HIPAA
Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient 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 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 Notice 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.

Acknowledgement of Notice of Privacy Practices

My signature below verifies that I, _____, have received
(Print Name)
a copy of the Notice of Privacy Practices from Romagosa Dermatology Group, LLC

Signature of Recipient _____ Date: _____/_____/_____

Protected Health Information Authorization

My signature below indicates that I □ **DO** / □ **DO NOT** (please check one) authorize Romagosa Dermatology Group, LLC to discuss my PHI with my spouse or personal representative.

If yes, please provide their name and phone number.
Name: _____ Phone #: _____-_____-_____
Relationship : _____

Signature of Patient _____ Date: _____/_____/_____

Medicare Patient Registration

Name: _____ □Jr □Sr □Dr
First Middle Last

SS#: _____-_____-_____ DOB: _____/_____/_____ Sex: □ M □ F

Primary Language: _____ Race: _____ □ Hispanic □ Non-Hispanic □ Decline

E-Mail address: _____
Is it okay to email you about upcoming cosmetic promotions and events (your e-mail will not be shared with any outside parties)? **Yes** or **No**

Primary address: _____

_____
City State Zip Code

Home #: (_____) _____ Work #: (_____) _____ Cell #: (_____) _____

Secondary address: _____

_____
City State Zip Code

Home #: (_____) _____

Answer questions below by placing a check in the appropriate column:

Yes	**No**	
□	□	Have you recently joined a Medicare HMO? If yes, identify: _____
□	□	Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?
□	□	Are you covered by a HMO/PPO which makes Medicare secondary?
□	□	Is this illness covered by the VA (Veteran's Administration)?
□	□	Is this illness covered by the Federal Black Lung or End Stage Renal Disease Program?
□	□	Is this illness due to an automobile accident?
□	□	Is this illness due to an injury at work?
□	□	Are you receiving Medicaid?

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% co-payment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.**

- CONTINUED ON BACK -

Payment Policy

Medicare Health Insurance Claim Number as it appears on your card (This is usually your social security number. Be sure to include the letter after the nine digit number. It is important that we have both number and letter).

_____

Please sign so we may have your Medicare Authorization on File: I authorize any holder of medical or other information about me to be released to the Social Security Administration, Health Care Financing Administration or its intermediaries or carrier of 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 or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Date: _____/_____/_____ Signature: _____

Are you in a Medicare HMO or other Senior Medicare Plan? □ Yes □ No

Name of Plan: _____
Policy #: _____ Group #: _____
Name Policy Holder (Insured): _____ Sex: □ Male □ Female
DOB: _____/_____/_____

Supplemental (MEDIGAP) Insurance (This includes ALL SECONDARY insurances)

In the event of a major procedure or hospitalization, we request secondary insurance information for our records (supplemental Medicare insurance information). Please fill out below if you are covered by a plan which covers the 20% NOT covered by Medicare (MEDIGAP Coverage).

Name of Insurance Company: _____
Policy #: _____ Group #: _____
Name Policy Holder (Insured): _____ Sex: □ Male □ Female
DOB: _____/_____/_____

Please Sign So We May Have Your Supplemental Authorization On File:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Date: _____/_____/_____ Signature: _____

Please present your MEDICARE AND SECONDARY INSURANCE CARD(S) and a photo ID to the receptionist along with this completed form. Thank you.

Romagosa Dermatology Group, LLC
Medical History and Intake Form

Patient Name: _____**Date of Birth:**_____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Thyroid Problems
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
NONE

Other :_____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

NONE

Other:_____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
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

Other:_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Romagosa Dermatology Group, LLC
Medical History and Intake Form

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 enter all current medications)
_____
_____
_____

Allergies: (Please enter all allergies)
_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:

EtOH- None
EtOH- less than 1 drink per day
EtOH -1-2 drinks per day
EtOH -3 or more drinks per day

Other:_____

Family History (Only first degree relatives)
_____
_____
_____
_____

Preferred Language: _____

Race:_____ Ethnic Group:_____

Preferred pharmacy Name: _____ Pharmacy Phone#: _____

Pharmacy City or Zip code:_____

ALERTS: (please circle all that apply)

Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heartbeat with epinephrine
Pregnant or currently trying to get pregnant?

PLEASE COMPLETE BOTH SIDES OF THIS FORM

To Our Patients:

As you know if you have ever checked into a hotel or rental car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share. At the time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This will not compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays due at the time of the visit will, of course, still be due at the time of the visit.

If you have any questions about this payment method, do not hesitate to ask.

Sincerely yours,

Romagosa Dermatology Group, LLC

I authorize Romagosa Dermatology Group, LLC to charge outstanding balances on my account to the following credit card:

Visa MasterCard American Express Discover Other: _____

Account number: _____ Expiration Date: _____

Name on card (please print):_____

Signature: _____ Date: _____

optional