Ash Dermatology & Skin Cancer Center

50 Catalina Isle Drive
Merritt Island, Florida 32953
321-986-9335 Office
321-986-9337 Fax

PATIENT INFORMATION

Pt Acct #:_____

First Name: _____ Middle Initial: _____ Last Name:_____
Name of Parent (for Minor Patient):_____

Nickname:_____ SS#: _____DOB: _____ Age: _____ Sex: M / F
Maiden Name:_____

Marital Status (circle one): Married Single Divorced Widowed

Ethnicity (circle one):
Hispanic-Latino /
Non-Hispanic or Latino / Other

Race (cirlce one): American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / White / Decline to state / Other

Street Address: _____ Apt/Unit: _____
City: _____ State: _____ Zip Code: _____

Phone	Phone Number	Okay to leave detailed message	Call this number (circle one)
Home	(_____) _____	Yes _____ No _____	1st 2nd 3rd
Mobile	(_____) _____	Yes _____ No _____	1st 2nd 3rd
Work	(_____) _____	Yes _____ No _____	1st 2nd 3rd

Preferred Language: _____ **E-Mail Address: _____**
Would you like to receive correspondence by email? Yes / No
Employer:_____ Phone Number: (_____) _____
Occupation:_____

Primary Care Physician: _____ Phone #: _____

INSURANCE INFORMATION

Primary Insurance

Insurance Company Name:_____ Phone Number: (_____)_____
Insurance Company Address:_____
Policy # _____ Group # _____
Insured's Name: _____ Relation: _____

Secondary Insurance

Insurance Company Name:_____ Phone Number: (_____)_____
Insurance Company Address:_____
Policy # _____ Group # _____
Insured's Name:_____ Relation: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Phone #:(_____)_____
Address: _____

EMERGENCY INFORMATION

Please list emergency contact person:
Name: _____ Relation: _____
Home Phone: (_____) _____ Other Phone: (_____) _____

Referred to practice by(check):
____ Dr. _____|_____ Insurance Plan | _____ Advertising | _____Family/Friend | _____ Web Site | _____ Other

Patient (or Legal Guardian) Signature: _____ Date: _____
Print Name: _____

MEDICAL HISTORY

Pt Acct #:_____

Patient Name: _____

Reason for Visit:_____

Do you have any allergies to any medications or latex? □ Yes □ No **If yes please list:** _____

_____

Please list all medications(and Approximately how long you have been taking i.e. days, weeks, months, years)

_____

_ _____

Social History: **Have you received the PNEUMONIA vaccination?** □ Yes **Date** _____ □ No
Have you received the FLU vaccination? □ Yes **Date** _____ □ No

Do you drink alcohol? □ Yes **(# per week ____)** □ No
Do/Did you use tobacco products? □ Never □ Yes **(____packs per day) Total Yrs?:**_____ **Start:**_____ **Quit:**_____
Do/Did you sunbathe? □ Yes □ No **Total Yrs?:**_____ **Start:**_____**Quit:**_____
Do/Did you use a tanning bed? □ Yes □ No **Total Yrs?:**_____ **Start:**_____**Quit:**_____

Skin History:
Have you ever had skin cancer? □ Yes □ No
Have you ever had Melanoma? □ Yes □ No
Do you bleed easily? □ Yes □ No
Do you develop keloids? □ Yes □ No

Family Skin History:
Has anyone in your family had skin cancer? □ Yes □ No
Has anyone in your family had Melanoma? □ Yes □ No
Has anyone in your family had skin disease? □ Yes □ No

Do you have a history of any specific skin diseases? □ Yes □ No **If yes,**_____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Skin Disease History:	Yes	No
• Acne	□	□
• Actinic Keratosis	□	□
• Asthma	□	□
• Basal Cell Carcinoma	□	□
• Blistering Sunburns	□	□
• Dry Skin	□	□
• Eczema	□	□
• Flaking or Itchy Scalp	□	□
• Melanoma	□	□
• Psoriasis	□	□
• Squamous Cell Carcinoma	□	□
Lungs:		
• Chronic Bronchitis/Emphysema	□	□
Cardiovascular:		
• Chest Pain	□	□
• Heart Attack	□	□
• Pacemaker/AICD	□	□
• Artificial Heart Valve	□	□

Vascular:	Yes	No
• Blood clots	□	□
• Phlebitis	□	□
• Stroke	□	□
Other systemic:		
• Thyroid Disease	□	□
• Depression/Anxiety	□	□
• Kidney	□	□
• Immunosuppressed	□	□
○ Lupus	□	□
○ On chemotherapy	□	□
○ On steroids (i.e. Prednisone)	□	□
• Infectious Disease	□	□
o Hepatitis A, B, C	□	□
o TB Exposure	□	□
o HIV/AIDS	□	□
• Transplant	□	□
• Fainting	□	□
• Convulsions, Epilepsy or Seizures	□	□

Please explain any yes answers: _____

Please describe any recent hospitalization, surgeries or other conditions: _____
_____

_____ _____
Patient Signature **Date**

12/2022

Pt Acct #:_____

PAYMENT POLICY 2023

Payment or insurance information is due at time of service. To ensure compliance of Federal Laws, Co-pays, Deductibles, and Co-insurance balances will be collected. Insurance coverage is not a guarantee of payment and you are responsible at the time of service for co-payment, co-insurance, or deductibles that may apply. If your insurance policy has provisions such as deductibles, co-insurance or co-payments please note that these provisions that have been agreed to between you and your carrier. We cannot legally discount fees after their submission on your behalf to your carrier. If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined with your carrier. Writing off patient responsibility balances could jeopardize our contract with your carrier. If a portion of your fees are applied to an annual out of pocket maximum and we do not collect that fee, your out of pocket maximum has not been correctly calculated. If we are not participating with your insurance, you will be responsible for 100% of the out-of-network amounts. Contract discounts will not apply. In the event any insurance company does not render payment to Ash Dermatology & Skin Cancer Center in a timely manner (within 60 days of filing) then you agree to be responsible for any unpaid claim(s). Any previous balances, or any known copay's will be collected upon arrival to your appointment.

- **Medicare:** We are a participating provider of Medicare. We will accept assignment on all Medicare claims. Patients are responsible for meeting and keeping track of their **annual $226.00 deductible** and paying the 20% co-payment at time of service unless you have a secondary supplemental insurance. Medicare will file most secondary insurances if the patient has it set up with Medicare to crossover. We do not file your secondary/ supplemental insurance. However, in the event the secondary does not pay within 60 days, you will be billed and be responsible for payment.
- **Contracted HMO, PPO or Other managed care:** If we are contracted participating provider of your insurance carrier, we will file your claims, however, you are responsible for paying and keeping track of your annual deductible, co-pays, and co-insurance.
- All patients will be responsible for all non-covered services (e.g. cosmetic surgery). Payment on all services is due at time of service.

Patient/Responsible Party Signature: _____ **Date**: _____

Pt Acct #:_____

PAYMENT POLICY 2023
continued

Commercial, Non-contracted: If you are covered by private, commercial insurance or any other plan in which our physician is not a contracted participating provider, you will be responsible for payment at time of service. We will provide you with all the necessary paperwork so you will be able to file with your particular insurance provider.

In the event an account is forwarded to a collection agency, you agree that you will be responsible for the full amount owed to Ash Dermatology Skin & Cancer Center plus any collection agency fees to our collection service.

For payment of services rendered, we accept cash, checks, MasterCard/Visa/Discover and Amerian Express. **All checks returned unpaid will be charged a $30.00 administrative fee in addition to the amount of the returned check**.
Patient/Responsible Party Signature: _____ **Date**: _____

No Show/Cancellation Policy

PLEASE NOTE: There will be a $30 cancellation fee for office appointments and $50 for surgery appointments canceled/re-scheduled or no show less than 24 hours from appointment time.

I am aware of the cancellation / no show fee
(SIGNATURE): _____ Date: _____

Medicare Patients

MEDICARE Patients Only : This office is required to keep your signature on file authorizing us to file claims to Medicare for you and release information to the payer if they require it for proper consideration of a claim. Please read and sign the following statement: " I authorize any holder of medical or other information about me be released to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers 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 to the party who accepts assignment. Regulations pertaining to Medicare benefits apply."
Signature as it appears on your Medicare Card: _____
Date:_____

MEDIGAP PATIENTS: If you have a supplemental policy and it's a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file: "I authorize MEDIGAP benefits to me made on my behalf for any services furnished to me. I authorize the holder of information to release to the above MEDIGAP carrier information to determine these benefits payable for related services.
Signature as it appears on your MEDIGAP Card: _____
Date:_____

Acknowledgment of HIPAA Notice of Privacy Practices

Patient acct# _____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and professional certification and licensures.

I have received (let us know if you would like a copy) or have reviewed a copy (located on our website www.ashdermatology.com) of Ash Dermatology & Skin Cancer Center's HIPAA Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization to obtain a current copy of the practices.

Print Patient Name: _____

_____ _____

Signature of Patient (OR Legal Guardian if Minor) Date

Release of Information

"I authorize the release of medical information to my primary care or referring physician and to consultants as necessary to process insurance claims, insurance applications, and prescriptions as so noted on my patient registration form. I also authorize payment of medical payments to the providers at Ash Dermatology and Skin Cancer Center". If any of the information changes, I will notify the office of changes with written notification.

You have the right to choose to whom we may release your health information to in regards to your family members.

Please list the family members or other person(s), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name: _____ Phone Number: _____ Relationship: _____
Name: _____ Phone Number: _____ Relationship: _____
Name: _____ Phone Number: _____ Relationship: _____

Print Patient Name: _____

_____ _____

Signature of Patient (OR Legal Guardian if Minor) Date

PROCEDURE CONSENT

Patient Name: _____ **Patient acct#** _____

My signature permits Dr. Barbara A Ash to examine me for the purpose of making a diagnosis and providing treatment. I further permit and request that she perform the tests and procedures deemed necessary and I agree are appropriate for my medical care.

Biopsy
A biopsy entails obtaining a small piece of skin using local anesthesia in order to determine or verify a diagnosis and to plan a future course of therapy. The biopsy site may bleed, become irritated or infected. A small scar may form. If cancerous or precancerous changes are found on the biopsy specimen further treatment will be required even though the growth may appear to be gone.

Cryosurgical Therapy
Cryosurgical Therapy entails using liquid nitrogen to locally destroy skin cells. It is routinely used to treat pre-cancers, benign lesions, such as warts, and occasionally some small skin cancers. Following cryosurgical therapy, a small blister may form. The treated area will crust and slough off within two-three weeks. You may experience inflammation at the site and rarely infections. Complications may include scarring and pigmentary changes.

Dermatopathology is a critical part of giving you excellent care. We recommend that you use our preferred laboratories because of diagnostic accuracy, timeliness, and the ability of our providers to correlate clinical findings with pathology.

The Patient is responsible for any laboratory charges outside of this office

Signed: _____ Date: _____
Patient or person authorized for this patient

Provider Witness: _____