Welcome to

We would like to take this opportunity to personally welcome you to our practice and thank you for choosing Derrow Dermatology. In preparation for your upcoming appointment, please complete the forms below and bring them to your first visit (please do not mail them in advance). Please arrive 20 minutes before your scheduled appointment time so that we can process your paperwork at that time.

In addition, please bring the following information with you to your first appointment:

- Insurance card(s)
- Driver's License/Photo ID
- Medical Records/Test Results (applicable to your condition)
- Authorization/Referral from your Primary Care Physician (if required)
- List of your Medications/Dosages

If you are unable to keep your scheduled appointment time, please call our office immediately.

For further information about Derrow Dermatology, feel free to visit our website at: www.derrowdermatology.com, or call our office at 407-389-2020.

We look forward to seeing you soon!

Sincerely,

Derrow Dermatology Staff

PATIENT REGISTRATION FORM

Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs. ❑ Dr.	❑ Miss ❑ Ms.	Marital status ❑ Married ❑ Single ❑ Separated ❑ Divorced ❑ Widow

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Cell Phone: ❑Okay to text ( )	Birth date: / /	Age:	Gender: ❑ M ❑ F

Street Address:	Social Security Number:	Home Phone: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer/School:	Work phone: ( )

Primary Care Provider:	Preferred Pharmacy Name/Location:
Referring Physician:	How did you find us:

Email Address:

Other family members seen here: Name: ______________________________________

PERSON RESPONSIBLE FOR BILL

Legal Name: ❑ Mr. ❑ Mrs. ❑ Dr. ❑ Miss ❑ Ms. Gender: ❑ M ❑ F

____ SSN: _________________

(Last) (First) (Middle)

Relationship to Patient:	Birth date: / /	Address (if different from above):	Cell phone (if different from above): ( )

IN CASE OF EMERGENCY

Name of person to contact (other than spouse):	Relationship to patient:	Cell phone : ( )	Home phone : ( )

Address:

How may we contact you regarding follow-up, labs or biopsy results, etc?

- May we send a message via e-mail? ❑ Yes ❑ No
- May we leave a message on your answering machine at home? ❑ Yes ❑ No
- May we call you at work? ❑ Yes ❑ No
- May we call you on your cell phone? ❑ Yes ❑ No
- May we discuss your medical condition with any member of your household? ❑Yes ❑ No
- If yes, whom ______________________________ Relationship? ______________________

The above information is true to the best of my knowledge. I authorize Derrow Dermatology Associates LLC to perform procedures and treatment including the administration of medicine and local anesthetics along with other surgical and medical procedures that may be necessary. I authorize the release of any medical information necessary to process a claim and hereby assign benefits payable to Derrow Dermatology Associates LLC in the event of another health insurance becoming primary over my health insurance. Furthermore, any services not covered by my insurance will become my responsibility for full payment of services rendered by Derrow Dermatology Associates LLC.

____ ________________________

Patient/Guardian signature **Date**

DERROW DERMATOLOGY ASSOCIATES LLC
OFFICE FINANCIAL POLICY AND AUTHORIZATION FORM

**Please read the following policies so that you understand your responsibility regarding the charges for the services rendered to you by this office.

Basic Policy: Payment for service is due in full at the time service is provided in our office. Accounts that have balances more than 90 days past due may possibly be turned over to a collection agency unless previous arrangements have been made.

Medicare: We are Medicare participating providers. We will bill Medicare carriers. We will also bill the secondary insurance companies that we are contracted with for you. If no secondary insurance information is provided, patients will be responsible for 20%of the medicare allowable charge at the time of service. Any copayments, coinsurance and/or deductibles are due at the time of service. * * You will be asked to sign an Advance Notice of Liability Form in the event that a service is provided which we know is not covered by Medicare.

For Patients with Insurance: If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for all covered, medically necessary services rendered. We will bill both your contracted primary and secondary insurance carriers if proper and correct information is provided. Because of various time limits, insurance information must be filed correctly the first time. If incorrect information is given, then the patient will be responsible for payment in full. Copayments, Coinsurance and/or Deductibles are due at the time of service. I understand that it is the responsibility of the patient to obtain prior authorization from your primary care physician before each visit to our office. I understand that if this is not done, I will be responsible for any unpaid balance due.

Self Pay Patients: I have agreed to accept full responsibility for payment of any charges incurred to Derrow Dermatology Associates LLC and have agreed to pay for these services in full at time of service.

Non-covered Services: Any service not paid for by your existing insurance coverage will require payment in full at the time services are provided. These services are usually considered Cosmetic and will be discussed prior to being performed.

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Insured Name: ______________________________	Insured Name: ______________________________
Date of Birth: _______/________/________	Date of Birth: _______/________/________
SSN: _________-________-___________	SSN: _________-________-___________
Insurance: __________________________________	Insurance: __________________________________
ID#: ____________________ Group#: ____________________	ID#: ____________________ Group#: ____________________
Address: ____	Address: ____
Employer:	Employer:

Your Signature Will Serve For Any or All of the Following:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carrier and independent laboratories any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to me or to the party who accepts assignment. Regulation pertaining to Medicare assignment of benefits apply.

AUTHORIZATION OF MEDICAL RELEASE AND PAYMENT: We only file insurance claims to plans in which we participate. If you are not covered by one of the insurance plans that we participate in, then payment is expected at the time of service. I authorize the release of medical information necessary to process claims and also authorize payment of medical benefits to the physician. If insurance does not pay, I will become financially responsible for payment in full. I permit a copy of these authorizations to be used in place of this original which is on file at the physician's office.

LIFETIME SIGNATURE AUTHORIZATION FOR MEDICARE: I authorize the release of any medical information necessary to process a claim. I also request payment benefits either to myself or to the party who accepts assignment.

LIFETIME SIGNATURE AUTHORIZATION FOR MEDIGAP: I request that payment of authorized Medigap benefits be made on my behalf to Derrow Dermatology Associates LLC for any services furnished by Derrow Dermatology Associates LLC. I authorize any holder of medical information about me to release to the above Medigap carrier any information needed to determine these benefits or the benefits payable for related services. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim, because my signing this authorization will cause Medicare payment information concerning this Medicare claim, and because my signing this authorization will cause Medicare payment information to cross over automatically.

____ ____/____/_______

Patient/Legal Guardian Signature **Date**

Notice of Privacy Practices Acknowledgement and Consent

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:
The Notice of Privacy Practices tells you how we may use and share your health records. **Please read it.**

- We will use and share your health records to treat you and to bill for the services we provide.
- We will use and share your health records to run our business.
- We will use and share your health records as required by law.

All the ways we may use and share your health records are explained in more detail in the Notice of Privacy Practices.

You have the following rights with respect to your health records:
1. You have the right to look at and receive a copy of your health records.
2. You have the right to receive a list of whom we have given your health records to.
3. You have the right to ask for us to correct a mistake in your health records.
4. You have the right to ask that we not use or share your health records.
5. You have the right to ask us to change the way we contact you.

How would you like to receive your medical records? Fax Email Regular Mail
Please list that information here: ______________________________________
All of these rights are explained in more detail in the Notice of Privacy Practices.

I have received a copy of Derrow Dermatology Associates LLC Notice of Privacy Practices.

Signature: ______________________________ Date: ________________
(of Patient or Legal Representative)

Relationship of Legal Representative: ___________________________________

CONSENT:

I consent to the use and sharing of my health records for treatment, payment and operation purposes as described in the Notice of Privacy Practices. I know that if I do not consent, you cannot provide services to me.

Signature: ______________________________ Date: ________________
(of Patient or Legal Representative)

Relationship of Legal Representative: ___________________________________

Derrow Dermatology Associates LLC
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Amy E. Witt, M.D. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Derrow Dermatology Associates LLC 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.

Derrow Dermatology Associates LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Derrow Dermatology Associates LLC Privacy Officer at 800 N. Maitland Ave, Suite #202, Maitland, FL 32751.

With my consent, Derrow Dermatology Associates LLC 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, Derrow Dermatology Associates LLC 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 as long as they are marked Personal and Confidential.

With my consent, Derrow Dermatology Associates LLC may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements and laboratory results. I have the right to request that Derrow Dermatology Associates LLC 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 Derrow Dermatology Associates LLC, 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, Derrow Dermatology Associates LLC may decline to provide treatment to me.

____ ______/____/_______
Signature of Patient/Legal Guardian Date

______________________________ _________________________________
Patient's Name (print) Legal Guardian's Name (print)