LAZZARA
DERMATOLOGY &
MOHS SURGERY
of Milton

Welcome To Lazzara Dermatology & Mohs Surgery of Milton, LLC

This form is designed to acquaint you with our office policies. You have an opportunity to question, at this time and prior to service, the office policy and procedures. Once you have read the policies, please initial each item and sign the bottom of the form.

1. Keep Us Accurately Informed: You have a responsibility to provide, to the best of your knowledge, accurate and complete information about present complaints, past illness, hospitalizations, procedures, medications, and other matters relating to your health, including unexpected changes in your condition. You must also notify the office of any change of insurance, addresses, phone number, or other contact information.

2. Follow Your Treatment Plan: You are responsible for following the treatment plan recommended by the physician, physician assistant or her designee. If you cannot follow through with the prescribed treatment plan, is your responsibility to communicate this with the physician/physician assistant.

3. Keep Your Appointments: You are responsible for keeping scheduled appointments. Text message reminders are a courtesy that do not work all the time. When unable to do so for any reason, please notify the practice at least 2 business days prior to the appointment in order to avoid a late fee cancellation penalty.

4. Conduct Yourself Properly: Physician, staff and patient relationships are built upon mutual respect. Our staff will always treat you with respect, and we expect the same courtesy from you. It is your responsibility to respect practice property and property of other persons visiting the practice.

5. Phone Calls: All patient phone calls are triaged to the medical staff.

6. Cell Phone Policy: Please silence your cell phone when in the office. You may use it for calls, texts and emails. Please refrain from answering your phone while the medical staff is attending to you.

7. To protect the privacy of our patients in the office, use of recording devices of any kind audio or video are strictly prohibited.

8. Billing, Diagnostic and Treatment codes will not be altered for billing purposes.

9. Medication Refills: are provided at the discretion of the medical staff and may be declined based on potential side effects. Prescriptions will only be refilled during office hours.

10. Yearly skin cancer screenings prevent and decrease skin cancers. This may or may not be covered under your health insurance policy, however they are recommended by your physician/provider.

11. Emergencies- only if you have a true medical emergency and are on your way to the hospital should you contact us. Cosmetic filler patients if you notice skin changes you should also contact us.

12. HIPAA Policy: All patients are protected under the Federal Health Insurance Portability and Accountability Act. This federal law prohibits any staff member of Lazzara Dermatology & Mohs Surgery of Milton from discussing appointments, medications, test results, and/or treatment plans with anyone other than the patient, except as provided above. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information on their behalf. **If you would like to permit someone to discuss your medical condition, obtain results or make appointments for you, please list their name(s) below.** Only individual names listed below will be provided with information. Should you wish to update the names provided, please ask the patient service representative at the front desk for a new HIPAA form.

Patient or Legal Representative Name/Relationship: _____

Patient or Legal Representative Signature: _____

Date: _____

Patient Information

Patient Name: _____ Date of Birth: _____
First M.I. Last

Reason(s) for Visit: _____

Date of Birth: _____ Age: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Sex: Female or Male

Address: _____ Town: _____

State: _____Zip Code: _____

Home Phone: (___)_____ Cell Phone: (_____)_____

Email*: _____
*By providing my email, I authorize Lazzara Dermatology & Mohs Surgery of Milton to web-enable me with the practice and I understand that I can unsubscribe at any time.

Employer Name: _____ Occupation: _____

Employment Status: O Employed Full-Time O Employed Part-Time O Unemployed
O Self Employed O Retired O Student

Primary Doctor (Name &Town): _____

Referring Doctor (Name & Town): _____

Race*: Asian _____ Black/African American _____ Caucasian _____ Hispanic _____ Other _____
*Please note these questions are asked to comply with U.S. Government requirements.

How did you hear about our practice? (Check all that apply)

O Referring Physician O Family/Friend O Website O Social Media O Insurance Directory O Other

<u>Emergency Contact Information:</u>

Name: _____

Relationship: _____ Phone: (_____)_____

PRIMARY
INSURANCE: _____
Policy Holder Name: _____
Date of Birth: _____
Policy Number: _____

SECONDARY
INSURANCE: _____
Policy Holder Name: _____
Date of Birth: _____
Policy Number: _____

MEDICARE PATIENTS

Lazzara Dermatology & Mohs Surgery of Milton, LLC accepts what is allowed and approved by Medicare. Your co-payment and yearly deductible are your responsibility. I request that payment of authorized Medicare benefits be made on my behalf to Lazzara Dermatology & Mohs Surgery of Milton, LLC for any services furnished to me by that provider.

Signature: _____ Date: _____

I agree that my Protected Health Information (PHI) may be shared with the following people:

_____ _____

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY AND SECURITY OF YOUR PROTECTED HEALTH INFORMATION (PHI). WE ARE ALSO REQUIRED TO PROVIDE YOU WITH OUR NOTICE OF PRIVACY PRACTICES WHICH DESCRIBES OUR LEGAL RESPONSIBILITES AND YOUR RIGHTS REGARDING THE USE AND DISCLOSURE OF YOUR PHI. YOUR SIGNATURE BELOW IS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED OUR NOTICE OF PRIVACY PRACTICES. (PLEASE ASK FOR YOUR COPY)

Signature: Date:

_____ _____

I AUTHORIZE; 1. THE USE OF THIS FORM, WHETHER ORIGINAL OR COPY, TO BE USED ON MY INSURANCE AND/OR MEDICARE SUBMISSIONS; 2. RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES INCLUDING MEDICARE; 3. PAYMENT DIRECTLY TO LAZZARA DERMATOLOGY & MOHS SURGERY OF MILTON FROM MEDICARE, ALL INSURANCE COMPANIES, AND/OR THIRD-PARTY PAYERS; 4. LAZZARA DERMATOLOGY & MOHS SURGERY OF MILTON TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANY AND/OR MEDICARE.

I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL. I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE ON MY BEHALF TO LAZZARA DERMATOLOGY & MOHS SURGERY OF MILTON. I GIVE PERMISSION TO LAZZARA DERMATOLOGY & MOHS SURGERY OF MILTON TO FILL OUT THE MEDICARE FORM ON MY BEHALF. I UNDERSTAND THAT MEDICARE AND MOST INSURANCE COMPANIES DO NOT COVER MEDICAL SERVICES THAT ARE DEEMED COSMETIC IN NATURE. THIS INCLUDES BUT IS NOT LIMITED TO PROCEDURES SUCH AS REMOVAL OF SKIN TAGS, UNSIGHTLY BLOOD VESSELS, SCLEROTHERAPY OF LEG VEINS, BOTOX, SCULPTRA, AND JUVEDERM INJECTIONS. Print Name.

Signature: Date:

_____ _____

Patient Consent for Medical Photography

I give my consent for medical photographs to be made of me (or for the patient for whom I am the parent/legal guardian). I understand that these images will be stored in my/their private medical record with strictly controlled access as mandated by the Department of Health and Human Services' "Privacy Rule."

Name of Patient's Guardian (if under 18): _____

I acknowledge I have received a copy of this practice's notice of privacy practices.

I hereby authorize you to leave messages regarding appointments and to inform me that diagnostic results are available. Diagnostic results are never left on a message.

Print Patient Name: _____

Guardian Name (if patient under 18): _____

Signature (Guardian's if under 18): _____ **Date:** _____

PAST MEDICAL HISTORY

Current or Prior Medical Conditions (Circle all that apply)

Anxiety	Depression	Liver Disease
Arthritis	Diabetes	Lung Cancer
Asthma	Kidney Disease or Failure	Lymphoma
Atrial Fibrillation	GERD / Acid Reflux	Radiation Treatments
Bone Marrow Transplant	Hearing Loss	Stroke
Breast Cancer	Hepatitis	Seizures
Colon Cancer	High Blood Pressure	Thyroid Problems
COPD	High Cholesterol	Ulcerative Colitis
Coronary Artery Disease	HIV/AIDS	**OTHER** _____
Crohn's Disease	Leukemia	**NONE**

Past Surgical History (Circle and specify between the listed options)

Appendix (removal)	Kidney (biopsy, kidney stone removal)
Breast (biopsy, lumpectomy, mastectomy)	Ovaries (removal)
Breast (reduction, implants)	Prostate (biopsy, TURP/removal)
Colon (biopsy, partial removal, full removal)	Spine (fusion, laminectomy, other)
Eyes (cataracts)	Spleen (removal)
Gallbladder (removal)	Stomach (gastric band, sleeve gastrectomy)
Heart Stent (CABG)	Testicles (removal, other)
Heart Valve Replacement	Tonsils (removal)
Hernia Repair	Uterus (fibroid removal, uterine cancer, C-section, D&C)
Joint Replacement (knee, hip, shoulder)	Organ Transplant (heart, kidney, liver, lung)
OTHER _____	**NONE**

Cancer History (not including skin cancer)

Do you have history of current or prior cancer **within the past 5 years**? Specify type of cancer, year cured or ongoing, and oncologist name or practice.

_____

_____

_____

Print Patient Name: _____ **Signature (Guardian's if under 18):** _____

Date: _____

OTHER MEDICAL HISTORY

Height: _____ **Weight:** _____

SOCIAL HISTORY: (Check the applicable box for each category)

Cigarette Smoking: ☐ Currently smokes ☐ Former smoker ☐ Never smoker

Alcohol Use: ☐ None ☐ 1-2 drinks per day ☐ 3 or more drinks per day

Current Medications	Dosage	Frequency

If no medications check this box ☐

I authorize Lazzara Dermatology to retrieve my medication history through their e-prescribing system and then import it into my electronic record.

Allergies to Medications	Reaction to medication (rash, anaphylaxis, etc)

If no allergies check this box ☐

Pharmacy Name: _____ **Location or Phone:** _____

ALERTS: (circle all that apply)

- Allergy to latex
- Allergy to adhesive
- Allergy to lidocaine
- Allergy to topical antibiotics
- Artificial heart valve
- Artificial joint replacement
- Blood thinners
- Defibrillator
- Pacemaker
- Require antibiotics prior to surgical procedure
- Rapid heartbeat with epinephrine
- Pregnant or currently trying to get pregnant
- Breast feeding
- MRSA history

Do you have an Advance Care Plan? ☐ Yes ☐ No

If yes, who is your surrogate decision maker? _____

Print Patient Name: _____ **Signature (Guardian's if under 18):**_____

Date: _____

Skin History

Do you wear sunscreen? ☐ Yes ☐ No **Do you tan in a tanning bed?** ☐ Current ☐ Past ☐ Never

Do you have a family history of melanoma skin cancer? (This does not include Basal or Squamous Cell Carcinoma.)

☐ Yes ☐ No **If yes, which relative(s)?** _____

Current or Prior Skin Conditions: (Circle all that apply)

Acne	Flaking or itchy scalp
Actinic Keratoses	Itchy Skin
Blistering Sunburns	Poison Ivy
Dry Skin	Precancerous or Atypical Moles
Eczema	Psoriasis
Fever blisters or cold sores	Other _____

Skin Cancer History:

If you have had skin cancer previously but do not know which type, check this box. ☐
Otherwise, please specify below.

Basal Cell Carcinoma ☐ Yes ☐ No

Squamous Cell Carcinoma ☐ Yes ☐ No

Melanoma ☐ Yes ☐ No

If you have history of **melanoma** skin cancer, please specify the body location(s) and year(s) treated below:

_____

_____

_____

_____

Print Patient Name: _____

Signature (Guardian's if under 18): _____ **Date:** _____

Financial Policy Statement

To help our patients understand our billing process, we ask that you read and sign our Financial Policy.

Lazzara Dermatology & Mohs Surgery of Milton will submit claims to insurance companies with which we participate. Proof of insurance must be provided at the time of service, along with any necessary authorizations/referrals.

Depending upon your individual policy, your coverage, your deductible and/or co-insurance requirements, you may have a balance after insurance. You are still responsible for paying any balance as indicated by your carrier, as well as any non-covered services under their contract. Once payment has been made or payment has been denied by an insurance company you will be responsible to pay the balance. Co-pays are due at the time of the visit. Without proper documents you may be required to make full payment.

It is your responsibility to maintain your account in good standing, regardless of insurance or any other circumstances (such as litigation). If your account is submitted to collections, you will be responsible for all costs associated with collecting owed balances including but not limited to: collection agency, attorney and court fees. The collection fee may be up to 50% of your account balance.

Please be aware that Lazzara Dermatology & Mohs Surgery of Milton will not become involved in disputes between you and your insurance carrier regarding covered charges, secondary insurance issues or "usual and customary" charges other than to provide factual information requested by the insurance carrier.

Lazzara Dermatology & Mohs Surgery of Milton asks if you need to cancel or change an appointment, please contact our office at least 48 hours before your scheduled appointment. Failure to do so will result in a cancellation fee of $50.00 for general dermatology/cosmetic appointments and $100.00 for surgical visits.

THANK YOU FOR REVIEWING LAZZARA DERMATOLOGY & MOHS SURGERY OF MILTON'S FINANCIAL POLICY STATEMENT.

I acknowledge that I have read and agree to the above Terms and Condition:

Print Name: _____

Signature: _____

Date: _____

Cancellation Policy

Cancellation Policy: Should you be unable to keep your appointment, please contact our office to cancel your appointment.

Failure to contact our office within 48 hours of the appointment will result in a $50 no-show fee for medical/cosmetic appointments and $100 no-show fee for surgical appointments.

These fees are not reimbursable by your insurance company.

Patient or Legal Representative Name/Relationship: _____

Patient or Legal Representative Signature: _____

Date: _____

Acknowledgment of Receipt of Notice of Privacy Practices

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

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand the Notice of Privacy Practices document containing a more complete description of the uses and disclosures of my health information. I understand that Lazzara Dermatology & Mohs Surgery of Milton has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time for a current copy of the Notice of Privacy Practices document.

Acknowledgement: I acknowledge that a copy of Lazzara Dermatology & Mohs Surgery of Milton Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996 is available for review upon request. I may ask a front desk representative for a copy if I wish to review it in detail. I certify that the information that I have provided is correct.

Must be signed by patient 18 years of age or older. Patients under 18, must be signed by a parent or legal guardian:

Patient or Legal Representative Name/Relationship: _____

Patient or Legal Representative Signature: _____

Date: _____