727 US Hwy 27 South
Sebring, FL 33870
(863) 385-7183

400 Avenue K SE Ste. 3
Winter Haven, FL 33880
(863) 293-7546

Patient Information

Date_____ Soc.Sec. #_____Birthdate_____

Name_____
Last Name First Name Middle Initial

Home Phone_____Cell Phone_____

Mailing Address_____City, State, Zip_____

2nd Address_____City, State, Zip_____

Employer_____Work Phone_____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated

Preferred Language:_____ Race:_____ Ethnic Group: Hispanic ☐ Y ☐ N

Pharmacy Information (This will be the pharmacy where all of your prescriptions will be sent)

Pharmacy Name_____

Location_____Phone Number_____

Insurance Information (Please Give Insurance Cards and Photo ID to Receptionist to Copy)

Insured Name_____ Relationship to patient_____

Insured Birthdate_____ Insured SS #_____

Insured Employed By_____ Work Phone_____

Primary Insurance Name

Insurance Provider Billing Address_____

Policy #_____ Group #_____

Secondary Insurance Name

Insurance Provider Billing Address_____

Policy #_____ Group #_____

Referral Information, Patient Financial Policy and Signature On File

Other family members that are patients _____

Primary Care Physician _____Phone _____

In Case of Emergency (Contact Person) _____ Phone _____

How Did You Hear About Us? (Circle one)

Doctor / Family / Friend / Internet / Webpage / Facebook / Twitter / Magazine / Other _____

Do You Give Our Office Permission To Discuss Your Medical Information With Any One Else?

☐ YES ☐ NO If yes, please provide their names and phone numbers below.

#1 Name_____ Phone _____

#2 Name_____ Phone _____

#3 Name_____ Phone _____

#4 Name_____ Phone _____

May we leave personal medical information on your answering machine or cell phone? ☐ YES ☐ NO

May we e-mail personal medical information to you? ☐ YES ☐ NO

E-mail address (Please Print Legibly)

_____

Receipt Of Notice Of Privacy Practices

My signature below indicates that I have received and/or reviewed a copy of Lakeside Dermatology's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

Patient or Responsible Party Signature _____ Date _____

Payment Policy

Self-Pay Patients- I understand that I am required to pay 100% of the total bill at the time of service.

Insured Patients- I understand that I will be responsible for paying my deductible, co-payment, co-insurance, and charges for any non-covered and/or cosmetic services.

Laboratory Services-I understand that if I have a skin biopsy and/or any other laboratory services performed, it will be sent to an outside laboratory to be tested and I may receive a bill from the laboratory. (For example: Ameripath, Quest, LabCorp, etc.)

Patient or Responsible Party Signature _____ Date _____

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Patient Name _____ Date_____

Past Medical History (Please circle all that apply)

Anxiety	Coronary Artery Disease	HIV/AIDS	Seizures
Arthritis	Depression	High Cholesterol	Stroke
Asthma	Diabetes Type _____	Thyroid Problems	**NONE**
Atrial Fibrillation	End Stage Renal Disease	Leukemia	Other_____
Bone Marrow Transplant	GERD	Lung Cancer	_____
Breast Cancer	Hearing Loss	Lymphoma	_____
Colon Cancer	Hepatitis A B or C	Prostate Cancer	_____
COPD	High Blood Pressure	Radiation Treatment	_____

Past Surgical History (Please circle all that apply)

Appendix	Joint Replacement, Hip (Rt, Lt, Both)	Ovaries Removed: Ovarian Cancer
Bladder Removed	Joint Replacement, Knee (Rt, Lt, Both)	Prostate Biopsy
Breast Biopsy (Right, Left, or Both)	Joint Replacement, Shoulder (Rt, Lt, Both)	Prostate Removed: Prostate Cancer
Breast Implants	Joint Replacement was within last 2 years	Prostate Removed: TURP
Breast Reduction	Kidney Biopsy (Nephrectomy)	Spleen Removed
Colectomy: Colon Cancer Resection	Kidney Removed (Right or Left)	Testicles Removed (Right, Left, or Both)
Colectomy: Diverticulitis	Kidney Stone Removal	Valve Replacement : Biological
Colectomy: IBD	Kidney Transplant	Valve Replacement: Mechanical
Coronary Artery Bypass	Lumpectomy (Right, Left, or Bilateral)	Transplant: Heart
Gallbladder Removed	Mastectomy (Right, Left, or Both)	**NONE**
Hysterectomy: Fibroids	Ovaries Removed: Cyst	Other_____
Hysterectomy: Uterine Cancer	Ovaries Removed: Endometriosis	_____

Skin Disease History (Please circle all that apply)

Acne	Dry Skin	Poison Ivy	Squamous Cell Skin Cancer (SCC)
Actinic Keratoses (AK)	Eczema	Precancerous Moles	**NONE**
Basal Cell Skin Cancer (BCC)	Flaking of Itchy Scalp	Psoriasis	Other_____
Blistering Sun Burns	Melanoma	Psoriasis	_____

Medications: (Please list all current prescription and/or OTC medications)

Name (Ex: Aspirin)	**Strength** (Ex: 81mg)	**Dose** (Ex: 1 tablet)	**Frequency** (Ex: at night)

Allergies (Please list all allergies)

_____

_____

_____

Social History (Please circle all that apply)

Smoking Use	**Alcohol Use**	**Drugs Use**
Currently Smokes (How many packs per day? _____)	None	Currently Use _____
Former Smoker (How long ago did you stop? _____)	Less than 1 drink per day	Formerly Used _____
Total Years Smoked _____	1-2 drinks per day	Never Used Drugs
Never Smoked	3 or more drinks per day	IV Drug Use?

Family Medical History (Please only list first degree relatives and their history)

_____

_____

_____

Assignment and Release

I hereby authorize payment directly to Michael J. Rogers, M.D. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of services in Lakeside Dermatology to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient or Responsible Party Signature _____ Date _____

Notice of Privacy Practices

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that information.

This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this notice, please contact the privacy officer at this practice.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

Changes To This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice, with the effective date on the posted copy.

Lakeside DERMATOLOGY

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully

Effective Date: 10/01/2002

Privacy Officer: D. Overstreet

Phone: (863) 385-7183 Sebring
(863) 293-7546 Winter Haven

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.

For Treatment: We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Options: We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Your Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your authorization, and we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding

Disclosures and Changes To Your Medical Information

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the privacy officer at this practice. In your request, you must tell us what information you want to limit.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the privacy officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to Amend. If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the privacy officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Your Access To Medical Information

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the privacy officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to a Paper Copy of This Notice. You have the right to a paper copy of our current Notice of Privacy Practices at any time. Even if you have agreed to receive the notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current notice, please request one in writing from the privacy officer at this practice.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the privacy officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the privacy officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.