INDIGO DERMATOLOGY

SELECT LOCATION

- ☐ MELBOURNE, 675 S BABCOCK ST. SUITE 200, MELBOURNE, FL 32901
- ☐ TAMPA, 14499 NORTH DALE MABRY HWY TAMPA, SUITE #129-S FL 33618
- ☐ 375 S 12TH STREET, TAMPA FL 33602
- ☐ PALM BAY, 5200 BABCOCK ST. SUITE 106, PALM BAY, FL 32905
- ☐ TAMPA, INSIDE TLC MEDICAL OFFICE, 10866 SHELDON RD, TAMPA, FL 33626

PATIENT PROFILE

First Name: ..... M.I.: ..... Last Name: .....

Sex: ☐ Male ☐ Female ☐ Other DOB (mm/dd/yyyy): ..... Social Security Number: .....

Language: ..... Employer / Occupation: .....

How did you hear about us?: ☐ Referring Doctor ☐ Friend ☐ Online Search ☐ Newspaper/Magazine

☐ Other (please specify) .....

ADDRESS

HOME

Street: .....

City: .....

State: ..... Zip: .....

SEASONAL (Optional)

Street: .....

City: .....

State: ..... Zip: .....

PERSONAL CONTACT INFORMATION

(Select "NO" if you would not like a detailed communication 'i.e. lab results' to be left for all below contacts.)

Home Phone: ..... ☐ Yes ☐ No

Cell: ..... ☐ Yes ☐ No

Email: ..... ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

(Select "NO" if you would not like a detailed communication 'i.e. lab results' to be left for below contact.)

Emergency Contact Name: ..... Relation to Patient: ..... Phone: .....

☐ Yes ☐ No

POWER OF ATTORNEY OR MEDICAL PROXY (if applicable)

Name: ..... Relation to Patient: ..... Phone: .....

PARENT / GUARDIAN OF MINOR (if applicable)

Name: ..... Relation to Patient: ..... Phone: .....

PRIMARY CARE PHYSICIAN

Physician Name: ..... Phone: ..... Fax: .....

PHARMACY INFORMATION

Pharmacy Name: ..... Phone: ..... Town: .....

HEALTH HISTORY

Reason for your Visit	Duration	List any Treatment
1		
2		
3		
4		
5		

WOULD YOU LIKE A COMPLETE SKIN EXAM?

☐ Yes ☐ No ☐ Yes, but on another day

ALL EMERGENCY APPOINTMENTS MUST SCHEDULE THE EXAM ON ANOTHER DAY

PAST MEDICAL HISTORY (Select ones that apply)

☐ Anxiety
☐ Atrial Fibrillation
☐ Hay Fever
☐ Depression
☐ Heart Attack
☐ Chronic Obstructive Pulmonary Disease
☐ Hearing loss
☐ Stroke
☐ Pulmonary Embolism / Blood Clots
☐ Seizures
☐ Hypertension
☐ Ulcerative Colitis / Crohn's Disease
☐ Cold Sores
☐ Hypercholesterolemia
☐ GERD (Heartburn)
☐ Hyperthyroidism
☐ Pancreatic Cancer (in Self or Family)
☐ Lupus
☐ Hypothyroidism
☐ Current Cochlear Implant
☐ Leukemia / Lymphoma
☐ Myasthenia Gravis
☐ Uveal Cancer (in Self or Family)
☐ HIV / AIDS
☐ Diabetes
☐ Kidney Disease
☐ COVID-19
☐ Coronary Artery Disease
☐ Asthma
☐ Radiation Treatment (if yes, what location) .....
☐ Arthritis (if yes, what type) .....
☐ Hepatitis (if yes, what type) .....
☐ Cancer (if yes, what type) .....
☐ Autoimmune Disease (if yes, what type) .....
☐ Other (specify): .....

PAST SURGICAL HISTORY (Select ones that apply)

- [ ] Pacemaker
- [ ] Artificial Heart Valve
- [ ] Pre-op/ dental antibiotics
- [ ] Defibrillator
- [ ] Mitral valve prolapse
- [ ] Heart Stent Placement (Angioplasty)
- [ ] Hip replacement (if yes, enter details) Left Date (MM/YYYY) ..... Right Date (MM/YYYY) .....
- [ ] Knee replacement (if yes, enter details) Left Date (MM/YYYY) ..... Right Date (MM/YYYY) .....
- [ ] Organ Removal (if yes, which one) .....
- [ ] Organ Transplant (if yes, which one) .....
- [ ] Other (specify): .....

REVIEW OF SYSTEMS (Current Symptoms)

- [ ] Fever
- [ ] Easy bruising
- [ ] Depression
- [ ] Chills
- [ ] Blood clots
- [ ] Eye Irritation
- [ ] Fatigue
- [ ] Swollen lymph nodes
- [ ] Shortness of breath
- [ ] Unintentional weight loss
- [ ] Are you currently breastfeeding?
- [ ] New loss of smell or taste
- [ ] Nausea / Vomiting
- [ ] Joint pain
- [ ] Sore Throat
- [ ] Diarrhea
- [ ] Rash / Itch
- [ ] New onset of cough
- [ ] Constipation
- [ ] Headache
- [ ] Do you have COVID-19
- [ ] Abdominal Pain
- [ ] Anxiety
- [ ] Have you been in contact with someone with COVID-19

- [ ] Are you currently pregnant? (if yes, enter details) .....
- [ ] Other (specify): .....

SKIN DISEASE HISTORY (Select ones that apply)

- [ ] Acne
- [ ] Eczema
- [ ] Psoriasis
- [ ] Actinic Keratoses
- [ ] Flaking or Itchy Scalp
- [ ] Squamous Cell Skin Cancer
- [ ] Basal Cell Skin Cancer
- [ ] Hay Fever/Allergies
- [ ] Keloid Scars
- [ ] Blistering Sunburns
- [ ] Precancerous Moles
- [ ] Blistering Sunburns
- [ ] Family History of Melanoma (if yes, enter details) ..... Relationship with Patient: .....
- [ ] Melanoma (if yes, enter details) Location ..... Year ..... Treatment .....
- [ ] Other (specify): .....

MEDICATIONS

Medication 1: ..... Dosage (Mg): ..... How Many Times A Day? .....

Medication 2: ..... Dosage (Mg): ..... How Many Times A Day? .....

Medication 3: ..... Dosage (Mg): ..... How Many Times A Day? .....

Medication 4: ..... Dosage (Mg): ..... How Many Times A Day? .....

Medication 5: ..... Dosage (Mg): ..... How Many Times A Day? .....

ALLERGIES (Select ones that apply)

☐ Lidocaine ☐ Latex ☐ Codeine or other narcotics

☐ Aspirin ☐ Epinephrine ☐ Other (specify): .....

☐ Antibiotics (if yes, which antibiotic) .....

SOCIAL HISTORY

Cigarette Smoking:

☐ Yes ☐ No ☐ In the past

Alcohol:

☐ Yes ☐ No ☐ Occasional

Tanning Bed Use:

☐ Yes ☐ No ☐ In the past

INSURANCE INFORMATION: ☐ Yes ☐ No

(SELF PAY patients, please select 'NO') (All patients must provide a copy of their insurance card at the time of their visit)

PRIMARY

Referral Required: ☐ Yes ☐ No

Insurance Company Name: .....

ID Number: .....

Group Number: (If Medicare type "None") .....

Subscriber Name: .....

Subscriber DOB (mm/dd/yyy): .....

Relationship to Patient: .....

SECONDARY

Referral Required: ☐ Yes ☐ No

Insurance Company Name: .....

ID Number: .....

Group Number: (If Medicare type "None") .....

Subscriber Name: .....

Subscriber DOB (mm/dd/yyy): .....

Relationship to Patient: .....

OFFICE POLICIES

FINANCIAL POLICY

Payment is required for all services. If you have insurance, your payment is based on your negotiated contracted rates with your insurance company. You are responsible to verify with your insurance company, that the provider you are seeing is in-network with your insurance policy. You are responsible for any copays, deductibles, coinsurance, out of network balances, any non-covered services, and usual and customary amounts for non-contracted insurance. Co payments and unpaid balances will be collected at the time of service at check-in. If you are unsure of your copay, deductible, or coinsurance amount, please contact your insurance company for clarification prior to your appointment. I understand that in the event that services are not covered or out of network under my insurance, I accept full financial responsibility for all non-covered services. For patients without insurance, $200.00 will be collected during check- in and the remaining balance based on the services provided will be collected at checkout. For cosmetic visits, a $150.00 cosmetic consultation fee will be charged when the appointment is made, this will be applied to the cosmetic service fee if a procedure is completed within 3 months. The remaining fee for the cosmetic service will be collected at checkout on the day of the procedure. Cosmetic fees are non refundable. You will be sent a statement to the physical address or email address you have on file. You will be responsible to contact the office if you have a change in either address. Once the final statement is sent, your account may be sent to our legal collection agency. I acknowledge that I shall be responsible for the collection agency fee or the actual collection cost to the practice. At this point, all contact regarding your account must then be made with the legal collection agency's account representative. If you need to set up a payment plan, please call the office prior to your visit. I further acknowledge that there is a $25.00 banking fee for all returned checks.

REFERRAL POLICY

If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my primary care provider and assure that it is available at the time of my visit. I further understand that it is my responsibility to keep track of the number of visits I have used, the expiration date, and obtain a new referral as needed. I understand that should I fail to have a valid referral at the time of my visit, I will need to pay the cancellation fee and reschedule.

CANCELLATION POLICY

Should you be unable to keep the appointment, please cancel at least 24 hours prior to the appointment time. Cancellations must be on a business day. (i.e. Monday appointments need to be cancelled on Friday). Otherwise, there is a cancellation fee of $50 for general dermatology appointments & $100 for surgical and cosmetic dermatology appointments.

INSURANCE CARD POLICY

All patients new and returning are required to present their current insurance card(s) at every visit. I understand by signing below that I am responsible for notifying the office of any changes to my insurance or contact information.

- [ ] **I am stating that all information listed above is true to the best of my knowledge and that I understand the office policies. I will inform the office if there are any changes to my contact information.**

- [ ] **In efforts to GO GREEN, I acknowledge that Indigo Dermatology may send the billing statements and payment receipts to the email address on file.**

- [ ] **I agree to the use of my images for all marketing purposes including social media and website.**

DATE **SIGNATURE** (Signature of Patient or Person Authorized to Sign for Patient)

Notice of Privacy Practices Summary & Receipt of Written Acknowledgement Form

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices.

Our full length notice is available upon request. PLEASE REVIEW IT CAREFULLY. Effective Date: Today

This notice describes how medical information about you may be used and disclosed & how you may gain access to this information. We understand that your medical information is personal to you, and we are committed to protecting your information. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your Protected Health Information is kept private.

How will we use or disclose your information? Here are a few examples:
• For Medical treatment
• To obtain payment for our services
• In emergency situations
• For appointment & patient recall reminders
• To run our Practice more efficiently & ensure all our patients receive quality care
• To avert a serious threat to health or safety
• For organ and tissue donation
• For workers' compensation programs
• In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:
• The right to inspect and copy
• The right to amend
• The right to an accounting of disclosures
• The right to request restrictions
• The right to a paper copy of this notice
• The right to request confidential communications

WRITTEN ACKNOWLEDGEMENT

☐ **I hereby acknowledge receipt of Indigo Dermatology's Notice of Privacy Practices.**

Patient Name: .....

OR I am a parent/legal guardian of Name: ..... Relationship to Patient: .....

DATE **SIGNATURE** (Signature of Patient or Person Authorized to Sign for Patient)

....

COVID-19 RISK INFORMED CONSENT

I wish to be seen for a dermatologic issue(s). I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that the doctors and staff at Indigo Dermatology are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is inherent risk of becoming infected with COVID-19 by virtue of being seen in Indigo Dermatology's offices. I hereby acknowledge and assume this risk, and I give my express permission for Indigo Dermatology's doctors and staff to proceed with my upcoming visit(s).

I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand that possible exposure to COVID-19 before/during/after my upcoming visit(s) may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death.

I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my upcoming visit(s).

WRITTEN ACKNOWLEDGEMENT

☐ **I hereby acknowledge receipt of Indigo Dermatology's COVID-19 informed consent.**

Patient Name: .....

OR I am a parent/legal guardian of Name: ..... Relationship to Patient: .....

☐ **I understand if I have any questions regarding this form I can call the office prior to signing, and I will be able to download a copy of this waiver upon submitting the form.**

DATE **SIGNATURE** (Signature of Patient or Person Authorized to Sign for Patient)

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