DERMATOLOGY SURGERY CENTER

Scott L. Beals, DO, FAAD
www.dermsurgctr.com
Fax: 850- 897-7547
Dsc1@derm-surg.com

4566 Hwy 20 E, Suite 101 Niceville, FL 32578 (850) 897-7546	184 E Redstone Ave, Suite B Crestview, FL 32539 (850) 398-8554	301 Medical Drive, Suite B Andalusia, AL 36420 (334) 222-7546

PATIENT INFORMATION: Complete with PATIENT Information

First Name: _____ Last: _____ M.I.: _____

Social Security Number: _____-_____-_____ DOB: _____/_____/_____ Age: _____

Gender: M ( ) F ( ) Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated

Race: White ( ) Black or African American ( ) Asian ( ) Other Race ( )

Ethnic Group: Unknown ( ) Hispanic or Latino ( ) Not-Hispanic or Latino ( )

Preferred Language: English ( ) Spanish ( ) Other ( )

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (____) _____

E-Mail Address: _____

Emergency Contact Name: _____ Phone: (____) _____

Guarantor's Name (if patient is a minor) _____ Relationship: _____

Preferred Pharmacy: _____

Who may we thank for referring you to us? _____

INSURANCE INFORMATION: This information is REQUIRED

Primary Insurance

Relationship to Patient: ( ) Self ( ) Parent ( ) Spouse ( ) Employer ( ) Other: _____

Insurance Company: _____ Policy ID/Member ID #: _____

Primary Policy Holder(If not self):

Primary Insured Name: _____ Gender: M ( ) F ( ) Primary Insured's Date of Birth: ___/___/___

Secondary Insurance

Relationship to Patient: ( ) Self ( ) Parent ( ) Spouse ( ) Employer ( ) Other: _____

Insurance Company: _____ Policy ID/Member ID #: _____

Primary Policy Holder(If not self):

Primary Insured Name: _____ Gender: M ( ) F ( ) Primary Insured's Date of Birth: ___/___/___

Tricare/Tricare for Life:

Sponsor's Date of Birth: ____/_____/_____ Social Security Number: _____-_____-_____Status: _____

The contents of DERMATOLOGY SURGERY CENTER PRACTICE POLICIES have been fully reviewed by me and I have been given the opportunity to ask questions. Any questions which I have asked have been answered to my satisfaction. I certify that I understand the contents of that form.
(A copy of DERMATOLOGY SURGERY CENTER PRACTICE POLICIES or HIPAA PRIVACY GUIDELINES is available for you to keep upon request.)

_____

Printed Patient (and Authorized Representative) Name

_____ _____

Signature of Patient or Authorized Representative **Date**

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HISTORY AND INTAKE FORM

Name: _____ **DOB:** _____/_____/_____

Language: English Other:_____ **Gender: M F Race:** _____

Preferred Pharmacy: _____ **Pharmacy Phone:**_____

Pharmacy Address:_____

Primary Care Provider & Phone: _____

Past Medical History: (Please circle all that apply)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Artificial Joints	End Stage Renal Disease	Lymphoma
Asthma	GERD	Pacemaker
Atrial Fibrillation	Hearing Loss	Prostate Cancer
BPH	Hepatitis	Radiation Treatment
Bone Marrow Transplantation	Hypertension	Seizures
Breast Cancer	HIV / AIDS	Stroke
Colon Cancer	Hypercholesterolemia	Valve Replacement
COPD	Hyperthyroidism	None
Coronary Artery Disease	Hypothyroidism	

Other: _____

Past Surgical History: (Please circle all that apply)

Appendix Removed	Kidney Biopsy
Bladder Removed	Kidney Removed (Right, Left)
Mastectomy (Right, Left, Bilateral)	Kidney Stone Removal
Lumpectomy (Right, Left, Bilateral)	Kidney Transplant
Breast Biopsy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Breast Reduction	Ovaries Removed: Cyst
Breast Implants	Ovaries Removed: Ovarian Cancer
Colectomy: Colon Cancer Resection	Prostate Removed: Prostate Cancer
Colectomy: Diverticulitis	Prostate Biopsy
Colectomy: IBD	TURP
Gallbladder Removed	Skin Biopsy
Coronary Artery Bypass	Basal Cell Cancer Surgery
PTCA	Squamous Cell Carcinoma Surgery
Mechanical Valve Replacement	Melanoma Surgery
Biological Valve Replacement	Spleen Removed
Heart Transplant	Testicles Removed (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)	Hysterectomy: Fibroids
Joint Replacement, Hip (Right, Left, Bilateral)	Hysterectomy: Uterine Cancer
Joint Replacement within the last 2 years	None

Other: _____

(Please continue on the back)

Skin Disease History: (please circle all that apply)

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Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/ Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	None

Other: _____

Do you wear Sunscreen? Yes No What SPF? _____

Do you have a family history of melanoma? Yes No If yes, which relative(s)? _____

Do you tan in a tanning salon? Yes No

Medications: (Please list all current medications, strength, and how you take them)

_____

_____

_____

Allergies: _____

Social History: (Please circle all that apply)
Current Smoker Former Smoker Never Smoked Type of Tobacco Used_____

What is your current occupation? _____

Review of Systems: Are you currently experiencing any of the following? (please circle all that apply)

Abdominal Pain	Changing Mole	Hay Fever	Seizures
Anxiety	Chest Pain	Joint Aches	Shortness of Breath
Bleeding Problems	Cough	Muscle Weakness	Sore Throat
Bloody Stool	Depression	Neck Stiffness	Thyroid Problems
Bloody Urine	Fever or Chills	Night Sweats	Unintentional Weight Loss
Blurry Vision	Headaches	Rash	Wheezing

Other Symptoms: _____

Surgical Precautions: (Please write Y for Yes or N for No in the blanks below)
Have you ever had difficulty stopping bleeding? _____
Do you require antibiotics prior to a surgical procedure? _____
Have you had an artificial joint replacement? _____
If yes, when and what body locations? _____
Have you had an artificial heart valve? _____
Do you have a pacemaker? _____
Do you have a defibrillator? _____
Are you pregnant or currently trying to get pregnant? _____

Reason for visit: _____

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DERMATOLOGY SURGERY CENTER PRACTICE POLICIES

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release or any information in relation to all claims, including Medicare for benefits submitted on my behalf and/or my dependents. I further agree and acknowledge that my signature of this document authorizes my physician to submit claims for benefits, for services rendered or to be rendered, without obtaining my signature on each claim form to be submitted for myself and or dependents, and that I will be bound by this signature as though the undersigned had personally signed each claim. I hereby authorize my insurance carrier to pay and assign all medical and/or surgery benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Scott L. Beals, D.O. I authorize the release of any medical records for treatment, payment or healthcare operations.

INSURANCE COVERAGE IS NOT A GUARANTEE OF PAYMENT FOR ANY CLAIM, FURTHER I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED REGARDLESS OF INSURANCE COVERAGE. COPAYS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE.

RELEASE OF PATIENT INFORMATION

I acknowledge that records concerning the patient are the property of Dermatology Surgery Center and are maintained for the use and benefit of Dermatology Surgery Center and its staff in providing care and treatment to the patient. I hereby authorize Dermatology Surgery Center to disclose all or any part of my patient records to my admitting physician, consulting physician(s), hospital based physicians. I further authorize Dermatology Surgery Center and providing physicians to disclose all or any part of my patient record to any person or corporation which is or may be liable under contract to Dermatology Surgery Center or to me or a family member of mine, for all part of Dermatology Surgery Center's charges, including but not limited to, hospital or medical service companies, insurance companies, Worker's Compensation carriers, welfare agencies, or my employer, provided such release of information shall be in accordance with state and federal laws and regulations.

FINANCIAL AGREEMENT

For and in consideration of services rendered, each of the undersigned agrees to pay Dermatology Surgery Center for all charges not covered by insurance and any insurance administrative/ payment processing fees incurred by Dermatology Surgery Center as statements are rendered. Further, should it become necessary to enforce collection of any unpaid balance for medical services rendered, each of the undersigned agrees to pay all collection and legal expenses incurred by Dermatology Surgery Center including reasonable attorney's fees which shall include but not be limited to such fees incurred prior to institution of litigation, or in litigation, including trial and appellate reviews, and in arbitration, bankruptcy, or other administrative or judicial proceedings. Pursuant to Florida Statues 222.111, the undersigned patient and/or responsible party waives his or her exemption to have disposable earnings of the head of the family which are greater than $500 per week garnished.

PLEASE NOTE: PATIENTS WHO NO SHOW OR FAIL TO CANCEL THEIR SCHEDULED APPOINTMENT WITHIN 24 HOURS OF THEIR APPOINTMENT TIME WILL BE CHARGED A FEE OF $50.00 FOR EVALUATIONS OR A FEE OF $100 FOR SURGICAL PROCEDURES.

- **Cosmetic procedures must be paid two days prior to the procedure to avoid a $100.00 charge FOR NO-SHOW or FAIL TO CANCEL their scheduled appointments.**

ACKNOWLEDGEMENT OF HEALTH INFORMATION PRACTICES (HIPAA Privacy Guidelines)

The Dermatology Surgery Center Notice of Health Information provides information about how health information about patients may be used and disclosed. I have been offered an opportunity to review the Notice before signing this consent. I understand the terms of this Notice may change and that a copy of the revised Notice will be posted. By signing this form, I acknowledge that I have been offered and/or received the Dermatology Surgery Center Notice of Health Information Practices.

COMMUNICATION

I grant permission for Dermatology Surgery Center to communicate via phone, voicemail or email in regards to my health information, care, and appointments.

AUTHORIZATION FOR MEDICAL CARE AND TREATMENT

1. I recognize that a condition exists requiring medical care and I voluntarily consent to such medical care and treatment, diagnostic procedures by Dermatology Surgery Center and its medical and professional staffs, associates and agents and as deemed necessary.
2. I hereby authorize my physician, as provided by law to furnish medical treatment, diagnostic procedures, x-ray diagnosis or therapy as he considers necessary and proper in the treatment of the patient.
3. I am aware that the practice of medicine and surgery, and the administration of medical care, are not exact sciences and I acknowledge that no guarantees have been made to me as to the result of diagnostic procedures, treatments, examinations or care undertaken with Dermatology Surgery Center.

The contents of this form have been fully explained to me and I have been given the opportunity to ask questions. Any questions which I have asked have been answered to my satisfaction. I certify that I understand the contents of this form.

_____	_____	_____
Print Name	Signature	Date

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PATIENT CARE POLICIES

Medical Records

- ALL PATIENTS NOW HAVE FREE ACCESS TO THEIR RECORDS THROUGH OUR ONLINE PATIENT PORTAL. Ask the front desk if you have not received this information. Any records that you would like to have printed or faxed to another facility by our office will have an ADMINISTRATION FEE:
    - These fees are based on Florida law, Statutes 395.3025. Fees are:
        - $1.00 per page for the first 25 pages
        - $0.25 per page for each additional page.
- To comply with government regulated HIPPA Privacy Laws, we need you to SIGN A RECORDS RELEASE FORM. You can sign this form in the office or download it from our website. Please bring a signed copy by the office or send by fax or email.
- PLEASE ALLOW 2 WEEK FOR RECORDS TO BE PROCESSED. Medical providers review your records before we release them. Records will be reviewed on a first come first served basis outside of patient service hours.

Prescription Refills

- You must come to the office for an examination and evaluation by a Dermatology Surgery Center provider annually to receive a prescription refill.
- Please have your pharmacy send a fax to our office for your medication refills. Please allow 3 to 5 business days for all refill requests to be processed. Refill requests will be handled after patient service hours.

Call Back Policy

- Please allow 3 to 5 business days to receive a return phone call. If you would like to schedule a time to visit with the provider, please schedule an appointment so that we may address your concerns.

FINANCIAL POLICIES

Complete understanding of and cooperation with our practice financial policy is an essential element of your care and treatment. For your convenience we accept cash, check and major credit cards. Please remember, whether you have insurance or not, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please do not hesitate to ask or call our office. Our friendly staff is ready to help and provide any information.

No-Shows or Failure to Cancel

- We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel an appointment by you to avoid any cancellation fees.
- **PATIENTS WHO NO SHOW OR FAIL TO CANCEL THEIR SCHEDULED APPOINTMENT WITHIN 24 HOURS OF THEIR APPOINTMENT TIME WILL BE CHARGED A FEE OF $50.00 FOR EVALUATIONS OR A FEE OF $100 FOR SURGICAL PROCEDURES.**
- Cosmetic procedures must be paid two days prior to the procedure to avoid a $100.00 charge FOR NO-SHOW or FAIL TO CANCEL their scheduled appointments.

Insurance Policy

- Dermatology Surgery Center is a participating provider with most major insurance companies.
- Insurance coverage is verified prior to being seen at each appointment. It is your responsibility to provide us with the correct information to bill your insurance.
- Your insurance is a contract between you, your employer, and the insurance company. We are not a part of that contract. It is very important that you understand the provisions of your policy. We cannot guarantee your insurance company will pay all claims. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, their policy holder.
- If you are covered by one of our participating plans, your predetermined portion of charges set by your insurance plan (co-pay and/or co-insurance and deductible) will be collected at the time of service.
- If you are not covered by one of our participating plans, we will file your insurance claim for you as a courtesy. You will be expected to make payment in full at the time service is rendered.
- After we submit a claim for payment to your insurance company for services provided at your office visit, they will determine what charges they will and will not pay. Your company should send you an Explanation of Benefits form, explaining their payment and what you may still owe based on your policy agreement.
- Your insurance company will pay Dermatology Surgery Center their portion of your charges and notify us of any remaining balance that may be owed by you.
- Any balance owed by you will be charged to your account and you will receive a bill.
- If your insurance company denies our charges or does not pay us in a timely manner, we will charge that balance to your account.
- You may take advantage of our credit card policy and avoid having multiple bills mailed.
- If your account becomes delinquent, we reserve the right to refer your account to a collection agency and to be reported to the credit bureau.

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ACKNOWLEDGEMENT OF FINANCIAL AND PATIENT CARE POLICIES

SIGNATURE REQUIRED TO BE SEEN

I understand that insurance coverage IS NOT A GUARANTEE of payment for any services claimed by myself or Dermatology Surgery Center. Further I understand that I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES incurred, regardless of insurance coverage or payment of copays or deductibles due and collected at time of service.

By signing below, I acknowledge that I have read the Dermatology Surgery Center Financial and Patient Care Policies. I certify that I understand these Policies and will comply with them.

_____	_____	_____
Printed Name	**Signature**	**Date**

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CREDIT CARD POLICY

We have instituted a credit card payment policy due to the increasing cost of collections, declining reimbursements from insurance companies, and number of patients who owe for co-pays and deductibles. This policy is an advantage to both you, the environment, and our company -- checkout is faster and more efficient, you do not have to write or mail us checks, your balance owed is adjudicated in a timely manner, and we mail less statements and bills.

- When you check-in for your office visit, we will ask you for a credit card, which is held securely in your file. We will use this card to charge any outstanding balance or no-show/failure to cancel fees you owe.
- After your insurance has paid for your care and notified you and Dermatology Surgery Center of any balance owed by you, we will charge the remaining balance to your credit card on file and a receipt or copy of the charge will be mailed to you.
- If your insurance company denies our charges or does not pay us in a timely manner or if you have a balance from any unpaid charges, we will charge your credit card.
- If you have a balance from any unpaid charges, we will charge your credit card.
- This policy will not compromise your ability to dispute a charge or question your insurance company's determination of payment.

AUTHORIZATION

I authorize Dermatology Surgery Center to charge outstanding balances on my account or any no-show/failure to cancel fees to the following credit card:

Name on Card: _____ **Type: Visa Master Card**

Account Number: _____ **Expiration Date:** _____

Signature: _____ **Date:** _____