of Insured:_____ Name of Insured:_____

Relationship to Patient:_____ Relationship to Patient:_____

Social Security #:_____ Social Security #:_____

Date of Birth:_____ Date of Birth:_____

Emergency Contact Information:

Name:_____ Phone Number:_____

Parent or Responsible Party Information (*for treatment of minors*)

Name:_____ Date of Birth:_____

Social Security #:_____ Sex: Male / Female

Relationship to patient:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____Alternate Phone:_____

Dermatology Medical History

Patient: _____ Date of Birth: _____/_____/_____Today's Date: ____/____/____

Reason for today's visit:_____

Are you allergic to any medications? ☐ YES ☐ NO If yes, list below:

1. _____ 2. _____

Have you ever had dental anesthesia (Novocaine)? ☐ YES ☐ NO Any bad reaction? ☐ YES ☐ NO

List all medications you are currently taking (including prescriptions, over-the-counter-med., 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	☐	☐
Wheezing	☐	☐

Cardiovascular:	**YES**	**NO**
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
Inflammation of vein	☐	☐
Blood clots	☐	☐
Pacemaker	☐	☐

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

Do you have a history of any specific skin diseases? ☐ YES ☐ NO

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? ☐ YES ☐ NO If YES, _____drinks per day

Do you use IV drugs? ☐ YES ☐ NO If YES, what? _____ How often? _____

Do you smoke or use tobacco products? ☐ YES ☐ NO If YES, how much: _____

Office use-Pamphlet given: _____

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 _____ ____/____/____

☐ Medical Assistant _____ Signed by Patient Date

Initials

_____ ____/____/_____

Reviewed by Date

TREASURE COAST DERMATOLOGY

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

RECORDS RELEASE

RELEASE MEDICAL RECORDS TO / FROM (Please Circle):

Treasure Coast Dermatology:

□ 140 SW Chamber Ct, # 200, Port St Lucie, FL 34986
Ph: 772-878-3376 Fax: 772-879-9970

□ 448 SE Osceola St, Stuart, FL 34994
Ph: 772-221-3330 Fax: 772-221-3336

□ 2402 Frist Blvd, # 101, Fort Pierce, FL 34950
Ph: 772-464-6464 Fax: 772-464-6062

□ 1260 37th St, # 101, Vero Beach, FL 32960
Ph: 772-226-7218 Fax: 772-226-7534

□ 801 Wellness Way, # 103, Sebastian, FL 32958
Ph: 772-388-1740 Fax: 772-388-8623

RELEASE MEDICAL RECORDS TO / FROM (Please Circle):

_____
Name

_____
Street Address

_____
City, State, Zip Code

_____
Phone Number

_____
Fax Number

PATIENT INFORMATION

_____ _____ _____
Patient Name Date of Birth Phone Number

_____ _____ _____ _____
Address City State Zip

_____ _____
Patient Legal Guardian/Rep (If Applicable) Relationship to Patient

INFORMATION REQUESTED

Date(s) of Service: _____

□ Pathology Reports □ Lab Results □ Other: (Specify): _____

PURPOSE

□ Self □ Continuing Medical Care □ Attorney Request □ Other: (Specify): _____

This authorization will expire on the following: DATE: _____ OR EVENT: _____

DISCLOSURE OF SPECIALLY PROTECTED INFORMATION

My records may contain the following and, unless crossed out and initialed, I specifically authorize their release:

HIV Test Results (Test for AIDS) AIDS Related Records Drug or Alcohol Records TB Records

STD Records (Sexually Transmitted Disease) Mental Health Records Pregnancy Records

- I do not have to sign this authorization form in order to receive treatment from Treasure Coast Dermatology. In fact, I have the right to refuse to sign this authorization form.
- I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. My written revocation must be submitted to Treasure Coast Dermatology, Attn: Privacy Office, 140 SW Chamber Ct, #200, Port St Lucie, FL 34986
- I understand that if this information is disclosed to a third party, the information may no longer be protected by the state and federal regulations and may be re-disclosed by the person or organization that receives the information.

_____ _____
Signature of Patient Date

_____ _____ _____
Signature of Legal Guardian / Representative Relationship to Patient Date

Patient Name:_____
Please Print

Medicare Recipient:

Yes / No If you or your spouse work in a company that has more than 20 employees, do you receive health benefits through their group plan?

Yes / No Are you covered by a Medicare Advantage Plan which replaces your Medicare?

Yes / No Are you covered by a health plan which makes Medicare your secondary coverage?

Yes / No Do you receive medical assistance through any state-aid programs?

Medicare Authorization:
I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration or its intermediaries 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 the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature:_____ Date:_____

Supplemental Authorization:
I authorize MEDIGAP claims be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the submitted MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services. I authorize and direct my insurance carrier(s) to issue payment check(s) directly to Treasure Coast Dermatology.

Signature:_____ Date:_____

Non-Medicare Recipient:

I authorize the release of medical information to my primary care physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize and direct my insurance carrier(s) to issue payment check(s) directly to Treasure Coast Dermatology.

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 prepaid plan with which we participate. For those patients, applicable co-payments and deductibles will be collected. 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.

Signature_____ Date:_____

NAME: _____ DATE OF BIRTH: _____

TREASURE COAST DERMATOLOGY

Acknowledgement of Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires us to provide you with our Notice of Privacy Practices which explains our privacy practices and how we may legally use and disclose your Protected Health Information (PHI). In order to protect your privacy and confidentiality, we ask that you authorize when, and to whom, protected health information can be released.

By signing below, I acknowledge that I have received a copy of the Treasure Coast Dermatology's Notice of Privacy Practices and have been given an opportunity to ask questions. A copy of this consent will be included in my chart for future reference.

_____ _____
Print Name Date

_____ _____
Signature of Recipient Date

FOR MINORS ONLY

I am a parent or legal guardian of _____. I hereby acknowledge receipt of Treasure Coast Dermatology's Notice of Privacy Practices with respect to the patient.

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Name (print): _____

_____ _____
Signature of Recipient Date

Please list below the authorized representative(s) that we may speak with about your health care. You may at any time, with written authorization, change or revoke this authorization. By completing this form, please be aware that you authorize the health care providers and staff of Treasure Coast Dermatology to discuss all your health care needs, billing issues, and questions with those listed below.

Name:_____ Date of Birth:_____ Relation:_____

Name:_____ Date of Birth:_____ Relation:_____

Name:_____ Date of Birth:_____ Relation:_____

_____ _____
Patient Signature Date

TREASURE COAST DERMATOLOGY

NOTICE OF PRIVACY PRACTICES

Privacy Officer: 140 SW Chamber Court, # 200, Port St Lucie, FL 34986 772-878-3376

Effective Date: September 23, 2013 (Revised 3/9/2016)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief

organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]

22. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

23. Research. We may disclose your health information to researchers conducting research.

24. General Liability. In the event you are involved in an accident on our property we may disclose your information as necessary to report the incident or to file a claim to the insurance company.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health

professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

U.S. Department of Health and Human Services, Office for Civil Rights, Centralized Case Management Operations, 200 Independence Ave., SW, Suite 515F, HHH Building, Washington, D.C. 20201.

The complaint form may be found at http://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/complaints/hipcomplaintform.pdf.

You will not be penalized in any way for filing a complaint.