Dermatology Center of Florida, PC

Joseph M. Masessa, M.D., F.A.A.D.

OFFICE POLICY & PATIENT RESPONSIBILITY REGARDING PAYMENTS

Your insurance coverage is a contract between you and your insurance company (not this office.) As such, you acknowledge and agree that:

A. Payment of your deductible is your responsibility (even Medicare has a deductible.)

B. Co-payments are your responsibility and are due at the time of visit.

C. Co-insurance payments are your responsibility. Example: If your insurance company pays 80% of covered/discounted charges, you are responsible for 20% of covered/discounted charges. The 20% is called the co-insurance. If you have secondary insurance, we will submit the 20% for reimbursement.

D. Referrals, if required, are your responsibility. You will not be seen if you do not have the proper referral and will need to reschedule.

E. Filing insurance claims is a service provided by this office without charge and in no way relieves you of the responsibility of paying your bill. It is your responsibility to provide us with your current insurance information. Additionally, it is your responsibility to confirm that your insurance coverage is in effect at the time of your visit and to respond to your insurance company's request for any additional information needed from you to process the claim.

F. We accept assignment with most insurance companies and Medicare. We do not accept Medicaid. We do participate with most Medicaid HMO plans. Assignment means that we allow your insurance company to discount the charges. Your insurance company will set the fees for the procedures performed. These fees are deemed customary and reasonable charges. Any fees your insurance company deems to be in excess will not be your responsibility and will be adjusted accordingly.

G. You are responsible for forwarding to our office any payments sent directly to you by your insurance company, along with the EOB (Explanation of Benefits).

H. It is your responsibility to advise this office which lab your insurance company is affiliated with.

I. In cases of divorced or separated parents, our policy is that the parent accompanying the child to the office visit is responsible for full payment of all fees.

I am in agreement with the office policy and patient responsibility set forth above.

Name of Patient: ______________________________

______________________________ ______________________________

Signature of Patient/Legal Guardian **Date**

Dermatology Center of Florida, PC

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HISTORY & INTAKE FORM

Past Medical History: (Check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Atrial Fibrillation
- ☐ BPH
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Valve Replacement
- ☐ None
- ☐ Other ______________________________

Past Surgical History: (Check 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
- ☐ PTCA
- ☐ 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
- ☐ 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
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma surgery
- ☐ Spleen Removed
- ☐ Testicles Removed [Right, Left, Bilateral]
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ None
- ☐ Other ______________________________

Skin Disease History: (check all that apply)

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ 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

Social History: (Please check all that apply)

- ☐ Currently Smokes
- ☐ Has smoked in the past
- ☐ Drug Use
- ☐ None
- ☐ Other ______________________________

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)? ____________________________		

Cautions: (please circle all that apply)

Have you ever had difficulty stopping bleeding?	Yes	No
Do you require antibiotics prior to a surgical procedure?	Yes	No
Have you had an artificial joint replacement?	Yes	No
If yes, when and what body locations? ________________	Yes	No
Do you have an artificial heart valve?	Yes	No
Do you have a pacemaker?	Yes	No
Do you have a defibrillator?	Yes	No
Are you pregnant or currently trying to get pregnant?	Yes	No

Medications: (Please enter all current medications)

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Allergies: (Please enter all allergies)

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Review of Systems: Are you currently experiencing any of the following symptoms? (please check all that apply)

- ☐ Abdominal Pain
- ☐ Anxiety
- ☐ Bleeding Problems
- ☐ Bloody Stool
- ☐ Bloody Urine
- ☐ Blurry Vision
- ☐ Changing Mole
- ☐ Chest Pain
- ☐ Cough
- ☐ Depression
- ☐ Fever or Chills
- ☐ Headaches
- ☐ Hay Fever
- ☐ Joint Aches
- ☐ Muscle Weakness
- ☐ Neck Stiffness
- ☐ Night Sweats
- ☐ Rash
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Sore Throat
- ☐ Thyroid Problems
- ☐ Unintentional Weight Loss
- ☐ Wheezing
- ☐ Other Symptoms:

Ethnicity ______________
Race ______________
Language ______________

NAME OF PATIENT: ______________________________
SIGNATURE OF PATIENT/LEGAL GUARDIAN: ______________________________
DATE: ______________________

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Official Use only

Date /Initials	Date /Initials	Date /Initials	Date /Initials

Dermatology Center of Florida, P.C.

Joseph M. Masessa, M.D., F.A.A.D

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Dermatology Center of Florida, PC, to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent.

Dermatology Center of Florida, PC reserves the right to revise its Notice of Privacy Practices at anytime. A revise Notice of Privacy Practices may be obtained by forwarding a written request to Dermatology Center of Florida, PC, Privacy Officer, 35 Green Pond Road, Rockaway, New Jersey 07866.

With this consent, Dermatology Center of Florida, PC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Dermatology Center of Florida, PC may mail to my home or other alternative location any Dermatology Center of Florida, PC items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I have the right to request that Dermatology Center of Florida, PC restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

BY SIGNING THIS FORM, I AM CONSENTING TO DERMATOLOGY CENTER OF FLORIDA, PC's USE AND DISCLOSURE OF MY PHI TO CARRY OUT TPO.

I MAY REVOKE MY CONSENT IN WRITING EXCEPT TO THE EXTENT THAT THE PRACTICE HAS ALREADY MADE DISCLOSURES IN RELIANCE UPON MY PRIOR CONSENT. IF I DO NOT SIGN THIS CONSENT, OR LATER REVOKE IT, DERMATOLOGY CENTER OF FLORIDA, PC, MAY DECLINE TO PROVIDE TREATMENT TO ME.

(Sign in duplicate and provide patient with copy for their records)

I ACKNOWLEDGE READING THE PRIVACY PRACTICE NOTICE ABOVE AND SIGN BELOW TO ACCEPT.

Name of Patient: ______________________________

______________________________ ______________________________

Signature of Patient/Legal Guardian **Date**

Dermatology Center of Florida, PC
Joseph M. Masessa, M.D., F.A.A.D

TO ALL PATIENTS:

If your insurance company requires a referral from your primary doctor, you must have it with you at the time of your visit. It is also your responsibility to keep track of how many visits you have used on your referral and when it expires.

If you do not have a referral with you at the time of your appointment, we will not be able to see you and will reschedule your appointment.

This office cannot follow up with your insurance company to check on individual referrals. THIS IS YOUR RESPONSIBILITY. If seen without referral, the balance will be the patient's responsibility.

Also, if you need a surgery or special procedure, we will check with your insurance company to see if a pre-certification is needed but it is your responsibility to check with your insurance company regarding your benefits, co-pays, co-insurance, deductibles and what percentage you are responsible for paying.

I understand that any fees not covered by my insurance company, such as co-pays, co- insurance and deductibles, will be my responsibility to pay to North Jersey Dermatology Center, P.C.

Name of Patient: ____

______________________________ ______________________________
Signature of Patient/Legal Guardian **Date**

OFFICE POLICY

Dermatology Center of Florida, P.C.

AT TIME OF BIOPSY, YOU ARE REQUIRED AS OUR PATIENT TO SCHEDULE A FOLLOW UP OFFICE VISIT WITHIN (4-8) WEEKS TO REVIEW YOUR PATHOLOGY RESULTS. THIS ALSO ENSURES THAT YOUR RESULTS HAVE BEEN RETURNED FROM THE LAB.

Name of Patient: ______________________________

______________________________ ______________________
Signature of Patient/Legal Guardian Date