SKIN WELLNESS PHYSICIANS

PATIENT REGISTRATION

Name _____Today's Date_____
Last First M.I.

Date of Birth ____/____/_____ Age _____

Mailing Address _____
City State Zip code

Seasonal Address _____
City State Zip code

Home Phone (_____) _____ Cell Phone (_____) _____ Ok to leave detailed voicemail? Y N

E-Mail _____SS # _____ Gender _____

Marital Status_____ Spouse's Name: _____ Phone # _____

Employer _____ Work # _____

Race: _____ Ethnicity: _____ Primary Language: _____

Person to notify in case of emergency _____ Phone _____

Primary care provider: _____ Referring provider: _____

If patient is a minor, please enter responsible party information. (Note: We do not bill absent parents, the adult presenting the minor for care is the responsible party.)

Name _____ Relationship: _____
Last First M.I.

Date of Birth ____/____/_____ SS# _____ Email: _____

Address _____
Street City State Zip

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

****

Policy Holder (if different from patient or responsible party) _____
Policy Holder's Date of Birth _____/_____/_____SS# _____
Employer of Policy Holder _____ Work Phone (_____) _____
Patient's Relationship to Policy Holder _____

****

How did you hear about our practice?

- ☐ Referred by a Provider
- ☐ Google
- ☐ Facebook
- ☐ Instagram
- ☐ Naples Daily News
- ☐ Magazine:_____
- ☐ Friends or Family
- ☐ Insurance
- ☐ SkinCeuticals
- ☐ Other: _____

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Assignment of Benefits

I hereby assign and authorize my insurance carrier including Medicare, other government sponsored insurances of which I may be covered and/or all commercial payors to make payments on behalf directly to Skin Wellness Physicians. I also assign any Medigap benefits to be paid directly to my provider. I permit a copy of this authorization to be used in place of the original.

_____ _____

Responsible Party Signature Date

Medicare Authorization

I request that payment for authorized Medicare benefits be made on my behalf to Skin Wellness Physicians (SWP) for any services furnished to me by providers of SWP. I authorize SWP to release to the CMS and its agents any information needed to determine these benefits payable for related services.

Medicare is not always the Primary Insurance. Federal regulations REQUIRE that we obtain information to determine if another insurer may be primary to Medicare;

Yes	No	
☐	☐	Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at the job?
☐	☐	Are you covered by an HMO/PPO which makes Medicare secondary?
☐	☐	Is this illness/injury covered by the VA (Veterans Administration)?
☐	☐	Is this illness/injury covered by the Federal Black Lung or End Stage Renal Disease Program?
☐	☐	Is this illness/injury due to an automobile accident?
☐	☐	Is this illness/injury due to work related causes?

_____ _____

Signature as it appears on Medicare Card Date

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FINANCIAL & DISCLOSURE POLICY

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

Your insurance is a 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.

Insurance coverage will normally cover payment for some of the healthcare services we provide. Most insurance plans have co-pays, deductibles, or co-insurances that are paid by the patient.

For the plans that Skin Wellness Physicians participates with, we will honor the amount allowed by your insurance company. We will file your claim with them for reimbursement of the charges associated with the services we provided, and we will write off the amount we have agreed to discount. If your plan has a copay/deductible/co-insurance, we are required by the agreement, to collect it at the time of service. We cannot pre-determine what your insurance carrier will/will not define as necessary care. We believe that should be determined by your physician. If, for whatever reason, the company does not pay for the services, please understand you will be responsible for the unpaid balance. You will receive a detailed statement including your insurance companies' response. Due to the delay in receiving payment for the services, and the cost of communicating with them and you, we would appreciate your timely response to any balance remaining. For your convenience, we accept all major credit cards.

For patients that are presently without insurance coverage, we want you to know that both your physical and financial interests are considered as we treat your illness, however, we are primarily dedicated to treating that illness as effectively as we can. For us to remain efficient and viable, we ask that you pay for treatment at the time of service. Unfortunately, it is impossible to determine what the cost of the care will be prior to the date of service. We will do our best to inform you of what to expect along the way, but please understand that we do not have control over the cost of many of the elements involved in that care. We are contracted with an outside collection agency to help collect outstanding, past due balances. If you have a returned check, you will be charged a $25.00 billing fee. If your account is sent to collections, you will be charged an additional 15% of the original delinquent amount.

Medicare & Contracted Insurance Plans
If you are on traditional Medicare or are a member of a health plan we participate with, we will submit your claim to your insurance company. Our staff will verify your benefits and collect any co- payment, coinsurance and/or deductible, or any non-covered services at the time services are rendered.

Secondary/Supplemental Insurance Plans
We will file your secondary claims as a courtesy. If your secondary insurance has not paid us within 30 days, the balance will become your responsibility.

Non-Contracted Insurance Plans
If we do not participate with your insurance carrier, we will give you a form to attach to your claim for direct filing with your insurance carrier. Payment in full is required at the time of service.

Out of Network Insurance

I understand it is my responsibility to determine if Skin Wellness Physicians is an in-network provider with my insurance plan.

I understand that if Skin Wellness Physicians is an *out-of-network provider* with my insurance plan and if I have out-of-network benefits under the terms of my benefit plan, I may have higher out-of-pocket costs (such as higher copay, coinsurance or deductible) for utilizing a non-participating provider.

I also understand that if I do not have out-of-network benefits under the terms of my benefit plan I may be responsible for the entire cost of the services.

Medicaid
We are not contracted with any Medicaid plan. Medicaid patients seeking services are responsible for payment in full at the time of service.

Minors
A parent or legal guardian must accompany all patients under the age of 18 to authorize treatment and financial arrangements. We can submit the charges to an absent parent's insurance only with a signed permission. The parent presenting the child for care is responsible for payment at the time of service. Any patient over the age of 18 will be financially responsible for all charges incurred.

Cosmetic Services
Patients are financially responsible for all cosmetic procedures at the time of service. This office does not bill insurance companies for cosmetic procedures.

Cancellations & No-Show 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. Office appointments, cosmetic and/or Procedure/Surgery appointments which are cancelled with less than one business day notice, may be subject to a **$50.00** cancellation fee.

Patients who do not show up for an appointment without a call to cancel will be considered a **NO SHOW**. Patients who No-Show two (2) or more times in a 6-month period, may be dismissed from the practice thus they will be denied any future appointments. Patients may also be subject to **a $50.00 No Show fee.** The Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that special unavoidable circumstances may cause you to cancel within 24 hours. If you reschedule within 24 hours, fees in this instance may be put towards your service or waived but only with management approval.

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Medical Records
Medical records requests and/or completion of documents (e.g. disability, life insurance, cancer policy, etc.) are subject to fees determined by state law and contractual agreements. Medical records requests require time to be processed and cannot be provided the same day requested.

Collection Fees
If your account becomes delinquent and you have not established or met payment options with our billing office, your account will be turned over to a collection agency. If you have a credit of $25.00 or less once your insurance claim has been processed, you will be notified, and it will remain on your account unless a refund is requested. Refunds are only given in the form of a check and will be mailed out upon request. We are contracted with an outside collection agency to help collect outstanding, past due balances. If your account is sent to collections for non-payment, you will be responsible for an additional 15% of the account balance.

Returned Check Fee
A $25.00 fee will be added to your account balance in addition to the amount of the check which has been returned for insufficient funds. This total must be paid by cash or credit card within 7 days.

Referred Patients
Patients have the right to choose the practitioner for their initial examination or consultation as per the requirements outlined within Florida Statute 459.025. Patients must be informed of the type of license held by the practitioner that they were referred to and/or any other practitioner who may provide services. Providing a signature below indicates these requirements have been met and you have authorized the practitioner you are scheduled with to proceed with the initial examination or consultation as required by the referral.

Pathology Fees
Depending upon specific factors, your provider may send a specimen to an outside lab for slide processing and interpretation. In those cases, patients or their insurance company will receive a bill from an outside lab. If the initial review of your biopsy indicates that further, more in-depth testing will be required to reach the correct diagnosis, additional charges may be billed to you or your insurance company

Benign Lesions
Patients are financially responsible for the removal or treatment of all benign skin lesions unless they have met certain clinical criteria, including, but not limited to change in quality or character, increase in size, pain, or bleeding. Billing insurance for such circumstances may represent fraud.

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

_____ _____

(Signature of Patient or Guardian) **(Date)**

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Patient Communication Consent Form

Email and/or Text Message Account Alerts

Skin Wellness Physicians has the advantage of communicating appointment reminders via email/text message with our patients.

- ☐ **I authorize** Skin Wellness Physicians to send ☐**email** ☐**text** message appointment reminders to me on my provided cell phone number. I understand that I may reply with various commands to receive account information. By accepting these terms, I agree to receive text messages from the practice. Text charges from your cell phone provider may apply.
- ☐ **I do not authorize** Skin Wellness Physicians to send ☐**email** ☐**text** message appointment reminders to me on my provided cell phone number

My signature below indicates that I represent and warrant that I am the person legally responsible for use of the account, and that I agree to the terms and conditions for the use of the text and email messaging services. I understand that I may opt out of text and email message communication at any time.

_____ _____

Signature of Patient (or Legal Representative) Date

Monthly Skin Wellness Newsletter

Skin Wellness Physicians keeps their patients informed through our monthly newsletter. The newsletter contains our monthly promotions, give aways, events, and much much more!

- ☐ **I authorize** Skin Wellness Physicians to send their monthly newsletter to my provided email address.
- ☐ **I do not authorize** Skin Wellness Physicians to send their monthly newsletter to my provided email address.

My signature below indicates that I represent and warrant that I am the person legally responsible for use of the account, and that I agree to the terms and conditions for the use of the text and email messaging services. I understand that I may opt out of text and email message communication at any time.

_____ _____

Signature of Patient (or Legal Representative) Date

SKIN WELLNESS
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Acknowledgement of Receipt of Notice of Privacy Practices

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice.

_____ _____

Signature of Patient (or Legal Representative) Date

Release of PHI
HIPAA 1 226 Authorization to Release Protected Health Information to Friends or Family Members

Please complete this form only if you wish to give us permission to speak directly with a friend or family member about your appointments, care plan, or any other protected health information related matter.
I hereby authorize medical providers and personnel Skin Wellness Physicians to discuss my protected health information with:

_____ _____

(Printed Name) (Phone #, with area code) (Relationship)

_____ _____

(Printed Name) (Phone #, with area code) (Relationship)

This authorization shall remain in effect for all past, present, and future periods unless revoked, preferably in writing, at any time by notifying your doctor or his/her staff. I understand I have the right to revoke this authorization, in writing, at any time.

- ☐ I understand information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- ☐ I understand I have the right to refuse to sign this authorization.

_____

Printed Name of Patient/Personal Representative

_____Date: _____

Signature of Patient/Personal Representative

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AUTHORIZATION TO RELEASE/OBTAIN HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

❖ For the purpose of patient care, I hereby request and authorize Skin Wellness Physicians to release my medical records to:

Name of organization or individual: _____

❖ I request/authorize _____ to release the healthcare information of the patient named above to:
(name of organization or individual)

Skin Wellness Physicians

1300 Goodlette-Frank Road N. | Naples, Florida 34102

8625 Collier Blvd. | Naples, Florida 34114

531 Bald Eagle Drive | Marco Island, Florida 34145

Telephone: (239) 732-0044 | Fax: (239) 732-0094

This Request/Release applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

_____

☐ All healthcare information

☐ Other: _____

Non – expiring release _____ This release expires _____ from date of signature

I understand that my authorization will remain effective as indicated above and that the information will be handled confidentially in compliance with all applicable federal laws.

I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication. I have read and understand the nature of this release.

Patient/Representative signature: _____ Date: _____

Relationship to Patient: _____

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Reason(s) for visit:

_____

_____

Referred By:

_____

Primary Care Doctor:

_____

PAST MEDICAL HISTORY:

Please CIRCLE if you have/had any of the following or check

Anxiety
Arthritis
Asthma
Atrial Fibrillation
BPH
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
HIV/AIDS
High Blood Pressure
High Cholesterol
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Thyroid Problems:
Hypo ☐ Hyper ☐
NONE OF THE ABOVE

Other:_____

_____

PAST SURGICAL HISTORY:

Please CIRCLE all that apply or check

Appendix removed
Bladder removed
Mastectomy: Right ☐ Left ☐ Both ☐
Lumpectomy: Right ☐ Left ☐ Both ☐
Breast Biopsy: Right ☐ Left ☐ Both ☐
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Mechanical Valve Replacement
Hysterectomy: Fibroids ☐ Uterine Cancer ☐
Organ Transplant: _____
What Organ_____
NONE OF THE ABOVE

Joint Replacement:
Knee: Right ☐ Left ☐ Both ☐
Hip: Right ☐ Left ☐ Both ☐
Shoulder: Right ☐ Left ☐ Both ☐
Kidney Biopsy: Right ☐ Left ☐ Both ☐
Ovaries Removed: Endometriosis ☐ Cyst ☐ Ovarian Cancer ☐
Prostate Removed
Gallbladder Removed
Spleen Removed
Coronary Artery Bypass
Biological Valve Replacement

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SKIN DISEASE HISTORY: Please CIRCLE all that apply or check

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

Other:

_____

Do you wear Sunscreen? Yes No If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

FAMILY HISTORY OF SKIN DISEASE: (Please indicate which Family Member)

Melanoma: _____
Psoriasis: _____
Skin Cancer: _____
Eczema: _____
Keloids: _____
Other: _____

Other:

_____

_____

Do you have a cosmetic or antiaging concern (i.e. fine lines, loss of volume, texture)? ☐Y ☐N
Have you had a cosmetic or antiaging treatment in the past? (i.e. Botox, fillers, laser rejuvenation) ☐Y ☐N
Have you noticed a loss of vaginal lubrication, tone, and/or laxity? ☐Y ☐N

Name of Person Completing this form:

Patient Name (Printed) Relationship to patient Date

Signature

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REVIEW OF SYSTEMS: (Please CIRCLE if you have experienced any of the following in the **past 30 days**)

Itch
Irregular menses
Problems with bleeding
Problems with healing
Problems with scarring (hypertrophic/keloid)
Rash
Unintentional Weight Loss
Hay Fever
Joint Aches
Muscle Weakness
Wheezing
Night Sweats
Anxiety
Chest Pain
Fever or Chills
Thyroid Problems
NONE OF THE ABOVE

Sore Throat
Blurry Vision
Abdominal Pain
Neck Stiffness
Headaches
Shortness of Breath
Depression
Cough

OTHER: (Please CIRCLE all that apply)

Allergy to adhesive
Allergy to lidocaine
Allergy to topical antibiotic ointments
Allergy to betadine
History of Leukemia
History of Lymphoma
Currently taking prednisone
HIV/AIDS
Allergy to latex
Artificial heart valve
Artificial joints
Blood thinners
Defibrillator
Rapid heartbeat with epinephrine
Premedication prior to procedures
History of poorly differentiated Squamous Cell Carcinoma

Pregnancy or planning a pregnancy
Immunosuppression
Pain during intercourse
Urinary Incontinence
History of melanoma
Vaginal Dryness
Hepatitis
History of organ transplant
Referred from another dermatologist
History of Merkel Cell Carcinoma
History of MRSA
NONE OF THE ABOVE

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MEDICATIONS: (Please enter current medications; both prescribed and over the counter)

No Medications: ☐ **Medication List Attached:** ☐

No Changes Since Last Visit: ☐

Name:	Dose:	Frequency:

MEDICATION ALLERGIES: (Please enter all medication allergies)

No known Drug Allergies: ☐

Name:	Type of Reaction:

Pharmacy: _____ Phone:_____

Patient Signature Date

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Patient Name (Printed)

*****NOTICE*****
We are now required to have you answer the questions below.
Failure to complete this information will result in a delay of your appointment.
We apologize for any redundancies.

1. Alcohol Use (patients 18 years and older):
   - ☐ None
   - ☐ 1 drink or less per day
   - ☐ 1-2 drinks per day
   - ☐ 3 or more drinks per day

   How many times in the past year have you had 5 (for men) or 4 (for women) or more drinks in a day? _____

2. Check the one that best fits (patients 12 years and older)
   - ☐ Never Smoked
   - ☐ Ex-smoker
   - ☐ Current Smoker (cigarettes, cigars or pipes)

3. Over the past 2 weeks, how often have you been bothered by any of the following problems.
   (0 = Not at all, 1 = Several Days, 2 = More than half the days, 3 = Nearly every day) (PHQ-2)

   (Patients 12 years and older)

	Circle the one that best fits.			
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

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4. Please answer the following (patients 18 years and older) Screening **# 8472**

Have you been tested for Hepatitis C? □ Yes or □ No

If no, would you like an order for the test sent to your lab or primary care physician? □ Yes or □ No

Do you have a history of Hepatitis C? □ Yes or □ No
Were you born between 1945 – 1965? □ Yes or □ No
Do you have a history of blood transfusions prior to 1992? □ Yes or □ No
Are you receiving maintenance hemodialysis? □ Yes or □ No
Do you have a history of injection drug use? (recreational or prescribed) □ Yes or □ No
Are you a current intravenous drug user? (recreational or prescribed) □ Yes or □ No

Patient Name (Printed) Relationship to patient Date

Signature