James J. DeVoursney, MD, FAAD*†‡
Andrew H. Weinstein, MD, FAAD*†‡
Rama Vaitla, MD, FAAD*‡
Yuval Bibi, MD*
Elana Aharonoff, MMS, PA-C

BB SKIN BOYNTON BEACH

*Diplomates, American Board of Dermatology
†Board Certified Micrographic Dermatologic Surgery (Mohs)
‡Fellows, American Academy of Dermatology

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Today's date _____

Primary care physician: _____

Patient Information (Please Print)

Name: _____
Last First M.I

Date of Birth _____ Age _____ Sex: ☐Male ☐Female

Mailing address: _____
Address City State Zip

Home Phone: ( ) _____ Work Phone: ( ) _____

Cell Phone: ( ) _____ E-mail: _____

Parent or Guardian- Please give both parents names (if patient is a minor)

Mother: _____
Last First Phone Number

Father: _____
Last First Phone Number

Other Guardian: _____
Last First Phone Number

Relationship: _____

Insurance Subscriber (if other than the patient)

Name: _____ Date of Birth _____ Sex: ☐Male ☐Female
Last First M.I

Please present your insurance card(s) and a photo ID to the receptionist along with this completed form. Thank you.

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DATE ____ / ____ / ____ **NAME _____** **DOB ____ / ____ / ____**

DO YOU HAVE ANY OF THE FOLLOWING?

	Y	N
Arthritis	☐	☐
Asthma	☐	☐
Atrial fibrillation	☐	☐
Benign prostatic hyperplasia	☐	☐
Stroke	☐	☐
Chronic kidney disease	☐	☐
COPD	☐	☐
Coronary arteriosclerosis	☐	☐
Depression	☐	☐
Diabetes	☐	☐
Liver Disease	☐	☐
Autoimmune disease	☐	☐
Thyroid disorder	☐	☐
GERD	☐	☐
Chemotherapy	☐	☐
In what year? _____		
High blood pressure	☐	☐
Hypercholesterolemia	☐	☐

	Y	N
Cancer	☐	☐
Type: _____		
Heart attack	☐	☐
Radiation therapy	☐	☐
In what year? _____		
Organ transplant	☐	☐
Type: _____		
Bone Marrow Transplant	☐	☐
Surgery (Please list)	☐	☐
_____		
_____		
_____		
_____		
Acne*	☐	☐
Precancerous lesions	☐	☐
Abnormal mole	☐	☐
Eczema	☐	☐

	Y	N
Keloid	☐	☐
Psoriasis*	☐	☐
Rosacea	☐	☐
Skin Cancer	☐	☐
☐basal cell ☐melanoma		
☐squamous cell ☐other		
☐unsure what type		
Family history of melanoma	☐	☐
Who? _____		
Other conditions (please list):	☐	☐
_____		
_____		

*If acne or psoriasis history, what medications have you used?
_____
_____
_____
_____

CURRENT MEDICATIONS (RX, OTC, & SUPPLEMENTS) ***OMIT IF YOU BROUGHT PRESCRIPTION LIST***

_____ _____ _____ _____

_____ _____ _____ _____

☐ No Rx, OTC, or supplements

ALLERGIES (MEDICATION, FOOD, ETC.) ***PLEASE LIST ITEM AND DESCRIBE THE REACTION YOU GET***

_____ _____ _____ _____

_____ _____ _____ _____

☐ No known allergies

SOCIAL HISTORY

- Tobacco Use: ☐ Current ☐ Former ☐ Never
- How many days per year do you have at least four* drinks in a day? ___
  *If you are a male under 65, please answer for five drinks instead of four.
- Do you have a healthcare proxy (i.e.: someone who can make decisions on your behalf) ☐ Yes ☐ No
  If yes, what is their name and phone number? _____

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS WHICH COULD AFFECT THE WAY WE CARE FOR YOU?

	Y	N
Immunosuppression	☐	☐
History of anaphylaxis	☐	☐
On blood thinner (Including aspirin)	☐	☐
Premedication prior to procedures	☐	☐
Fainting with procedures	☐	☐
Problems with bleeding	☐	☐
Problems with healing	☐	☐
Pacemaker	☐	☐
Defibrillator	☐	☐
Dementia	☐	☐
HIV/AIDS	☐	☐
Hepatitis C	☐	☐
Valve replacement In what year? _____	☐	☐
Joint replacement In what year? _____	☐	☐

	Y	N
Severe vision impairment or blindness	☐	☐
Hard of hearing or deaf	☐	☐
On the autism spectrum	☐	☐
Developmental disability	☐	☐
Severe anxiety	☐	☐
Allergy to:		
Adhesive (reaction: _____)	☐	☐
Latex (reaction: _____)	☐	☐
Antibiotic ointment (reaction: _____)	☐	☐
Lidocaine (reaction: _____)	☐	☐
Epinephrine (reaction: _____)	☐	☐
Currently pregnant	☐	☐

Any other conditions of which we should be aware of (Please list):

_____

_____

WHAT ARE YOU SEEING US FOR? (If more than two reasons, please advise the medical assistant in the room)

REASON #1

Is this a follow up visit or a new problem/recurrence?

☐Follow-up ☐New problem or recurrence ☐N/A

IF IT IS A FOLLOW-UP:

Is it any better since your last visit?

☐Completely better ☐Somewhat better

☐The same ☐Worse

IF IT IS A NEW PROBLEM OR RECURRANCE:

Where is it located? _____

Is it: ☐Bleeding ☐Changing ☐Enlarging ☐Irritated

☐Itchy ☐Painful ☐Oozing ☐Red ☐None of these

How long have you had it? _____

Has it been treated previously? ☐Yes ☐No

Did a doctor refer you for this? ☐Yes ☐No

If yes, what is his/her full name?

_____

REASON #2

Is this a follow up visit or a new problem/recurrence?

☐Follow-up ☐New problem or recurrence ☐N/A

IF IT IS A FOLLOW-UP:

Is it any better since your last visit?

☐Completely better ☐Somewhat better

☐The same ☐Worse

IF IT IS A NEW PROBLEM OR RECURRANCE:

Where is it located? _____

Is it: ☐Bleeding ☐Changing ☐Enlarging ☐Irritated

☐Itchy ☐Painful ☐Oozing ☐Red ☐None of these

How long have you had it? _____

Has it been treated previously? ☐Yes ☐No

Did a doctor refer you for this? ☐Yes ☐No

If yes, what is his/her full name?

_____

Height: _____ Weight: _____

Pharmacy Name & Location: _____

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CONTACT INFORMATION AND RECEIPT OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

Preferred primary phone number: _____

I acknowledge that I have received Boynton Beach Skin's Notice of Privacy Practices.

I give my permission to leave medical information on voicemail at the following number(s): ☐Home ☐Work ☐Cell

I give my permission to share my medical information with the following:

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

Signature: _____ Date: _____

(If signed by Legal Representative: Printed name: _____ Basis of authority: _____)

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Financial Policies

The providers and staff at Boynton Beach Skin want to welcome you to our practice! We would like to make you aware of our financial policies in advance so as to avoid any misunderstandings.

INSURANCE

1. Please know your deductible and co-insurance and what services your plan covers. This can be found in your policy documents or by calling your insurance company. (Please remember that even when a service is covered, your plan will only make payment if you have met your annual deductible.)
2. It is your responsibility to inform us of any changes in your insurance. If failure to notify us results in non-payment of a claim, the fee will be billed to you.
3. If your insurance plan requires a referral from your primary physician, we will be happy to contact your primary care doctor's office to request it; however, it is your responsibility to ensure that we do receive it in time; if we do not, you may have to reschedule.

IN-OFFICE PROCEDURES

1. The fee for your office visit includes the exam and counseling. Any additional treatment (such as injection, biopsy, freezing, extraction, etc.) is billed separately. Conversely, if you are scheduled to come in for a treatment (such as excision or injection), but have an additional problem to evaluate, there may be an added fee for an office visit.
2. Even treatments such as those mentioned above are paid by insurance as "minor surgery." Therefore, some plans apply the deductible and co-insurance in addition to the office visit co-payment.
3. The fee for most procedures includes ten days' follow-up care; after 10 days, this may be billed as a regular visit.

LAB WORK AND PATHOLOGY

1. Biopsies, cultures, and surgical procedures require that a skin specimen be sent to a laboratory or pathologist, whose fee is billed separately.
2. We generally will utilize a laboratory or pathologist who is in your network; however, we are unable to track or conform to the idiosyncrasies of each plan's "preferred" labs. Thus, there may be additional out-of-pocket costs for using a lab which is in-network, but not "preferred."
3. If you are given an order for testing, it is your responsibility to verify with your insurance whether it is covered; some tests that a doctor considers necessary to your care may be deemed "not medically necessary" by insurance.

OTHER FEES

1. Failure to provide 24-hour notice of appointment change or cancellation will result in a $25 fee for routine visits and $150 for surgery or patch test application.
2. There is a $25 service charge for a returned check, with future payments to be made by cash or credit card.
3. If your account is turned over to a collection agency, you will be responsible for the collection agency's fee.

MISCELLANEOUS

1. We accept cash, checks, MasterCard, Visa, and Discover.
2. Payment for self-pay services is due at the time of service.
3. It is your responsibility to inform us of any changes in address or phone number.
4. If a temporary financial problem affects your ability to pay your balance, please contact our billing department for assistance.

I confirm that I have read and agree to all the above policies.

_____ _____
Signature of Patient (or Parent/Legal Representative) Date

If signed by Parent or Legal Representative: Printed name: _____ Role: _____

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Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities: This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- **Get an electronic or paper copy of your medical record:** You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- **Ask us to correct your medical record:** You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- **Request confidential communications:** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- **Ask us to limit what we use or share:** You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information with your health insurer for the purpose of payment or operations. We will say "yes" unless a law requires us to share that information.
- **Get a list of those with whom we've shared information:** You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Get a copy of this privacy notice:** You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **File a complaint if you feel your rights are violated:** You can complain if you feel we have violated your rights by contacting us using the information at the top or bottom of the page. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your choices: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- **In these cases, you have both the right and choice to tell us to:**
  - Share information with your family, close friends, or others involved in your care.
  - Share information in a disaster relief situation.
  - Include your information in a hospital directory. (Not applicable, as we do not maintain a hospital directory.)
  - Contact you for fundraising efforts. (Not applicable, as we do not engage in fundraising.)

  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- **In the following cases, we never share your information unless you give us written permission***:*
  - *Marketing purposes*
  - *Sale of your information*
  - *Most sharing of psychotherapy notes (NOTE: not applicable, as we do not maintain psychotherapy notes).*

OUR USES AND DISCLOSURES: How do we typically use or share your health information? We typically use or share your health information in the following ways:

- **Treat you:** We can use your health information and share it with other professionals who are treating you. ***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
- **Run our organization:** We can use and share your health information to run our practice, improve your care, and contact you when necessary. ***Example:*** *We use health information about you to manage your treatment and services.*
- **Bill for your services:** We can use and share your health information to bill and get payment from health plans or other entities. ***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. *For more information see:* www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- **Help with public health and safety issues:** We can share health information about you for certain situations such as:
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting suspected abuse, neglect, or domestic violence
    - Preventing or reducing a serious threat to anyone's health or safety
- **Do research**: We can use or share your information for health research.
- **Comply with the law**: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- **Respond to organ and tissue donation requests**: We can share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- **Address workers' compensation, law enforcement, and other government requests:** We can use or share health information about you for workers' compensation claims; for law enforcement purposes or with a law enforcement official; with health oversight agencies for activities authorized by law; and for special government functions such as military, national security, and presidential protective services.
- **Respond to lawsuits and legal actions:** We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE:

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site. The current notice is effective 8/10/16.

I acknowledge receipt of Boynton Beach Skin's Notice of Privacy Practices

_____ _____

Name of Patient Patient's Date of Birth

_____ _____

Signature of Patient (or Parent/Legal Representative) Date

FOR OFFICE USE ONLY (IF SIGNATURE NOT OBTAINED):

Patient Name and DOB: _____ ☐Refused to sign ☐Unable to sign because _____

Your Name:_____ Date: _____

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Arbitration Agreement

This agreement is made between **Skin Care Physicians/Boynton Beach Skin**, their physicians, agents, employees, servants, or any of the foregoing, referred to hereinafter as "Doctor" and_____, referred to hereinafter as the "Patient". It is the intention of the parties to this Doctor-Patient Agreement to bind not only themselves, but also their heirs, personal representatives, guardians, or any persons deriving claims through or on behalf of the Patient.

It is understood by the Patient that he or she is not required to use the aforesaid practice, or any physician named for **Dermatology** and that there are many other Physicians in Florida who are qualified for **Dermatology.**

It is further understood, that in the event of any controversy or dispute, which might arise between the Doctor and the Patient, regardless of whether the dispute concerns the medical care rendered, including any negligence claim relating to the diagnosis, treatment, or care of the Patient, or payment of fees, or any other matter whatsoever, then the parties agree that the dispute shall be resolved by arbitration as provided by the Florida Arbitration Code, Chapter 682, Florida Statutes. This arbitration shall be in lieu and instead of any trial by Judge or Jury. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. The panel of arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties and may be enforced by a court of law if necessary.

In the event that either party to this Doctor-Patient Agreement refuses to go forward with arbitration, the party compelling arbitration reserves the right to proceed with arbitration, the appointment of the arbitrator, and hearings to resolve the dispute, despite the refusal to participate or the absence of the opposing party. The arbitrator shall go forward with the arbitration or despite his or her absence at the arbitration hearing.

Prior to commencing any action under this Doctor-Patient Agreement, Patient must comply with the presuit notice and investigation requirements of Chapter 766, Florida Statutes. The Patient understands that the Patient has a constitutional right under Article 1, Section 21 of the Florida Constitution of Access to Courts as follows: "The courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial, or delay." The Patient understands and acknowledges that signing this Doctor Patient Agreement waives this right to trial by judge or jury and instead agrees to dispute settlement by arbitration.

Limitation of Damages

Florida law does limit non-economic damages, but this agreement does not further limit these damages.

The limitation of damages provision does not limit or restrict in any way the Patient's right to seek all economic damages actually incurred by the Patient, including any medical expenses and lost wages.

The Patient has had an opportunity to read this Doctor-Patient Agreement, or to have it read to him or her if necessary. The Patient understands English or has had the Doctor-Patient Agreement translated for him or her by_____. The Patient has had an opportunity to ask questions about this Doctor-Patient Agreement. The Patient understands this Doctor-Patient Agreement and has no unanswered questions. The Patient has not been coerced or compelled to sign this Doctor-Patient Agreement and does so of his or her own free will. The Patient may consult with an attorney before signing this Doctor-Patient Agreement.

BY SIGNING THIS DOCTOR-PATIENT AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient Signature: _____ Date: _____

Parent, Guardian, or Legal Representative Signature: _____

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Consent for Medical Evaluation and Treatment

I do hereby authorize the evaluation treatment as may be deemed advisable, desirable, or necessary for treatment of my condition by the licensed medical professionals of Boynton Beach Skin and their designees or upon me or my minor.

I further consent to the examination for diagnostic or investigational purposes and disposal of any tissue or parts which may be removed if needed.

I understand that medical and surgical treatment entail the risk of side effects, and I consent to this risk. I recognize the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of any treatments or procedures.

I hereby give my permission to my provider or any of the medical personnel at Boynton Beach Skin to take photographs for diagnostic purposes and insurance purposes. I agree that these photographs are the property of Boynton Beach Skin and my photographs can be used for teaching purposes, to illustrate scientific papers, books, or for use in general lectures; it is understood that in any such publication or use, I shall not be identified by name.

This consent is effective indefinitely.

I understand that this consent can be withdrawn at any time and that no procedures will be performed without my permission.

_____ _____
Name of Patient Patient's Date of Birth

_____ _____
Signature of Patient (or Legal Representative) Date

If signed by Legal Representative:
Printed name: _____ Basis of authority: _____

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Direction to the Office
Boynton Beach Skin
7740 Boynton Beach Blvd.
Boynton Beach, FL 33437
Ph: 561-752-8000

If you are coming from East Boynton Beach Blvd.

- Head west on Boynton Beach Blvd.
- Just past Hagen Ranch Road take your first left on Enterprise Drive (at the Chevron Gas station)
- Take you first right at Enterprise Center Circle (on the side of the gas station)
- Take Enterprise Center Circle until you see the clock tower, follow this road off to the right approximately 200 yards and you will see our office. We are a free-standing building.

If you are coming from 441(State Road 7)

- Head east on Boynton Beach Blvd
- Turn right at the first street east of the Turnpike called Enterprise Drive (you will see a Chevron gas station)
- Then take the first right at Enterprise Center Circle (on the side of the gas station)
- Take Enterprise Center Circle until you see the clock tower, follow this road off to the right approximately 200 yards and you will see our office. We are a free-standing building.

If you are coming from the Turnpike

- Exit Turnpike at Boynton Beach Blvd. and head east.
- Turn right at the first street called Enterprise Drive (you will see a Chevron gas station)
- Then take the first right at Enterprise Center Circle (on the side of the gas station)
- Take Enterprise Center Circle until you see the clock tower, follow this road off to the right approximately 200 yards and you will see our office. We are a free-standing building.