WELCOME TO OUR PRACTICE

We are delighted you chose us for your dermatology care. To help ensure the highest quality of service and care for you, we have incorporated several office policies and procedures. We ask that, if you have any questions or concerns with these policies and procedures, you address them with one of the members of our staff prior to your office visit.

We require that you always bring the following to each of your office visit:

- **Insurance Card(s)**
- **Identity Verification**
- **Co-payment** for insurance patients and **Means of Full Payment** for self-pay patients
- **Prior Authorization** (If your insurance requires it)
- **Parent or Guardian** (if the patient is less than 18 years old)

If you do not bring the following items with you, Advanced Dermatology & Skin Surgery Specialists, PA (dba Yag-Howard Dermatology Center) may request that you reschedule your appointment.

Insurance Cards: All patients utilizing their insurance coverage are required to bring current insurance card(s) to each office visit. Insurance card(s) will be scanned into the patient's electronic medical record. If the patient does not have his or her insurance card, the patient may be rescheduled or given the option to make other payment arrangements.

Identity Verification: For legal, safety and insurance purposes, identification is necessary. A copy of your identity verification (example: drivers license, social security card, passport) will be scanned and kept in your electronic medical record. Also, we may request you show a copy of your identity at any subsequent visit to the office.

Copayments and Deductibles: As contractors with insurance carriers and Medicare, we are required by law to collect copayments and deductibles from all contracted patients at the time service is provided. It is the patient's responsibility to bring cash, check or credit card at the time of the visit in order to meet this legal and contracted obligation.

Self-Pay Patients: Patients without insurance or Medicare coverage are required to pay-in-full for services rendered at the time of service. The front desk staff will not be able to quote exact prices. Prices are determined by the provider based on the recommended course of treatment.

Prior Authorization: If your insurance company requires that you have authorization for any service or treatment we perform, it is your obligation to obtain said authorization. Our office staff will assist you with providing the information you need in order to obtain said authorization (i.e., correct ICD and CPT codes) from your insurance or Medicare carrier.

Legal Guardians: All minor patients (under 18 years-old) are required to be accompanied by a parent or authorized guardian. By law, this office is required to have consent from a parent or legal guardian prior to providing treatment. If a minor comes to the office unattended by a parent/guardian or unaccompanied by an authorizing note from the parent/guardian, he or she will be asked to reschedule said appointment.

Late Patients: You are asked to arrive on time for your appointment(s). Please arrive a few minutes early to check in and fill out any required paperwork. If you are more than 10 minutes late for your appointment, you may be asked to reschedule. Note: Your provider will determine if there is sufficient time to see you without causing you or patients scheduled after your blocked time that have arrived on time an extended wait.

Cancellations/No Shows: You are given a call prior to your appointment. If you are unable to keep said appointment, we ask that you kindly give 24 hours notice to avoid a cancellation or no show charge of $35.00. Notification fewer than 24 hours prior to an appointment does not allow our office enough time to ensure that another patient can be scheduled.

OTHER PERTINENT INFORMATION

Cosmetic Procedures: All cosmetic procedures require payment at the time of service. In addition, we have some cosmetic procedures that may require you to pay in advance. We have allotted a specific amount of time for you and would appreciate as much advanced notice of cancellation as possible to avoid a potential cancellation fee. All patients undergoing cosmetic procedures are required to sign a consent based on our specific policies prior to treatment.

Scheduling: Certain procedures in our office require special, advanced planning and/or scheduling with a certain provider. Therefore, we may not be able to schedule the cosmetic procedure you are requesting at your preferred time and may need to call you back. Please be assured we will get back to you within 24-48 hours to schedule your appointment or provide you with an update.

Prescription Refills: Please provide our office with your pharmacy information and we ask that you contact your pharmacy when a refill is needed. Your pharmacy will then forward a refill request to our office. Your provider will then approve or deny the refill request. Whenever possible, the prescription will be refilled electronically. If you have not been seen in our office for more than 12 months or if your prescription requires certain monitoring and/or testing to be done, your prescription refill request will be denied until you are seen by one of our providers in the office.

Copying of Medical Record(s): We are happy to provide copies of your medical record(s) to you, your other physicians or healthcare providers and your insurance company upon request. However, we do need you to complete a signed release to send said medical record(s). All other requests for medical records will be charged the current copying rates established by the State of Florida.

Please share with us how your heard about our office:____

Whom May We Thank For Your Referral: ____

Comments: We strive to provide exceptional medical care in a clean, friendly, caring, professional and comfortable environment. If we do not meet your needs or expectations, please let one of our staff members know. We are here to serve you and sincerely hope that you are pleased with the care that we provide. Your satisfaction is important to us.

Print Name: ____ **Date:** ______/_______/______

Signature: ____

HISTORY & INTAKE FORM

TODAY'S DATE: ______________________________________

LOCAL PRIMARY CARE PHYSICIAN: ______________________________________

PHONE: ______________________________ **FAX:** ______________________________

PRIMARY CARE PHYSICIAN IN OTHER RESIDENCE: ______________________________

PHONE: ______________________________ **FAX:** ______________________________

DERMATOLOGIST IN OTHER RESIDENCE: ______________________________

PHONE: ______________________________ **FAX:** ______________________________

LOCAL PHARMACY: ______________________________ **LOCATION:** ______________________________

PHONE: ______________________________ **FAX:** ______________________________

PHARMACY IN OTHER RESIDENCE: ______________________ **ADDRESS:** ______________________________

PHONE: ______________________________ **FAX:** ______________________________

PAST MEDICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

ANXIETY	COLON CANCER	HEARING LOSS	LEUKEMIA
ARTHRITIS	COPD	HEPATITIS (TYPE ___)	LUNG CANCER
ASTHMA	CORONARY ARTERY DISEASE	HYPERTENSION	LYMPHOMA
ATRIAL FIBRILLATION	DEPRESSION	HIV / AIDS	PROSTATE CANCER
ENLARGED PROSTATE (BPH)	DIABETES	HIGH CHOLESTEROL	RADIATION TREATMENT
BONE MARROW TRANSPLANT	RENAL DISEASE	HYPERTHYROIDISM	SEIZURES
BREAST CANCER	REFLUX (GERD)	HYPOTHYROIDISM	STROKE
OTHER:			

☐ ***PLEASE CHECK HERE IF NONE OF THE MEDICAL CONDITIONS LISTED ABOVE ARE APPLICABLE***

Patient Name: ______________________________

PAST SURGICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

APPENDECTOMY	COLON RESECTION ___ CANCER ___ DIVERTICULITIS	KNEE REPLACEMENT LEFT RIGHT BOTH	PROSTATE CANCER
BLADDER REMOVAL/ CYSTECTOMY		HIP REPLACEMENT LEFT RIGHT BOTH	PROSTATE BIOPSY
MASTECTOMY LEFT RIGHT BOTH	HEART BYPASS	KNEE REPLACEMENT LEFT RIGHT BOTH	PROSTATE REMOVAL
LUMPECTOMY LEFT RIGHT BOTH	ANGIOPLASTY (PTCA)	KIDNEY BIOPSY	SKIN CARCINOMA BASAL CELL
BREAST BIOPSY	HEART VALVE REPLACEMENT (MECHANICAL)	KIDNEY REMOVAL (NEPHRECTOMY)	SKIN CARCINOMA SQUAMOUS CELL
BREAST REDUCTION	HEART VALVE REPLACEMENT (BIOLOGICAL)	KIDNEY STONE REMOVAL	SKIN: MELANOMA LOCATION: ____________ WHEN: ________________
OVARIAN CYST	HEART TRANSPLANT	KIDNEY TRANSPLANT	SKIN BIOPSY
UTERINE FIBROIDS	ENDOMETRIOSIS	GALL BLADDER REMOVAL	SPLEEN REMOVAL
HYSTERECTOMY	**Joint Replacement Date(s):**		
Other:			

☐ ***PLEASE CHECK HERE IF NONE OF THE MEDICAL CONDITIONS LISTED ABOVE ARE APPLICABLE***

SKIN DISEASE HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

ACNE	SCALP CONDITIONS ___ DRY ___ FLAKING ___ ITCHING
ACTINIC KERATOSIS (PRE-CANCERS, AK'S)	MELANOMA
ASTHMA	POISON IVY
ALLERGIES/ HAY FEVER	PRECANCEROUS MOLES
BASAL CELL CARCINOMA	PSORIASIS
BLISTERING SUNBURNS	SQUAMOUS CELL CARCINOMA
DRY SKIN	GENITAL HERPES
ECZEMA	COLD SORES
GENITAL WARTS	**Other:** ____ ____
SHINGLES	

☐ ***PLEASE CHECK HERE IF NONE OF THE MEDICAL CONDITIONS LISTED ABOVE ARE APPLICABLE***

Do you wear Sunscreen? ☐ YES ☐ NO If yes, what SPF: _________

Do you Tan in a Tanning Salon? ☐ YES ☐ NO

Patient Name: ___________________________________

MELANOMA HISTORY:

LOCATION	DATE OF BIOPSY	WHO BIOPSIED LESION	DATE OF EXCISION	WHO EXCISED LESION	DEPTH OF MELANOMA	METASTASIS YES OR NO
Other:						

MEDICATIONS / VITAMINS / SUPPLEMENTS:

ALLERGIES:

SOCIAL HISTORY: (PLEASE check each of the following inquiries)

	YES	NO
Wear Sunglasses		
Drink More than 2 Alcoholic Beverages Daily		
Drink Caffeine?		
Currently Smoke Cigarettes		
Smoked Cigarettes in the Past		
If yes then, Start Date: Quit Date:		
Smoke Cigars/Pipes		
Smoked Cigars/ Pipes in the Past		
Chew Tobacco		
Chewed Tobacco in the Past		
Smoke Marijuana		
Use Illicit Drugs		

	YES	NO
Sexually Active?		
• Multiple Partners?		
Practice Safe Sex		
Do you have driving restrictions?		
Feel Safe at Home?		
Do You Exercise?		
If yes, frequency		
Please List All States of Residences:		

Patient Name: ______________________________________

FAMILY HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

DISEASE	**RELATIONSHIP TO YOU (Mother, Father, Brother, Sister, etc.)**
MELANOMA	
NON-MELANOMA SKIN CANCER	
PANCREATIC CANCER	
BREAST CANCER	
ECZEMA	
ALLEGIES/ HAY FEVER	
ASTHMA	
OTHER:	

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose “protected health information” or “PHI” about you. The Notice contains a Patients’ Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information (PHI), about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The Practice reserves the right to change the Notices of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this consent.

This consent was signed by:

Printed Name (Patient or Representative) ________________________________ Relation to Patient ____________________

Signature (Patient or Representative) __________________________________

Witness:
Printed Name Practice Representative __________________________________ Signature ___________________________

Patient Name: ______________________________________

INFORMATION SHARING

I give Advanced Dermatology & Skin Surgery Specialists, PA (dba Yag-Howard Dermatology Center) my permission to discuss biopsy results, lab testing or any other protected health information with the following individual(s):

NAME	RELATIONSHIP TO PATIENT

In the interest of encouraging comprehensive medical care, I give Advanced Dermatology & Skin Specialists, PA (dba Yag-Howard Dermatology Center) permission to engage in the following activities:

ACTIVITY	YES	NO
Leave a message at my preferred contact # concerning biopsy results, lab testing or any other protected health information.		
Leave a message at my place of employment to have me return a call to this office.		
Share my protected health information with other health care providers, laboratories, pathology offices and related medical service providers as necessary.		
Share my protected health information with insurance companies.		

In the interest of medical science and the advancement of medical education, Dr. Yag-Howard serves as a member of the faculty of the University of South Florida, College of Medicine. Additionally, she gives educational lectures nationwide and publishes educational and research articles in international, peer reviewed, and scientific journals. The primary focus of her educational expertise is on teaching advanced and innovative surgical techniques, ways to achieve the most cosmetically- pleasing surgical outcomes, and methods to optimize wound care. In order to continue serving as an educator, lecturer and author, she relies on the use of clinical photographs to document surgical techniques and outcomes. Under no circumstances are patients identifiable in the photographs, as no name is associated with photographs, no name is used in verbal or printed communications, and identifying features, such as eyes, are blocked out of the photographs.

ACTIVITY	YES	NO
This consent authorizes Dr. Cyndi Yag-Howard and staff to take and/or use photographs of me strictly for medical education, science or research purposes. I understand that under no circumstances, will any publications bear my name.		

I understand that I may change or rescind this authorization at any time.

Signature _________________________________ Witness By ______________________________

Printed Name _________________________________ Date ______________________________

Patient Name: ____________________________________

OFFICE FINANCIAL POLICY

BASIC POLICY - Payment for services is due in full at the time service is provided in our office.

PATIENTS WITH INSURANCE - We will bill most insurance carriers for you if proper paperwork and documentation is provided to us. We will also bill most secondary insurance companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for the services you received. If an insurance carrier has not paid within 60 days of billing, our professional fees are due and payable in full from you.

MEDICARE PATIENTS - We will bill Medicare for you. We will also bill secondary insurances for you. All copayments or deductibles are due and payable at the time our service is provided.

SURGERY FEES - All copayments and deductibles are due at the time our service is provided. Prior authorization may be required by your carrier.

NON-COVERED SERVICE - Any care not paid for by your existing insurance coverage will require payment in full at the time our service is provided.

FULL BODY EXAM - Periodic preventative health checks may or may not be covered under your health insurance policy; however, they may be recommended by your physician.

MISSED APPOINTMENTS - In fairness to other patients and our providers, we respectfully request a 24-hour in advance notice be given to cancel your appointment. Failure to cancel may result in you being charged for a missed appointment.

ASSIGNMENT OF INSURANCE BENEFITS - Patients with insurance, please read and sign below. “I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Advance Dermatology & Skin Surgery Specialists, PA (dba Yag-Howard Dermatology Center). This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.”

I have read, understood and agreed to the above financial policy for payment of professional fees. The patient is ultimately responsible for all professional fees.

Patient Signature: ____ **Date:** ____________________

Patient Name: ___________________________________

PATIENT INFORMATION

Race: ☐ White/American Indian/Alaska Native /Asian ☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander ☐ Other Race ☐ Declined to Specify

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown ☐ Declined to Specify

Preferred Language: ____

Gender: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Email ____

Last Name: ______________________________ **First Name:** _________________________ **MI**: _____

Birth Date: _______/_______/_______ **Social Security:** __________-______-__________

Primary Address: ____

City: ________________________ State: ______ Zip: ______________

Seasonal Address: ____

City: ________________________ State: ______ Zip: ______________

Local Numbers: **Please mark ☐ for preferred contact #**

☐ Home:_______________________ ☐ Work:_______________________ ☐ Mobile:_______________________

Seasonal Numbers:

☐ Home:_______________________ ☐ Work:_______________________ ☐ Mobile:_______________________

ATTN SEASONAL PATIENTS PLEASE READ: Please indicate which time of year you prefer we contact you either by mail or phone, at either your primary or seasonal address above.

Seasonal: ____________thru____________ **Local:** ____________thru____________

Employer: ______________________________________**Occupation:** ______________________________________

Referring Doctor/Provider/Acquaintance: ____

Name of Spouse/Significant Other: ____

Emergency Contact Name/Relation: ____________________________/_____________________________________

Emergency Contact's Phone Number: ____

INSURANCE INFORMATION

Primary Policy Holder Name: ___________________________________**Primary Ins:** __________________________

Policy #: ___________________________________ **Group#:** ________________________

Secondary Policy Holder Name: _______________________________**Secondary Ins:** _________________________

Policy #: ___________________________________ **Group#:** ________________________

*******ONLY COMPLETE THE NEXT SECTION BELOW IF PATIENT IS NOT INSURANCE POLICY HOLDER*******

Policy Holder Name: ____

Birth Date: _____/_____/_____ **Social Security:** ______-_____-______

Address (If different than patient):____

City: _________________________ **State:** ____________ **Zip Code:** ________________