DERMATOLOGY
& SKIN CANCER CENTER
DERMATOLOGY ASSOCIATES OF NORTHWEST FLORIDA, P.A.
Amy Pote Watson, MD

REV 03-2017

Dr. Watson and staff welcome you to Dermatology Associates of Northwest Florida, PA. In preparation of your upcoming appointment, please:

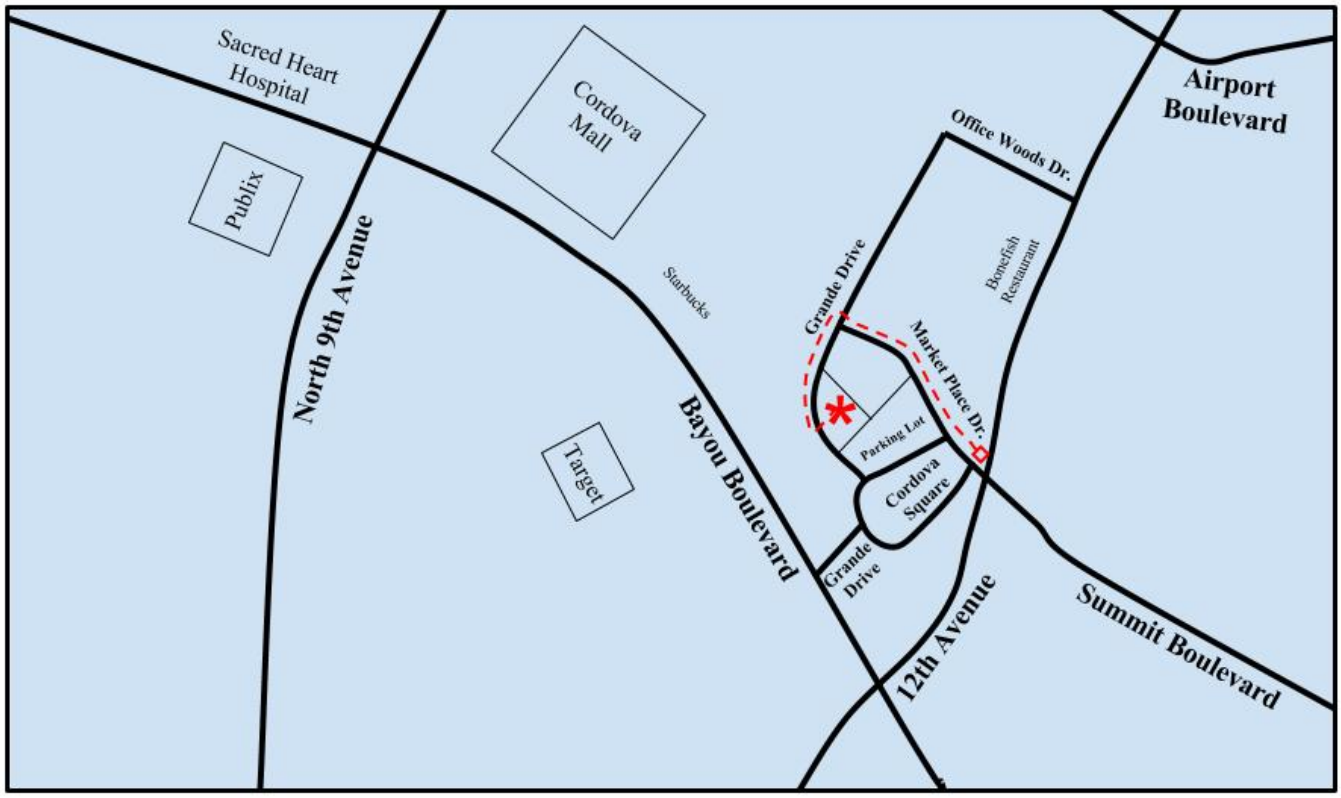
- complete, sign and bring attached Patient Registration, Patient Medical History and HIPPA Privacy Consent/Information forms to your appointment,
- bring your insurance card to your appointment and each subsequent appointment. Please notify a staff member if there is a change to your insurance or your contact information, and
- please arrive for your appointment at least 15 minutes early

FINANCIAL POLICY
All co-payments, deductible, out of pocket expenses and payments for non-covered services including cosmetic procedures are due in full at the time of service. For self-pay patients and patients with health insurance in which we do not contract, payment is due in full at the time of service. Insurance coverage is an agreement between you and your insurance provider. It is your ultimate responsibility to insure that payment is made in full for all services rendered to you by Dermatology Associates of Northwest Florida, PA. according to the practice's policies. If you anticipate not being able to make payment in full for surgical procedures at the time of service, please contact our billing office in advance to discuss possible alternative payment options.

CANCELLATION POLICY
To cancel an appointment, please notify our office at least (1) business day prior to your scheduled appointment. For cancellations not in accordance with this policy you may be charged $50 for a missed office visit, $100 for a missed surgery/procedure or 50% of the anticipated fee for cosmetic procedures.

DIRECTIONS
Our address is **4850 Grande Drive**, Pensacola, Florida 32504.

- Starting @ 12th Avenue and Summit/Market Place intersection, travel towards Grande Drive on Market Place
- Market Place Drive will quickly dead end into Grande Drive
- Left on Grande Drive and our office will be located on the left just as Grande begins to curve



Dermatology Associates of Northwest Florida, PA
Amy Watson, MD
(850) 477-4447

PATIENT REGISTRATION

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PATIENT INFORMATION

Patient First name _____ MI_____Last Name_____

Home street_____City_____State_____Zip_____

Mobile phone_____Home phone_____Work phone_____

Sex M or F Social Security_____Birthdate____/____/____Age_____

Email_____Marital status S M W D or SEP .

Preferred language_____Ethnicity HISPANIC or NON HISPANIC Race_____

Referred by_____Emergency contact_____Emergency contact phone_____

Employer_____How do you prefer to be contacted for appointment reminders? TEXT or EMAIL

PRIMARY INSURANCE ☐ SELF or ☐ OTHER

Insurance company_____ **Policy number**_____ **Group #**_____

IF OTHER, Insured's First name _____ MI_____Last Name_____

Your relationship to insured SELF SPOUSE PARENT or OTHER Insured's birthdate ____/____/____.

Insured's Home street_____City_____State_____Zip_____

Insured's Mobile phone_____Home phone_____Work phone_____

Insured's sex M or F Insured's Social Security_____

SECONDARY INSURANCE ☐ SELF or ☐ OTHER

Insurance company_____ **Policy number**_____ **Group #**_____

IF OTHER, Insured's First name _____ MI_____Last Name_____

Your relationship to insured SELF SPOUSE PARENT or OTHER Insured's birthdate ____/____/____.

Insured's Home street_____City_____State_____Zip_____

Insured's Mobile phone_____Home phone_____Work phone_____

Insured's sex M or F Insured's Social Security_____

OTHER INSURANCE Is there a third insurance company? Y or N .

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM: I acknowledge that I have been given an opportunity to review Dermatology Associates of Northwest Florida, PA's **NOTICE OF PRIVACY PRACTICES** and have been provided a copy if requested.

AUTHORIZATION FOR MEDICAL TREATMENT: I hereby authorize all providers at Dermatology Associates of Northwest Florida, PA, to treat my medical condition as deemed necessary. This authorization includes general medical care, anesthetics, medical or surgical diagnosis and treatment.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize direct payment of medical/surgical benefits to Dermatology Associates of Northwest Florida, PA or its providers for services rendered. I understand that I am financially responsible for any balance not covered by my insurance company.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Dermatology Associates of Northwest Florida, PA or its providers to release any medical information that may be necessary for either medical care or in processing application for insurance benefits.

PAYMENT POLICY: All co-payments, deductibles and out of pocket expenses are due at the time of service. In the event that the patient must be billed, payment is to be received by the office within 30 days from the date of service. I understand that I am financially responsible for any balance not covered by my insurance company.

NOTE: ALL PATHOLOGY SPECIMENS ARE SENT TO DERMPATH DIAGNOSTICS (a division of Ameripath & Quest Diagnostics)

_____ _____

PATIENT SIGNATURE (parent or guardian if patient is a minor) DATE

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PATIENT MEDICAL HISTORY

Date_____

Patient First Name _____ MI_____Last Name_____

Reason for visit_____

Pharmacy name & location_____

Primary care physician_____

CURRENT MEDICATIONS

1._____ 5. _____
2._____ 6. _____
3._____ 7. _____
4._____ 8. _____

MEDICATION ALLERGIES

1._____
2._____
3._____
4._____

PERSONAL & FAMILY HISTORY

skin cancer (basal cell, squamous cell or melanoma)	☐self	☐mother	☐father	☐brother	☐sister
acne	☐self	☐mother	☐father	☐brother	☐sister
anxiety disorder	☐self	☐mother	☐father	☐brother	☐sister
arthritis condition	☐self	☐mother	☐father	☐brother	☐sister
asthma	☐self	☐mother	☐father	☐brother	☐sister
bleeding tendencies	☐self	☐mother	☐father	☐brother	☐sister
bronchitis	☐self	☐mother	☐father	☐brother	☐sister
cancer	☐self	☐mother	☐father	☐brother	☐sister
congestive heart failure	☐self	☐mother	☐father	☐brother	☐sister
depression	☐self	☐mother	☐father	☐brother	☐sister
diabetes	☐self	☐mother	☐father	☐brother	☐sister
emphysema	☐self	☐mother	☐father	☐brother	☐sister
eczema	☐self	☐mother	☐father	☐brother	☐sister
heart condition	☐self	☐mother	☐father	☐brother	☐sister
hepatitis	☐self	☐mother	☐father	☐brother	☐sister
high blood pressure	☐self	☐mother	☐father	☐brother	☐sister
high cholesterol	☐self	☐mother	☐father	☐brother	☐sister
HIV/AIDS	☐self	☐mother	☐father	☐brother	☐sister
hyperthyroidism	☐self	☐mother	☐father	☐brother	☐sister
hypothyroidism	☐self	☐mother	☐father	☐brother	☐sister
keloids	☐self	☐mother	☐father	☐brother	☐sister
kidney problems	☐self	☐mother	☐father	☐brother	☐sister
mitral valve prolapsed	☐self	☐mother	☐father	☐brother	☐sister
psoriasis	☐self	☐mother	☐father	☐brother	☐sister
seizure disorder	☐self	☐mother	☐father	☐brother	☐sister

other: _____

PERSONAL INFORMATION

Do you currently use tobacco? ☐ yes ☐ no
Have you ever used tobacco? ☐ yes ☐ no
Do you use alcohol? ☐ yes ☐ no
if yes, how many drinks per week_____
Do you have a pacemaker and or defibrillator? ☐ yes ☐ no
Do you have an artificial heart valve? ☐ yes ☐ no
Do you have an artificial joint(s)? ☐ yes ☐ no

FEMALES ONLY

Are you pregnant or considering pregnancy? ☐ yes ☐ no
Are you currently breastfeeding? ☐ yes ☐ no

SKIN INFORMATION

Choose a statement that best describes your skin:

- ☐ sunburns and freckles easily, unable to tan
- ☐ sunburns at first, tans slightly
- ☐ sunburns occasionally, but tans readily
- ☐ never sunburns, tans readily

Do you use sunscreen? ☐ yes ☐ no
if yes, ☐daily, ☐before outdoor activity, ☐summer only or ☐occasionally
if yes, what is the usual SPF used?_____
Have you ever had blistering sunburns? ☐ yes ☐ no
How would you rate the amount of time you spend outdoors:

- ☐ high
- ☐ moderate
- ☐ low

What is your occupation?_____

List any major surgeries/procedures you have had:_____

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HIPAA PRIVACY CONSENT/INFORMATION FORM

WHAT IS THE NOTICE OF PRIVACY PRACTICES?
The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

THE FOLLOWING USE AND DISCLOSURES OF PHI WILL ONLY BE MADE PURSUANT TO US RECEIVING A WRITTEN AUTHORIZATION FROM YOU:

- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations
- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to obtain a paper copy of this notice from us upon request.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI. It is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We post a copy and you may request a written copy of the Notice of Privacy Practice from our office.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

Do you give our office permission to discuss your medical information with family members? _____YES _____NO If yes, please provide:

NAME: _____ RELATIONSHIP: _____

DAYTIME PHONE: _____ EVENING PHONE: _____

May we leave personal medical information on your answering machine/voicemail? _____YES _____NO

If yes, please provide the phone number where we can leave information _____

This Consent was signed by:

_____
Print name of Patient or Legal Representative Date
(parent or guardian if patient is a minor)

_____
Signature of patient or representative of patient Date
(parent or guardian if patient is a minor)

_____
Practice Witness Date