Associates in Dermatology

First Name:	Middle Name:	Last Name:	Gender:
Mailing Address:	City, State, Zip:		E-mail Address: *(Required)*
Billing Address:	City, State, Zip:		
Date of Birth:	Soc Sec #:	Marital Status:	
Preferred Phone: ☐ Home ☐ Cell Phone	Secondary Phone: ☐ Home ☐ Cell Phone	May we activate your Patient Portal so you may access your records ☐ Yes ☐ No	
What is your *preferred* method of contact? ☐ Home Phone ☐ Cell Phone ☐ E-Mail ☐ Mail			
Employer: ☐ Check here if retired	Occupation:	Referred by or how did you hear about us:	
Emergency Contact:	Contact Phone:	Relationship to Patient: ☐ Spouse ☐ Child ☐ Sibling ☐ Parent ☐ Friend	

In order to meet new Government Requirements for Meaningful Use Please answer the following:

Race:	
Preferred Language:	Ethnicity:
Do you have an Advanced Directive or Living Will? ☐ Yes (Please provide a copy for office records.) ☐ No	

Insurance

Name of Policy Holder:	Soc Sec #:	Date of Birth:
Relationship of Policy Holder to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian		
Address (if different from Patient):		Phone
Insurance Company: Group #	Subscriber/Member #	

Additional Insurance

☐ **Check here if No additional Insurance and skip this section**

Name of Policy Holder:		
Relationship Policy Holder to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian		
Address: (if different from Patient): Phone:	Soc Sec #:	Date of Birth: / /

Certification of Information

I hereby certify that the above information is true and correct. I certify that I have received and read the Associates in Dermatology, Patient Information Brochure and Notice of Privacy Practices. In accordance with Florida Statue 627.736(5), I agree to pay all applicable deductibles and co-pays. By my signature, I understand and agree to the terms set forth herein.

Patient Signature:			Printed Name:
Witness Signature:			Date

Medicare Authorizations

I request that payment of authorized Medicare benefits be made on my behalf to the Associates in Dermatology for any services furnished to me by their providers. I authorize any holder of medial information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of authorized Medigap/Medicare Supplement benefits to the Associates in Dermatology for any services furnished to me by their providers. I authorize any holder of Medicare information about me to release to my Medigap/Medicare Supplement insurance carrier any information needed to determine these benefits payable for related services.

Signature of Patient or Responsible Party	Date

Patient Portal

_____ *(initial)* Associates in Dermatology will offer you access to your own personal web portal where you can obtain your records and contact the office. The portal can be used to message your provider, request appointments or referrals, and to manage your prescriptions. The portal is not for urgent issues, messages sent through the portal will not be checked until the next business day. Please provide your email address for this function: _____ *(email)*

Consent to Release Health Information

() I hereby give consent to Associates in Dermatology to discuss or release my private health care information to

i.e. Spouse, parent, care-taker):	Name:		Relationship to patient:	
	Name:		Relationship to patient:	

Patient Signature or Responsible Party	Date

Consent to Leave Phone Message

I understand that as part of my health care, the Associates in Dermatology may need to reach me by phone.

() I **DO** authorize Associates in Dermatology to leave a message on my☐home telephone,☐cell phone, and/or ☐work phone regarding laboratory/test results and imaging studies. ***However, I understand that sensitive information and/or results that require medication, follow-up or discussion will require that I make an appointment with the provider.***

() I **DO NOT** authorize Associates in Dermatology to leave message on my telephone (home, cell, or work) regarding any type of testing results. ***I will accept the responsibility of making an appointment with the provider to obtain the results.***

Patient's Signature or Authorized Party:		**Date**	

ACKNOWLEDGEMENT AND AUTHORIZATION

****Please sign and date each item below****

- I hereby assign my insurance benefits to be paid directly to the healthcare provider
- I authorize ASSOCIATES IN DERMATOLOGY to release medical information required to process my claim
- I have read and understand the Financial Policy for ASSOCIATES IN DERMATOLOGY
- I authorize ASSOCIATES IN DERMATOLOGY to obtain/have access to my medication history

Signed_____ **Date:**_____

- I have read and understand the HIPAA/Privacy Policy for ASSOCIATES IN DERMATOLOGY

Signed_____ **Date:**_____

- I have read and understand the Arbitration Policy for ASSOCIATES IN DERMATOLOGY

Signed_____ **Date:**_____

Associates in Dermatology

SureScripts Authorization

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with Florida State Law and Privacy Rule of Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1.	Associates in Dermatology uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to Associates in Dermatology.
2.	This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to Associates in Dermatology.
3.	I have the right to revoke the authorization at any time by writing to Associates in Dermatology. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4.	Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5.	Information disclosed under this authorization might be re-disclosed by recipient, and this re-disclosure may no longer be protected by state or federal law.
6.	This authorization expires one year from the date of my signature below.
7.	THIS AUTHORIZATION DOES NOT AUTHORIZE ASSOCIATES IN DERMATOLOGY TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

	Signature of Patient or Representative Authorized by law		Date
	Relationship to Patient		Interpreter,if utilized