Patient Information Form

Please complete both sides of this form in ink and sign where indicated.

Date: ____/____/_______

Patient Name (last, first, middle initial):____

Date of Birth: ___/___/______ Social Sec. #:______________________________ Gender: Male / Female

Race: _________________Ethnicity: ____________________________ Language: ____________________ □ Decline

Mailing Address: Street ____

City________________________________ State____________________ Zip______________

Alternate Address: ____

Home Phone: (____)- ______________________________ Mobile Phone: (____)- ______________________________

Email Address: ____

(We will never give out your email address or send personal medical information via email without your permission)

Please check yes or no to authorize Riverchase Dermatology to contact you via email for appointment reminders, practice updates and informational promotions.

______ Yes ______ No

Primary Care Physician: ______________________________ Referring Physician: ______________________________

Marital Status (circle one): Single Married Divorced Widowed Separated

Parent, Spouse or Responsible Party (if different from patient)

Patient Name (last, first, middle initial):____

Date of Birth: ___/___/______ Social Sec. #:______________________________ Gender: Male / Female

Mailing Address: Street ____

City________________________________ State____________________ Zip______________

Alternate Address: ____

Home Phone: (____)- ______________________________ Mobile Phone: (____)- ______________________________

Email Address: ____

Insurance Coverage- Primary

Insurance Company Name: ____

Name of Policy Holder (Insured): ____ Date of Birth: ____________

Relationship to Insured: Self Spouse Child Other: ____

Employer: ________________________________ Employer Address: ________________________________

Insurance Coverage- Secondary (if applicable)

Insurance Company Name: ____

Name of Policy Holder (Insured): ____ Date of Birth: ____________

Relationship to Insured: Self Spouse Child Other: ____

Employer: ________________________________ Employer Address: ________________________________

RIVERCHASE
DERMATOLOGY

Patient Name: ____ Date: _____________ DOB: __________

Past Medical History: (Please circle all that apply)

Anxiety	Depression	Hyperthyroid
Arthritis	Diabetes	Leukemia
Asthma	End Stage Renal Disease	Lung Cancer
Atrial Fibrillation	GERD	Lymphoma
Bone Marrow Transplant	Hearing Loss	Prostate Cancer
BPH	Hepatitis	Radiation Treatment
Breast Cancer	Hypertension	Seizures
Colon Cancer	HIV/AIDS	Stroke
COPD	High Cholesterol	
Coronary Artery Disease	Hypothyroid	**NONE**

Other: ____

Past Surgical History: (Please circle all that apply)

Appendix Removed (Appendectomy)	Liver Transplant
Bladder Removal (Cystectomy)	Liver: Shunt
Mastectomy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Lumpectomy (Right, Left, Bilateral)	Ovaries Removed: Ovarian Cancer
Breast Biopsy (Right, Left, Bilateral)	Ovaries Removed: Cyst
Colon/ Colectomy: Colon Cancer Resection	Ovaries: Tubal Ligation
Colon/ Colectomy: Diverticulitis	Pancreas: Pancreatectomy
Colectomy: IBD	Prostate: Biopsy
Colectomy: Colostomy	Prostate: Cancer
Gallbladder Removed (Cholecystectomy)	Prostate: TURP (Prostate Removal)
Heart: Biological Valve Replacement	Rectum: APR
Heart CABG (Bypass)	Rectum: Low Anterior Resection
Heart: Transplant	Skin: Basal Cell Carcinoma
Heart: Mechanical Valve Replacement	Skin: Melanoma
Heart: PTCA (Angioplasty)	Skin: Skin Biopsy
Joint Replacement, Knee (Right, Left, Bilateral)	Skin: Squamous Cell Carcinoma
Joint Replacement, Hip (Right, Left, Bilateral)	Spleen
Kidney: Biopsy	Testicles Removed (Right, Left, Bilateral)
Kidney: Stone Removal	Uterus: (Hysterectomy) Fibroids
Kidney Transplant	Uterus: (Hysterectomy) Uterine Cancer
Kidney: Nephrectomy (Right, Left)	Uterus: (Hysterectomy) Cervical Cancer
Liver: Hepatectomy	**NONE**

Other: ____

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Skin Disease History: (please circle all that apply)

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

Other:

____

Do you wear sunscreen? Yes No
If yes, what SPF? ____________
Do you tan in a tanning salon? Yes No
Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? ____

Medications: (Please list all current medications & dosages)

____
____
____

Allergies: (Please enter all drug allergies)

____
____
____

Social History:

Cigarette Smoking:	**Alcohol Use:**
Never Smoked	None
Currently Smokes	Less than 1 drink per day
Has smoked in the past	1-2 drinks per day
Former Smoker	3 or more drinks per day

Family History: (Significant diseases & illness, skin or otherwise. Only first degree biological relatives- mother, father, brother, sister and children)

CONDITION	**RELATIVE**

RIVERCHASE
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Review of Systems: Are you currently experiencing any of the following? (Please check "YES" or "NO")

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Abdominal Pain			Muscle Weakness		
Anxiety			Neck Stiffness		
Bloody Stool			Night Sweats		
Bloody Urine			Problems with bleeding		
Blurred Vision			Problems with healing		
Chest Pain			Scarring (Hypertrophic/ Keloids)		
Depression			Seizures		
Fever or Chills			Shortness of breath		
Hay Fever			Thyroid Problems		
Headaches			Unintentional weight loss		
Immunosuppression			Wheezing		
Joint Aches			Other:		

Alerts: (please check all that apply)

□ Allergy to Adhesive
□ Blood Thinners
□ Defibrillator
□ Hepatitis B
□ Hepatitis C
□ History of Melanoma
□ HIV/ AIDS
□ Iodine Allergy
□ Lactating/ Breastfeeding
□ Latex Allergy
□ Lidocaine Allergy
□ Medication Allergy- PLEASE MAKE SURE ALL ALLERGIES ARE LISTED ON THE PREVIOUS SHEET
□ Pacemaker
□ Polysporin Allergy
□ Pregnant
□ Planning Pregnancy
□ Preoperative Antibiotics

Pharmacy:
Pharmacy Name: ______________________________
Location (crossroads): __________________________
Phone: _______________________________________
Fax: ____
City or Zip Code: ______________________________

Patient Name: ____

Patient DOB: ____

Provider: ____

Informed Consent – General Consent to Treat

INSTRUCTIONS

This consent provides our providers (physicians, nurse practitioners, and physician assistants) and staff, with your permission to perform reasonable and necessary medical examinations. By signing below, you are indicating that you consent to treatment that may include, but is not limited to:

- Examination
- Collection of medical information
- Photos of treatment areas for clinical documentation
- Communication with providers, pharmacies, laboratories, etc. involved in care
- Database import of pharmacy, laboratory, or other clinical information into the medical record
- Electronic communication using the patient portal, kiosk, and associated applications utilized in conjunction with the electronic health record (EHR)

Laboratory/Pathology Examinations

It is important to note that any biopsy or tissue specimen collected for diagnostic analysis must, by law, be analyzed by a laboratory, even if you wish to decline treatment based on the results of the pathology (please reference Title XXXII, Chapter 483 of the Florida Statute).

- I or my legal designee understand that my insurance company designates the laboratory and the pathologist where my biopsy is sent for diagnostic purposes.
- If I do not have insurance or have a high deductible I understand that I or my legal designee may be responsible for payment for these laboratory charges.
- If I or my legal designee have further questions regarding these charges, I understand that I must contact my insurance company regarding my coverage.
    - NOTE: Due to the wide variations in deductibles and coverage of health insurance policies, specimens may be subject to additional laboratory testing and/or consultation fees if deemed necessary to arrive at a diagnosis

GENERAL CONSENT FOR TREATMENT

- I or my legal designee have read and understand the information provided to me
- I or my legal designee had the opportunity to ask questions, and all my/our questions have been answered to my/our satisfaction.
- I or my legal designee have/has the right to consent to and to refuse procedures at any time during the treatment or visit
- I or my legal designee understand the risks of refusal of procedures, including the limitation of my provider to properly diagnose or treat my conditions and the risks associated with not following the plan of care ordered by my provider

- I or my legal designee agree to communicate with the provider via the kiosk, patient portal, or other associated applications with my EHR.
- I or my legal designee understand I have immediate access to my medical information using these applications and that I have the right to review, download and/or transmit my medical information from these applications to anyone I or my legal designee see fit.
- I or my legal designee accept full responsibility for my health care in case of a no show, cancellation, or failure to go to recommended referrals to other physician or health care providers.

You have the right to discuss the treatment plan with your provider including the purpose for the recommendation, the potential risks, and benefits of any test ordered for you, and any questions you have regarding these recommendations. If additional invasive testing, interventional procedures, or surgical procedures are recommended, informed consent for those tests or procedures will be required.

This consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

I certify that I have read and fully understand the above statements and consent to treatment by the providers and staff. I freely assume responsibility for financial costs not covered by my insurance company, and freely assume the responsibility for risks and outcomes that result from not following the plan of care ordered by the provider.

Patient Signature: ____ Date: __________________________

Witness Signature: ____ Date: __________________________

FINANCIAL POLICY

Understanding your financial responsibility is an essential component in establishing and maintaining a strong patient/practice relationship. In order to achieve this, we offer the following information regarding our insurance and financial policies.

Your insurance is a legal contract between your insurer and you. It is your responsibility to know and understand the terms, guidelines and limitations of your plan. It is also your responsibility to advise us of any changes in your insurance, your address or your employer. If current information is not obtained at the time of service, it will become the patient's responsibility to pay until current information is provided.

As a courtesy we will verify your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Although we are contracted with many insurance plans, our services may not be covered by your specific insurance plan. Your claim will process according to your policy based on the services provided. Please remember that you are fully responsible for all charges incurred - your physician's referral and our verification of your insurance benefits are not a guarantee of payment.

Medicare & Contracted Insurance Plans
If you are on traditional Medicare or are a member of a health plan that we participate with, we will submit your claim to your insurance company. Our staff will verify your benefits and collect any co- payment, co- insurance and/or deductible at the time services are rendered as required by your insurance carrier. You will be billed in full for any services that your health plan deems as "not a benefit" or a "non-covered service."

Secondary/Supplemental Insurance Plans
We are happy to file secondary and supplemental claims as a courtesy. In the case of non-contracted secondary carriers, the balance will become patient responsibility 30 days after that claim is filed.

Referrals
If your policy requires a referral from your Primary Care Physician to be seen in this office, the referral must be present at the time of visit. We will make every attempt to secure one on your behalf but ultimately the responsibility is yours. Without one, you may be required to reschedule your appointment. We welcome you to call your PCP and have your referral faxed to us.

Medicare Replacement Plans
We will file all PFFS (Private Fee for Service) plans that we are contracted with. Patients are responsible for all deductibles, coinsurances and co pays. For all other plans see contracted and non-contracted insurance plans above.

Medicaid
We are not contracted with most Medicaid plans. Medicaid patients with plans we are not participating with that are seeking services are responsible for payment in full at the time of service.

Card on File
For your convenience, we have implemented a policy which enables you to maintain your credit/debit card ("Card") information on file with us. If supplied and only with your consent, this information will be securely held to allow you the option to approve a payment without having to present your card again. Signing this Consent in no way requires you to place a card on file nor does it compromise your ability to dispute a charge. If opting to place a card on file you have the right to remove said card at any time either in writing or verbally in person or over the phone with a member of our team. Any card placed on file will be stored until requested to be removed or expires. No charges will be made without your initiation or request.

Minors
A parent or legal guardian must accompany all patients under the age of 18 to authorize treatment and financial arrangements. If this is a custodial parent, we can submit the charges to another parent's insurance, however, the parent presenting the child for care will be billed for the balance not covered by the insurance. Any patient over the age of 18 will be held financially responsible for all charges incurred.

Missed Appointments
Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations must be made 24 hours in advance of the scheduled appointment, or we reserve the right to assess a fee up to $100.

Medical Records
Copies of pathology reports are provided to you or another physician at no charge. Any additional medical records requests and/or completion of forms (e.g. disability, life insurance, cancer policies, etc.) are subject to processing fees determined by state law and contractual agreements. Please be advised that medical records requests require time to be processed and cannot be provided the same day requested.

Collection Fees
Statements are sent out monthly for patients with personal balances. Payment is due upon receipt of the statement. If you are unable to pay the balance in full, please contact our billing department at the phone number provided on your statement. Personal balances over 90 days from the date of service will be sent to our collection agency. In the event an account is turned over to an outside collection agency, patients will be responsible for any collection fees up to 35% as well as any court costs, attorney fees and collection agency charges.

Returned Check Fee
A $25 fee will be added to your account balance in addition to the amount of the check returned for insufficient funds.

Pathology Fees
Our practice has an on-site lab and pathologist who perform the slide preparation and interpretation of our patients' biopsy specimens. Fees associated with this service are separate from the procedure performed by your treating provider.

Depending upon specific factors, your provider may send the specimen to an outside lab for slide processing and interpretation. In those instances, patients or their insurance will receive a bill from the outside lab.

Our providers reserve the right to send their patients' specimens to the most qualified dermatopathologist of his or her choosing. Therefore, **if your insurance requires the use of a specific lab, it is your responsibility to provide us with that information prior to being seen. Failure to do so may result in additional out-of-pocket costs to you as assessed by your insurance plan.**

Cosmetic Services
Patients are financially responsible for all cosmetic procedures at the time of service including non-medically necessary and non-covered services. This office does not bill insurance companies for cosmetic procedures. For more detailed information, please see one of our cosmetic coordinators.

Consult Fee
We have the right to assess a consultation fee up to $100 for any non-medical visits. This credit may be transferred to any cosmetic procedure with the same provider in the following twelve months.

My signature below indicates that I have read, understand, and will comply with the information contained within this financial policy. A copy of this policy is available upon request.

Release of Information and Assignment of Benefits
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/Provider if applicable.

______________________________ ________________

Patient signature Date

HIPAA Authorization

I authorize the practice and its agents to disclose my protected health information among the practice, its agents and/or myself for the purpose of my care and treatment. I further authorize the practice to disclose my protected health information, including copies of applicable hospital and medical records and protected health information obtained prior to the date of this authorization to:

- Any third-party payer covering the medical services of the patient;
- Other health care professionals and institutions involved in the delivery of health care to the patient;
- The proponent of any legally sufficient subpoena, or in response to a court order;
- Employees, and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services;
- As otherwise required by law.

I further consent that photographs may be taken of me or parts of my body to be used for medical records. In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I also hereby authorize the disclosure of personal health information to persons that I choose to accompany me in the office while examined.

The practice may contact me to remind me of my appointment or collect money that I owe via telephone, text message or email at any number or email given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that such communication may come by autodialing devices and through pre- recorded messages, artificial voice messages or voicemail messages. I may opt out of these communications in writing at any time.

In granting this authorization, I understand that:

1. The term "protected health information" is individually identifiable information about the patient that includes the past, present or future healthcare of the individual and is transmitted and/or stored by a covered entity or business associate.
2. I have been given access to the Practice's Notice of Privacy Practice.
3. I have had the opportunity to place special restrictions upon the consent hereby given.
4. I have the right to revoke this authorization at any time in writing to 900 Village Square Crossing Ste 290, Palm Beach Gardens, FL., 33410
5. I may revoke this authorization except to the extent that information has already been disclosed based on this authorization.
6. Signing this authorization is voluntary. I agree that treatment may be denied if I do not authorize this release of protected health information.
7. I understand that the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I also hereby authorize the disclosure of personal health information in the following manners and to the following persons:

Initial if okay to leave a message on voicemail: _______________

E-Mail to the following address: ____

To the following individual:

1. Name: ________________________________ Relation to Patient: _______________
2. Name: ________________________________ Relation to Patient: _______________
3. Name: ________________________________ Relation to Patient: _______________

______ I do not want my personal health information disclosed to any other parties.

Special Restrictions: ____

This executed authorization will be stored in your medical record and will be available to you upon request. A copy of this authorization is as valid as the original.

This authorization does not have an expiration date and will remain in effect until updated or revoked in writing.

____ ________________

Patient signature Date

Effective Date: June 14, 2021

*Please request a copy of the full version of our Notice of Privacy Practices should you want to better understand how we manage your protected health information. You May Contact the Riverchase Chief Compliance Officer if you have additional questions or concerns regarding the privacy and security of your protected health information at compliance@riverchasederm.com or by phone 844-275-3458.

I have been provided and acknowledge receipt of the Notice of Privacy Practices.

Patient/Patient Representative Signature: ________________________Date:_____________