DERM 360

TopLine MD Alliance

Patient Information

Name: _____

Date of Birth: _____

Sex: ___Male ___Female

Address: _____

City: _____ State: _____ Zip code: _____

Cell: _____ Home: _____

Email Address: _____

Primary Care Physician: _____

Primary Care Physician Phone Number: _____

Parent/Guardian information (for minors only)

Name: _____

Date of Birth: _____

I hereby authorize payment, directly to Derm360 of benefits due to me from my insurance company, otherwise payable to me. I further authorize the release of any medical information required by my insurance carrier. I understand that I am financially responsible for charges, lab work and vaccines not covered by my insurance contract as performed in the office, and for any co-payment an/or deductible amount as specified in my insurance contract. I acknowledge that private health information material (HIPAA) is posted and available upon request.

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Insurance Information

Primary Insurance

Insurance company: _____

Insured/card holder name: _____ Date of birth: _____

Relationship: _____

Phone: _____

Member ID: _____ Group: _____

Secondary Insurance

Insurance company: _____

Insured/card holder name: _____ Date of birth: _____

Relationship: _____

Phone: _____

Member ID: _____ Group: _____

Pharmacy Information

Name: _____ Phone: _____

Address: _____

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Financial Policy

Patient Name: _____ Date of Birth: _____

_____ You are responsible for providing accurate information regarding your health insurance and for knowing your health insurance plan benefits. Prior to your visit, our office has checked:

- Insurance is active
- Deductible and copay amount for an office visit

_____ If a procedure is performed, you may be responsible for payment if is not covered by your insurance. Please review all insurance correspondence.

_____ All insurance copays and deductibles must be paid at the time of service.

_____ _____

Patient's signature Date

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Medical History

Patient Name: _____ DOB: _____

Reason for visit today? _____

_____

Duration: _____

Past treatments: _____

Current treatments: _____

Medical Conditions: _____

_____

Prior Surgeries or hospitalization and dates: _____

_____

_____

Current medications: _____

Allergies: _____

Family History: Skin Cancer: Basal Cell/Squamous Cell/ Melanoma

___ Abnormal Moles

___Diabetes

___High Cholesterol

___Eczema

___ Asthma

___Hyper/Hypo Blood Pressure

E-mail Consent & Acknowledgment Form

Dermatology360, LLC

1 RISK OF USING E-MAIL TO COMMUNICATE WITH YOUR PROVIDER:

Provider offers patients the opportunity to communicate by e-mail Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail communication. These include, but not limited to, the following risks:

a E-mails can be circulated, forward, and stored in numerous paper and electronic files

b. E-mails can be immediately broadcast worldwide and be received by unintended recipients

c E-mail senders can easily type in the wrong email address

d E-mail is easier to falsify handwritten or signed documents

e. Backup copies of e-mail may exist even after the sender or recipient has deleted his or her copy.

f Employers and on-line services have a right to archive and inspect e-mails transmitted through their system.

g. E-mail can be intercepted, altered, forward, or used without authorization or detection.

h. E-mail can be used to introduce viruses into the computer system.

i E mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL:

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of email for patient information Consent to the use of e-mail includes agreement with the following conditions.

a All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record will have access to those e-mails.

b. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.

c The patient is responsible for protecting his/her password or other means of access to e-mail. Provider s not liable for breaches of confidentiality caused by the patient or any third party.

d Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.

e It is the patient's responsibility to follow-up and/or schedule an appointment

3. PATIENT RESPONSIBILITIES AND INSTRUCTIONS:

E-mail Consent & Acknowledgment Form

To communicate by e-mail, the patient shall:

a. Limit or avoid using his/her employer's computer.

b Inform Provider of changes in his/her e-mail address.

c. Confirm that he/she has received and read the e-mail from the Provider.

d. Put the patient's name in the body of the e-mail.

e Include the category of the communication in the e-mail s subject line, for routing purposes (e.g. billing and questions).

f. Take precautions to preserve the confidentiality of e mail, such as using screen savers and safeguarding his/her computer password.

g. Withdraw consent only by e-mail or written communication to Provider.

4. TERMINATION OF THE E-MAIL RELATIONSHIP

The Provider shall have the right to immediately terminate the e mail relationship with you if determined in the sole Provider's discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the Provider determines to be unacceptable.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Provider or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. I agree to the instructions outlined herein, as well as any other instructions that my Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

HOLD HARMLESS

I agree to indemnify and hold harmless the Provider and its trustees, officers, directors, employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider, and any breach by me of these restrictions and conditions.

Patient Name (Print) : _____

Patient Signature : _____ Date : _____

Patient Email: _____

Notice of Privacy Practice Acknowledgement

Dermatology360,LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name or Legal Guardian (print) _____ Date _____

Signature _____

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

CONSENT FOR VOICE AND TEXT MESSAGING COMMUNICATION

In an effort to relay Normal results faster to our patients we have implemented Electronic Medical Records.

I understand that in order for *(Dermatology360,LLC)* to leave detailed messages containing specific medical information on my voicemail or answering machine, I need to give my permission to *(Dermatology360,LLC)*.

I further understand that in order for *(Dermatology360,LLC)* to text detailed messages containing specific medical information to my cell phone I need to give my written express permission to *(Dermatology360,LLC)* I also understand that my healthcare information at *(Dermatology360,LLC)* is protected and a copy of the Notice of Privacy Practices is available upon my request.

Consent for Messages

I give my written express consent to *(Dermatology360,LLC)* to leave detailed messages on my voicemail/answering machine about my NORMAL lab results, diagnostic and/or imaging results, prescription information, or appointment reminders.

- No abnormal results will be communicated via our automated system.

Patient Name (Please Print):_____Date:_____

Patient Signature:_____Cell #:_____
(this number will be used for messaging)

It is my responsibility to keep this information up to date, as I recognize that my information may change over time. This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that I must provide written notice in order to revoke this consent.

CONSENT, PERMISSION AND RELEASE
FOR USE OF PHOTO, VIDEO AND/OR AUDIO

I hereby give consent and permission to Dermatology360,LLC to record the appearance, physical likeness and/or voice on videotape, on film, or digital video disk, or other means, and/or take photographs of the appearance of (print name) _____, age (if minor) _____.

Notwithstanding any prohibition as may be contained in Section 540.08, Florida Statutes, I hereby freely and voluntarily consent to the use and publication of my name, participation, picture, and/or likeness by Dermatology360,LLC and/or its employees and/or agents, as well as the entity seeking this consent, and photographs, video and/or audio for any and all purposes including, but not limited to, educational, promotional, advertising, and trade, through any medium or format, including, but not limited to, film, photograph, television, radio, digital, internet, or exhibition, at any time from this date forward until I revoke this consent in writing.

I acknowledge that Dermatology360, LLC is the sole owner of all rights in, and to, this visual and/or sound production and/or photograph(s) and the recordings, thereof, and that it has the right to use or reproduce the resulting images and/or sound as often as it finds necessary. I acknowledge that the photographs, video and/or audio may be used indefinitely by television, radio, newspapers, magazines, newsletters, brochures, Internet, intranet, or in other media once released.

Dermatology360, LLC has the right, among other things, to edit and/or otherwise alter the visual or sound recording, or photographs, as needed. I understand I will receive no compensation for the appearance of the above-named person or for participation in said productions. I agree to hold Dermatology360, LLC, its employees and other parties harmless against claim, liability, loss, or damage caused by, or arising from, my participation in this production.

I have read this Consent before signing and fully understand the contents, meaning and impact of this consent. I understand that I am free to address any specific questions and have done so prior to signing this Consent.

Name: _____

Address: _____

Telephone: _____ Email address: _____

Signature: _____ Date: _____

Name of Parent/Legal Custodian (under age 18): _____

Signature of Parent/Legal Custodian (under age 18): _____

Witness Name: _____

Witness Signature: _____ Date: _____

I am revoking this consent. I understand that every effort will be made to remove the item from the site within a reasonable timeframe. I also understand that this file may have been copied without permission, and I agree not to hold Dermatology360, LLC responsible for instances of these violations.

Signature: _____ Date: _____