OCALA DERMATOLOGY & SKIN CANCER CENTER

PATIENT INFORMATION

Please Print Clearly **Date:**_____ **Acct #:**_____

PATIENT NAME:_____ _____ _____
last first mi

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: (_____) _____ - _____ CELL PHONE: (_____) _____ - _____ ☐ MALE ☐ FEMALE

EMAIL ADDRESS: _____

Date of Birth: _____ /_____ /_____ SS # _____ MARITAL STATUS: (circle one) M D W S

EMPLOYER: _____ OCCUPATION: _____

OUT OF STATE ADDRESS: _____ PHONE: (_____) _____ - _____

CITY: _____ STATE: _____ ZIP CODE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ ID/ POLICY # _____

GROUP # _____ S.S.# _____ DOB _____

SUBSCRIBER'S NAME _____

SUBSCRIBER'S ADDRESS _____

SUBSCRIBER'S EMPLOYER _____

SECONDARY INSURANCE _____ ID/ POLICY # _____

GROUP # _____ S.S.# _____ DOB _____

SUBSCRIBER'S NAME _____

SUBSCRIBER'S ADDRESS _____

SUBSCRIBER'S EMPLOYER _____

PRIMARY PHYSICIAN NAME: _____

OVER

LIFETIME AUTHORIZATION
INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

I. RELEASE OF INFORMATION - I, the below named patient, do hereby authorize any physician examining and/or treating me to release any third payor (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. PHYSICIAN INSURANCE ASSIGNMENT - I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

III. MEDICARE/MEDICAID - Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I PERMIT A COPY OF THESE AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third party payor within a reasonable period of time not to exceed 60 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

In the event my account is turned over to a collection agency for collections, I will be responsible for any and all costs incurred.

V. AGREEMENT TO BE TREATED - I, the below signed person, agree to be treated by Ocala Dermatology and Skin Cancer Center, P.A. and agree that I am responsible for payment of all services.

WE DO NOT ACCEPT AND DO NOT EVALUATE PATIENTS WITH CHAMPVA, TRICARE PRIMARY, OR ANY WORK COMP INSURANCE.
I DO NOT BELIEVE THAT MY SKIN CONDITION IS WORK RELATED.

DATE _____ PATIENT _____
Signature

SUBSCRIBER (if different from patient) _____
Signature

ORIGINAL SIGNATURE ON FILE AT PHYSICIAN'S OFFICE

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Ocala Dermatology & Skin Cancer Center, P.A. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Ocala Dermatology & Skin Cancer Center, P.A.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Ocala Dermatology & Skin Cancer Center, P.A. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Ocala Dermatology & Skin Cancer Center, P.A.'s Privacy Officer at 3233 SW 33 Rd., Ste. 101, Ocala, FL 34474.

With my consent, Ocala Dermatology & Skin Cancer Center, P.A. may call my home or other designated 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 call pertaining to my clinical care, including laboratory results, among others.

With my consent, Ocala Dermatology & Skin Cancer Center, P.A. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Ocala Dermatology & Skin Cancer Center, P.A. restricts 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.

I have **received** a copy of Ocala Dermatology & Skin Cancer Center, P.A.'s Privacy Practice Notice for my records.

By signing this form, I am consenting to Ocala Dermatology & Skin Cancer Center, P.A.'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, Ocala Dermatology & Skin Cancer Center, P.A. **may decline to provide treatment to me**.

_____

Patient's Name - Please Print

_____ _____

Signature of Patient or Legal Guardian *Date*

_____

Print Name of Legal Guardian