

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Medical History

**Past Medical History:** (please circle all that apply)

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

**Past Surgical History:** (please circle all that apply)

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

**Skin Disease History:** (please circle all that apply)

- |                        |                           |
|------------------------|---------------------------|
| Acne                   | Hay Fever/Allergies       |
| Actinic Keratoses      | Melanoma                  |
| Asthma                 | Poison Ivy                |
| Basal Cell Skin Cancer | Precancerous Moles        |
| Blistering Sunburns    | Psoriasis                 |
| Dry Skin               | Squamous Cell Skin Cancer |
| Eczema                 | None                      |
| Flaking or Itchy Scalp |                           |
| Other _____            |                           |

**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)

<u>Cigarette Smoking:</u>	<u>Alcohol Use:</u>	<u>How often do you exercise?</u>	<u>What is your Caffeine use?</u>
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:** \_\_\_\_\_

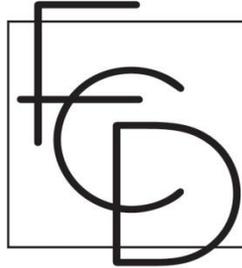
**Street:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

Occupation (if retired, previous occupation): \_\_\_\_\_

City & State of Residence: \_\_\_\_\_

FLORIDA COASTAL DERMATOLOGY ASSOCIATES

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Bradley T. Kovach, M.D.  
Kristen McLaughlin, PA-C  
Krista Koppenberger, PA-C  
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**Naples**  
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Naples, FL 34103  
(239) 263-1717

**Estero**  
1910 S. Tamiami Trail, Suite B  
Estero, FL 33928  
(239) 676-8677

**Patient Name:** \_\_\_\_\_

Name of Parent – If Child: \_\_\_\_\_ Parent Date of Birth: \_\_\_\_\_

**How Did You Hear About Us?** (Google Search, Word of Mouth, Facebook Ad, Welcome Wagon, etc)

\_\_\_\_\_

**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:** \_\_\_\_\_

**Protected Health Information Release:**

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 and phone below. If no one, please state (none). Cannot be left blank.**

\_\_\_\_\_  
\_\_\_\_\_

**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

We 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 or Gulf Coast Dermatopathology 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.

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**SIGNATURE OF RESPONSIBLE PARTY**

**DATE**

WITNESS

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## FLORIDA COASTAL SURGERY CENTER NOTIFICATION OF ADVANCE DIRECTIVES

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### 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.

\_\_\_\_\_  
**Patient or Personal Representative Signature**

\_\_\_\_\_  
**Date**

If applicable, reason for patient's refusal to sign

\_\_\_\_\_

## Acknowledgement of Receipt of Notice of Patient Bill of Rights

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

\_\_\_\_\_  
**Patient or Personal Representative Signature**

\_\_\_\_\_  
**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**

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FAX (239)676-8680

## Klara Communication Permissions

Florida Coastal Dermatology will be using the Klara system to help support the ease of communication between our offices and patients directly. This is a text message based system that allows our patients to easily contact our offices to make appointments, ask questions, and even received and submit linked documents directly to their personal charts. You will receive messages from the following number: 239-356-8095.

I, \_\_\_\_\_, give permission for Florida Coastal Dermatology to send me text message communications via the Klara system. These communications include but are not limited to; appointment reminders, office specific forms/documents, office specific marketing/sales opportunities, direct communications with office and clinical staff. I understand that I must receive an initial message from the system, but can opt out of this messaging system at any time.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

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## Patient Bill of Rights

The office of Florida Coastal Dermatology presents Patient's Bill of Rights with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, their provider, and the group organization. It is recognized that a personal relationship between the provider and the patient is essential for the provision of proper medical care. The traditional provider-patient relationship takes on a new dimension when care is rendered within an organizational structure. Legal precedent has established that the facility itself also has a responsibility to the patient. It is in recognition of these factors that rights are affirmed.

### The patient has the right to:

1. Respectful treatment with concern for individual, cultural, or educational difference.
2. Complete up-to-date information about conditions, treatments, and outlook for recovery.
3. Know who is responsible for the care provided.
4. Personal privacy and confidentiality in communication and medical records.
5. An explanation of the various types of care to be received.
6. Refuse treatment, except in some cases where lifesaving treatment is mandated.
7. Know any afflictions your hospital and provider(s) have with other institutions and providers.

### The patient has the responsibility to:

1. Provide accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other health related matters.
2. Report any unexpected change in condition to the responsible provider.
3. Say whether a contemplated course of treatment and the patient's obligation in its administration are understood.
4. Follow the treatment plan recommended by the provider. The patient is expected to follow up on their doctor's instructions, take medication when prescribed, and ask questions concerning their own health care that they feel is necessary.
5. Keep appointments or notify the appropriate person if it is not possible to do so.
6. Accept the consequences of choosing to ignore provider instructions or to refuse treatment.
7. To see that the financial obligations assumed in receiving health care are met as promptly as possible.
- 8.

### Patient Complaints:

If you are dissatisfied with any service you have received, please ask to speak to someone you are comfortable with so we may improve the quality of your care.

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No catalog of rights can guarantee for the patient the kind of treatment they have a right to expect. Within this facility, all activities must be conducted with an overriding concern for the patient and above all, the recognition of their dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient.

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## **Right to Request Restrictions:**

You may request, in writing, that we not use or disclose medical information about you for treatment, payment, or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request and work to accommodate it when possible, but we are not legally required to accept it. We will inform you of our decision on your request.

## **Requests for Confidential Communications:**

You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to communicate with you.

## **Change to this Notice:**

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice in waiting areas and exam rooms. You can receive a copy of the current notice at any time. The effective date is listed at the end. Copies of the current notice will be available each time you come to our facilities for treatment. You will be asked to acknowledge in writing your receipt of this notice.

## **Complaints:**

If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our practice's privacy officer at 239-263-1717.

If you are not satisfied with our response, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights, 200 Independence Avenue, S.W, Room 509F, HHH Building, Washington D.C. 20201. Under no circumstances will you be penalized or retaliated against for filing a complaint.

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## Notice of Privacy Practices

This notice describes how medical information about you can be used and disclosed and how you can get access to this information. Please review it carefully.

### Our pledge to you:

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of care and services you receive to provide quality care and to comply with legal requirements. We are required by law to:

1. Keep medical information about you private
2. Give you this notice of our legal duties and privacy practices with respect to medical information about you.
3. Follow the terms of this notice that is currently in effect.

### How we may use and disclose medical information about you:

We may use and disclose medical information about you without your prior authorization for treatment (such as sending medical information about you to a specialist as part of a referral), to obtain payment for treatment (such as sending billing information to your insurance company or Medicare), and to support our healthcare operations (such as comparing patient data to improve treatment methods or for professional education purposes).

Other examples of such uses and disclosures include contacting you for appointment reminders and telling you about or recommending possible treatment options, alternatives, health-related benefits or services that may be of interest to you.

We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give our medical information about you for public health purposes, abuse or neglect reporting, health oversight audits or inspections, medical examiners, funeral arrangements, organ donation, workers' compensation purposes, emergencies, national security and other specialized government functions, and for members of the Armed Forces as required by Military Command authorities.

We also disclose medical information when required by law enforcement in specific circumstances, or in response to a valid judicial or administrative orders or other legal process.

Under certain circumstances, we may use and disclose health information about you for research purposes, subject to a special approval process. We may also allow potential researchers to review information that may help them prepare for research, so long as the health information they review does not leave our facility and if they agree to specific privacy protection.

We may disclose medical information about you to a friend or family member whom you designate or in appropriate circumstances, unless you request restriction. We may also disclose information to disaster relief authorities so that your family can be notified of your location and condition.

**Other uses of medical information:**

In any other situations not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

**Right to access and or amend your records:**

In most cases, you have the right to look at or get a copy of medical information that we used to make decisions about your care, when you submit a request. If you request copies, we may charge a fee for the cost of copying, mailing, or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

If you believe that information in your record is incorrect or that important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information is not maintained by us, or if we determine that your record is accurate. You may submit a written statement of disagreement with a decision by us not to amend a record.

**Right to an accounting:**

You have the right to request a list accounting for any disclosure of your health information we have made, except for uses and disclosures for treatment, payment, and healthcare operations, circumstances in which have specifically authorized such disclosure and certain exceptions.

To request this list of disclosures, indicate the relevant period which must be after April 14, 2003 but in no event for more than the last six years. You must submit your request in writing.