Associated Dermatologists

John C. Long Jr, MD
Phone (386) 672-3111
Fax (386) 672-6532
155 North Nova Road
Ormond Beach, FL 32174

Patient Information:

First, MI, Last Name: _____ S.S. # _____ Home Phone: _____
Address: _____ Apt: _____ Cell Phone: _____
City: _____ State: _____ Zip Code: _____ Country: _____
Date of Birth: _____ Age: _____ Birth Sex: _____ Email Address: _____
Employer: _____ Work Phone#: _____
Occupation: _____ How did you hear about our office? _____
Marital Status: _____ Spouse's Name: _____ Spouse Contact #: _____

Guarantor Information:

_____: Same as Patient First, MI, Last Name: _____ S.S. # _____
Address: _____ Apt: _____
City: _____ State: _____ Zip Code: _____

Insurance Information:

Primary Insurance:
Ins Company Name: _____ ID#: _____ Group #: _____
Ins Contact # _____ Deductible/ Copay _____ Name of Subscriber _____
Patient Relation _____ Subscriber's SS# _____ Subscriber's D.O.B. _____
Subscriber's Birth Sex ____ Subscribers Tel # _____

Secondary Insurance:
Ins Company Name: _____ ID#: _____ Group #: _____
Ins Contact # _____ Deductible/ Copay _____ Name of Subscriber _____
Patient Relation _____ Subscriber's SS# _____ Subscriber's D.O.B. _____
Subscriber's Birth Sex ____ Subscribers Tel # _____

Medical History:

Current and Previous Medical Conditions: _____

_____

Medications and Dosage: _____

_____

Allergies to Medications and Reactions: _____

_____

Please Read: Your signature below authorizes the doctor to release to your insurance company, or its representatives, such as medical information necessary to process your insurance claim(s), if any. **Your signature consents to the release of any information contained in the medical records which may include to infection with Human Immunodeficiency Virus (HIV), AIDS, or related condition, alcohol or drug dependence history or treatment, or any psychiatric or psychological records.** It also requests and authorizes your insurance company to make payments directly to the doctor for any and all services performed. **Payment for "your part" of the charges are expected at time of service**.

_____ _____

Signature of Patient Signature of Responsible Party (if other than Patient)

Date _____

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Confidential New Patient Questionnaire
Associated Dermatologists P.A.

*Please complete entire form and sign

Date: _____

What are you seeing the doctor for today? _____

How long has this been bothering you? _____

What have you tried for this problem(s)? _____

Did anything help? □ Yes □ No If yes, what? _____

Do you currently have, or have you recently had:

Fevers	□yes □no	Swallowing difficulty	□yes □no
Weight loss or gain	□yes □no	Vomiting/heartburn	□yes □no
Fatigue	□yes □no	Urinary frequency	□yes □no
Hair or nail changes	□yes □no	Urinary pain or blood	□yes □no
Loss of vision	□yes □no	Genital lesions	□yes □no
Distorted vision	□yes □no	Breast masses	□yes □no
Eye pain or soreness	□yes □no	Vaginal bleeding or discharge	□yes □no
Hearing difficulty	□yes □no	Joint pains or swelling	□yes □no
Dizziness	□yes □no	Muscle pain	□yes □no
Sinus congestion	□yes □no	Headaches	□yes □no
Runny nose	□yes □no	Weakness or paralysis	□yes □no
Nosebleeds	□yes □no	Fainting or blackouts	□yes □no
Mouth dryness	□yes □no	Slurred speech	□yes □no
Chest pains	□yes □no	Anxiety	□yes □no
Palpitations	□yes □no	Depression	□yes □no
Cough	□yes □no	Easy bruising	□yes □no
Shortness of breath	□yes □no	Blood transfusions	□yes □no
Wheezing	□yes □no	Swollen lymph nodes	□yes □no
Excessive thirst	□yes □no	Temperature intolerance	□yes □no

Do you have or have you ever had any of the following conditions:

High blood pressure	□yes □no	Diabetes	□yes □no
Heart disease	□yes □no	Thyroid problems	□yes □no
Anemia	□yes □no	Glaucoma	□yes □no
Blood clots	□yes □no	Excess hair growth	□yes □no
Lung disease	□yes □no	Keloids	□yes □no
Ulcers	□yes □no	HIV	□yes □no
Hepatitis	□yes □no	Kidney disease	□yes □no
Liver problems	□yes □no	Stroke	□yes □no
Cancer	**□yes □no Type(s):** _____		
Do you live alone?	□yes □no	Are you pregnant/planning?	□yes □no
Do you smoke?	□yes □no	Do you drink alcohol?	□yes □no

Personal or family history of melanoma? □Yes □No

Have you had 3 or more blistering sunburns before you were 20 years old? □Yes □No

Did you have 3 or more outdoor summer jobs as a teen? □Yes □No

Patient signature _____

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REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name: _____ Date: _____
Other family members that are patient's _____
Referred by: _____ **Primary Care Physician**: _____
PCP: Contact # _____ PCP Location _____
Emergency Contact _____ Relation to Patient_____ Contact # _____

RELEASE OF INFORMATION:

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.

Patient or Responsible Party Signature _____Date_____

PAYMENT POLICY:

***Medicare:* We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% copayment. We do file with secondary/ supplemental carriers. However, in the event that the secondary does not pay within 30 days, patients will be balance billed.**

Note: If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers.

HMO. PPO or other managed care patients: You will be responsible for paying your annual deductible, copayment and charges for any non-covered, cosmetic services.

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 20%of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient or Responsible Party Signature _____**Date**_____

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

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

Signature as it appears on Medicare Card _____ **Date** _____

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:
I *request authorized MED/GAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical* information to *release* to *the above MED/GAP carrier any information needed to determine these benefits* or *the benefits payable for* related services.

Signature as It appears on Medigap Card _____**Date**_____

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Due to new Governmental regulations, we are required to keep the following information in your medical records on each of your visits. All of the information and choices below are written exactly as mandated by the Government.

Do you have an Advance Care Plan or surrogate decision maker? □ Yes □ No (65 years and Older)

This is someone who you wish to make decisions for you if you were to become incapacitated.

Name of Surrogate/ Decision maker: _____

Relationship to Patient: _____

Tobacco Use: Screening and Cessation Intervention: (12 years and up)

Are you a Current Tobacco user? □ Yes □ No **Former Tobacco user?** □ Yes □ No

If YES do you have plans to quit? □ Yes □ No

Provided Patient with Verbal Counseling Tips to quit Smoking and printed Intervention

Document □ Yes Staff Initials _____

Screening for Future Fall Risk: (65 years and older)

Have you had 1 or more falls in the last year? □ Yes □ No

If yes. Did any result in injury? □ Yes □ No Is your PCP aware of the fall(s)? □ Yes □ No

Primary care provider _____

Have you ever been referred to Physical Therapy for Balance and Strength training? □ Yes □ No

Provided Patient with verbal and printed counseling, Tips to prevent Future falls Document

□ Yes Staff Initials _____

Patient Name:_____ **Date:**_____

Patient Signature: _____

(To be filled in by staff member) **Patient MRN #:**_____

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IMPORTANT INFORMATION REGARDING INSURANCE BILLING

Dr. Long is here to provide you with the best medical care. His primary concern is your health and well-being, not your insurance company. Therefore, it is the patient's responsibility to be aware of what their policy covers.

It is very important for you to read your insurance policy very carefully. As we participate with numerous insurance companies, and each company has many different plans, we cannot possibly be aware of each patient's particular coverage. You will receive a bill if the service is one that is not covered under your policy. It is very important that you are familiar with the benefits and policies of your insurance plan including medications that are covered.

I have read the above and understand that I am responsible for knowing the coverage and benefits of my insurance policy.

_____ _____

Patient's Signature Date

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ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the attached Privacy Notice.

Patient or Personal Representative Signature _____ Date _____

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____

USE OF PROTECTED HEALTH INFORMATION FOR APPOINTMENT REMINDERS

☐ I authorize Associated Dermatologists to remind me of upcoming appointments by calling my home phone number. This consent includes leaving a message if necessary.
(Initial here) _____

☐ I **do not** wish to be reminded of my upcoming appointments. I understand that if I fail to give 2 days' notice of a cancellation I will be charged a $25 fee for a missed appointment.
(Initial here) _____

No medical information will be released. These calls are just to verify appointment day and time

I understand that, as set forth in the facility's Privacy Notice, I have the right to revoke this authorization, in writing, at any time by sending written notification to:

Associated Dermatologists

John C. Long, Jr. MD
155 N. Nova Road
Ormond Beach, FL 32174
ATTN: Privacy Officer

Associated Dermatologists

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AUTHORIZATION TO DISCUSS HEALTHCARE INFORMATION

I, _____ Date of Birth: _____, give permission to Associated Dermatologists to disclose and discuss my protected health information described below to:

Name(s):	Relationship:
_____	_____
_____	_____
_____	_____

HEALTH INFORMATION TO BE DISCLOSED (Check all that apply):

- ☐ My complete health record (including but not limited to both medical and cosmetic: diagnoses, lab tests, prognosis, treatment, scheduling and billing, for all conditions)
  OR
- ☐ My complete health records, as above, with the exception of the following information: (please specify):

  _____
  _____
  _____
  _____
  _____
  _____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event: _____
  unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying Associated Dermatologists, preferably in writing.)

_____
Name of the Individual Giving this Authorization

_____ _____
Signature of the Individual Giving this Authorization Date

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AUTHORIZATION & CONSENT FORM FOR A MINOR

PATIENT NAME: _____ DATE OF BIRTH: _____

I, the parent/legal guardian, authorize the health care professionals of Associated Dermatologists to provide medical care to my son/daughter; including, but not limited to, diagnostic examination (including radiological and laboratory testing), and necessary medical treatment (including minor surgical/cosmetic procedures).

By signing this form, I am agreeing to the following below:

_____ INITIALS

All minors seeking medical treatment must be accompanied by a parent/legal guardian during the initial visit. This helps the parent/legal guardian have a comprehensive understanding of your child's care and treatment options. After the initial appointment, a minor may be seen for treatment without a parent/guardian present if child has a written authorization from the parent/guardian.

_____ INITIALS

Please note that at the providers request that should your child be recommended an invasive procedure, such as a surgical excision, biopsy or laser treatments, a parent/legal guardian must be present at that appointment or give same day verbal consent.

_____ INITIALS

I, the parent/legal guardian understand that this consent will be valid indefinitely unless revoked by the parent/legal guardian in writing. I, the parent/legal guardian further understand that, once the minor patient reaches 18 years of age, my consent for treatment is no longer required.

Please provide the medication (prescription or non-prescription) the above named minor is currently taking?

_____

_____

_____

_____

Please describe any medical condition(s) the medical provider should be aware of before treatment?

_____

_____

_____

_____

This authority shall begin on date signed below:

SIGNATURE: _____ DATE: _____

PRINT PARENT/ LEGAL GUARDIAN NAME: _____

PRIMARY PHONE NUMBER: _____ RELATIONSHIP TO MINOR: _____

SECONDARY PHONE NUMBER: _____

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Authorization for minor to be treated without Parental/ Guardian Supervision

I _____, authorize my child _____

Date of birth _____/_____/_____ to be treated at Associated Dermatologists without my

Parental/Guardian supervision.

_____ _____

Parent/ Guardian Name Date

_____

Parent/ Guardian Signature

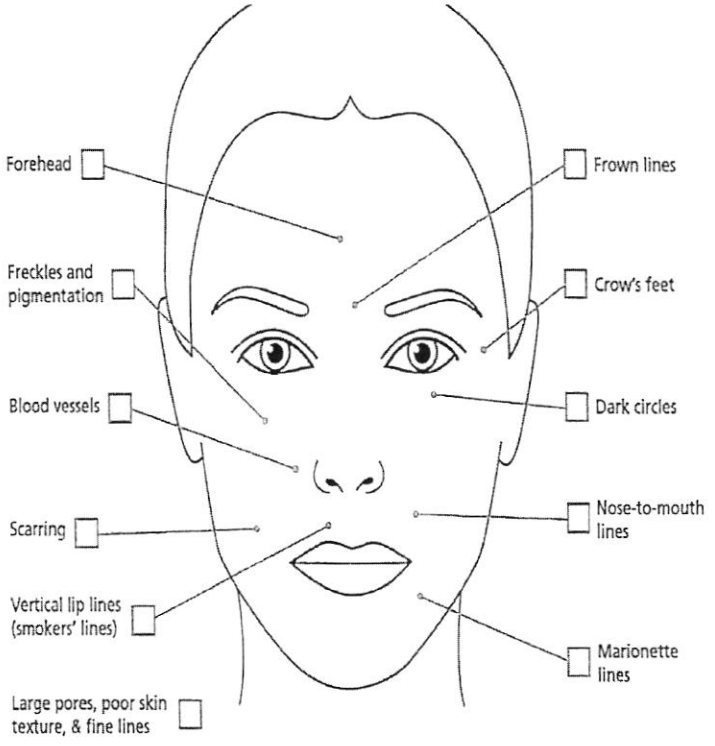
Associated Dermatologists

Cosmetic Questionnaire

I would like Dr. Long to make Cosmetic treatment recommendation to address my areas concern.

YES OR NO

Please identify all areas of personal concern:



What are your cosmetic concerns? (Please Circle all that apply)

Sun Spots/Age Spots *Fine Lines/Wrinkles* *Breakouts* *Skin Care*

Skin Texture *Discoloration* *Spider Veins* *Scarring* *Redness/Blotchy*

Eyelash Length/Fullness *Facial Sagging* *Double Chin/Jowls* *Thin Lips*

I am interested in a skincare routine and products appropriate for my age. YES NO

I would like to be contacted by the esthetician to schedule a complimentary skin care consultation? YES NO

Name_____ Phone Number: _____

Email_____