FLORIDA COASTAL DERMATOLOGY ASSOCIATES

Lisa D. Zack, M.D
Bradley T. Kovach, M.D.
Janalea Thomas, PA-C
Lidia Starr, PA-C
Hillary Cachet, PA-C

Naples
801 Anchor Rode Dr., Suite 100
Naples, FL 34103
(239) 263-1717

Estero
19910 S. Tamiami Trail, Suite B
Estero, FL 33928
(239) 676-8677

Patient Name: _____

Name of Parent – If Child: _____

Social Security Number: _____ **Sex**: _____ **Marital Status**: _____

Date of Birth: _____

Local Address: _____

City: _____ **State**: _____ **Zip**: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____

Out of State Address:

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Business Number: _____

Effective Dates: Starting Date: _____ Ending Date: _____

Primary Care Physician/Referring Physician:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Phone Number: _____

Primary Insurance Company _____

Policy Number: _____ Group #: _____

Policy Holder Name: _____ DOB: _____

Secondary Insurance Company _____

Policy Number: _____ Group #: _____

Policy Holder Name: _____ DOB: _____

Spouse, Relative or Person to Notify in an Emergency:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

Pharmacy Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

If you would like to give us permission to communicate your clinical and/or financial information with another person (i.e. spouse, children, friends**) please specify names below. If no one, please state (none).**

_____

_____

_____

Patients Signature: _____ Date: _____

I authorize Florida Coastal Dermatology Associates (Lisa D. Zack, M.D., PA., and/or Bradley T. Kovach, M.D.) to release any and all medical records to my referring/primary care physician.

Signature: _____ Date: _____

I authorize Lisa D. Zack, M.D., P.A., and/or Bradley T. Kovach, M.D., Florida Coastal Dermatology Associates to release any and all medical records to my insurance company (s).
This authorization shall be valid for services and treatment received today and all future visits/treatments.

Signature: _____ Date: _____

I authorize payment of medical/surgical benefits to Lisa D. Zack, M.D., P.A., and/or Bradley T. Kovach, M.D., Florida Coastal Dermatology Associates.
I understand that I am responsible for payment in full of medical services provided by any of the above.

Signature: _____ Date: _____

FLORIDA COASTAL DERMATOLOGY
FLORIDA COASTAL SURGERY CENTER

FEE STATEMENT

The Physicians and staff are very concerned about the cost of health care. Considerable care has been taken in setting our fees. Our charges accurately reflect the complexity of care rendered and the skill and expertise required for care. Our fees are comparable with the fees of other dermatologists in this geographic region. Dr. Zack and Dr. Kovach have specialty training in dermatology, and subspecialized training in skin cancer removal (Mohs surgery), Dermatologic Surgery, Mini Facelifts, and Blepharoplasty.

Medicare/Medicaid Beneficiaries: We are a participating provider with Medicare. We will file your claim, and they will send a payment of 80% on allowed services. If you have a secondary, assignable insurance, Medicare will either send a claim electronically, or we will do so following Medicare's determination. You will be responsible for any deductible or co-insurance amounts, and non-covered services (i.e. cosmetic procedures), and you may be asked to pay those charges at the time services are rendered. We do not participate with any Medicaid plans, and are unable to file a claim with them.

Commercial/PPO Members: We participate with several commercial/group insurance plans. **It is your responsibility as the patient to verify with your insurance company whether a physician is an active participating provider.** You will be responsible for any non-covered services by your plan, as well as deductibles, co-payments, and co-insurance amounts. Applicable co-payments are to be paid at the time services are rendered.

HMO, POS, Etc.: Certain health insurances (HMO, POS, etc.) require that you obtain a referral or prior authorization from your Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it**. Failure to obtain the referral and/or authorization may result in a lower and/or no payment from the insurance company, and the balance will be your responsibility.** Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

FINANCIAL POLICY

You are ultimately responsible for payment of the services you receive. The service we render is to you, not your insurance company. Our agreement is with you, not your insurance company. If your insurance company does not make a payment on your claim within 45 days, you may be billed for the entire amount. Our physicians and staff are here to be of services to you, to give you professional, quality care. An additional charge of $35 will be applied to your account for returned checks. Delinquent accounts may be referred to an outside collections agency, and you will be responsible for all costs of collection including reasonable interest, reasonable attorney's fees (if a suit is filed) and collection agency fees up to 35% of the unpaid balance.

Pathology Services: If you have a tissue biopsy done, you will receive a separate bill from Dermpath Diagnostics in addition to your bill from Florida Coastal Dermatology, as their pathologists perform the analysis of the tissue biopsy. There may be times where additional diagnostic testing needs to be done at a referenced lab to support the diagnosis; therefore, you will receive an additional bill for these services if applicable.
Laboratory Services: If you receive laboratory services, such as blood tests, you may receive a bill from an outside laboratory, as they perform the analysis of the lab specimen. Services may/may not be covered by your insurance company.

If you have any questions about our financial and/or insurance reimbursement, please feel free to discuss them with our billing staff.

I have read the above policy. I understand and agree to the above policy.

_____ _____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE WITNESS

FLORIDA COASTAL SURGERY CENTER
NOTIFICATION OF ADVANCE DIRECTIVES

ADVANCE DIRECTIVES

In order to be in compliance with the Self-Determination Act (PSDA) and State law and rules regarding advance directives, the Facility requires each patient prior to scheduled procedures to read and acknowledge the Facility position on advance directives.

Advance Directives are statements that indicate the type of medical treatment wanted or not wanted in the event an individual is unable to make those determinations and who is authorized to make those decisions. The advance directives are made and witnessed prior to serious illness or injury. There are many types of advance directives, but the two most common forms are:

Living Wills. These generally state the type of medical care an individual wants or does not want if he/she becomes unable to make his/her own decisions.
Durable Power of Attorney for Health Care. This is a signed, dated, and witnessed paper naming another person as an individual's agent or proxy to make medical decision for that individual if he/she should become unable to make his/her own decisions.

In the event of a medical emergency or other life-threatening situation, resuscitation will be instituted in every instance and patients will be transferred to a higher level of care.

Any previously formulated advance directives will not be honored at the Facility. If for any reason you disagree with this policy, please discuss your concerns with your physician before arriving for your scheduled procedure.

I have read and acknowledge that the Facility does not honor Advance Directives.

Patients Signature _____ DOB _____ Date _____

Witness Signature _____ Date _____

If the patient is unable to sign or is a minor please sign.

Relative/Guardians Signature _____ Date _____

Witness Signature _____ Date _____

FLORIDA COASTAL DERMATOLOGY ASSOCIATES

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

Signature _____ Date _____

If applicable, reason for patient's refusal to sign_____

_____

ACKNOWLEDGMENT OF RECEIPT OF PATIENT BILL OF RIGHTS

I acknowledge that I have received the attached Patient Bill Of Rights.

Patient or Personal Representative Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

FLORIDA COASTAL DERMATOLOGY

NOTIFICATION OF CLINICAL SUMMARY AND AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Name: _____ Date of Birth: _____

Clinical Summary: I acknowledge that a Clinical Summary of my visit today is available to me for pick-up within 3 business days.

Authorization for Release of information: I voluntarily authorize and direct my healthcare provider, Florida Coastal Dermatology Associates, to release my health information to me in the form of the Clinical Summary.

Signature _____ Date _____ Witness _____

If individual is unable to sign this Authorization, please complete the information below:

_____
Name Guardian/Representative

Legal Relationship _____

Date _____ Witness _____

FLORIDA COASTAL DERMATOLOGY

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Florida Coastal Dermatology reserves the right to charge a fee of $50.00 for all missed appointments ("No Shows"). We expect our patients to call at least 24 hours in advance and inform our office if you cannot make your appointment.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name Date

_____

Signature

Name: _____ Date of Birth:_____

Medical History

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Other_____
None

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Colostomy
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)
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Liver: Hepatectomy
Liver: Liver Transplant
Liver: Shunt
Ovaries Removed: Endometriosis
Ovaries Removed: Ovarian Cyst
Ovaries Removed: Ovarian Cancer
Ovaries: Tubal Ligation
Pancreas Removed
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Rectum: APR
Rectum: Lower Anterior Resection
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy; Fibroids
Hysterectomy; Uterine Cancer
Hysterectomy; Cervical Cancer
Other _____
None

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Other _____

Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None

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)? _____
Any other family history: _____

Medications: (Please list all current medications – please include dosage, how many, and how often you take them - OR provide copy of medication list)

_____
_____
_____

Allergies: (Please list all allergies)

_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:	Alcohol Use:	How often do you exercise?	What is your Caffeine use?
Never smoked	None	Once a day	Once a day
Quit; former smoker	Less than 1 drink per day	A few times a week	A few times a week
Smokes less than daily	1-2 drinks per day	A few times a month	A few times a month
Smokes daily	3 or more drinks per day	Never	Never

Pharmacy: _____

Street: _____ **Zip Code:** _____

Occupation (if retired, previous occupation):_____

City & State of Residence: _____