ADVANCED DERMATOLOGY SPECIALTIES
DR. JANET CHENG
326 DEL PRADO BLVD NORTH SUITE 301
CAPE CORAL, FL 33909

Thank you for scheduling an appointment at our office. Enclosed you will find the paperwork needed for this appointment. Please remember to bring in your photo ID and insurance card(s) and arrive 20 minutes early. If you have any questions please feel free to contact our office at 239-458-1131. We are open Monday thru Friday from 8:00am to 4:30pm. Our address is 326 Del Prado Blvd North Suite 301 in Cape Coral Fl 33909. We are located on the West side of Del Prado Blvd between Hancock Bridge Parkway and Pine Island Rd. We are on the corner of NE 3rd Terrace at the traffic light. The Racetrac gas station is a good landmark. We are to the right of it and the building name is Tuscan Place and we are on the 3rd floor.

We look forward to seeing you!!!

Fort Myers Dermatopathology, P.A. / Advanced Dermatology

Mazen Daoud, MD *Janet, Cheng, MD* *John L. Snow, MD*

Christal DiMarco, PA-C *Enid Martinez, PA-C*

12580 University Drive	*Suite 200*	*Fort Myers, FL 33907*	*239-274-0005*	*fax239 274-8185*
326 Del Prado Blvd N.	*Suite 301*	*Cape Coral, FL 33909*	*239-458-1131*	*fax239-458-7789*
11821 Palm Beach Blvd	*Suite 123*	*Ft Myers, FL 33905*	*239-690-0060*	*fax239-690-0079*
9250 Corkscrew Rd	*Suite 5*	*Estero, FL 33928*	*239-949-2366*	*fax 239-949-3641*

Patient Registration

Chart #: _____

Mr., Mrs., Ms, Miss, Dr. _____
First MI Last

Date of Birth: ____/____/____ Married Single Divorced Widowed **Spouse name:** _____

Social Security # ____-____-____ **Sex:** Male / Female

Ethnicity: Hispanic or Latino / non-Hispanic or Latino / unknown / Decline

Race: American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Pacific Islander / White / Other Race / Decline

Permanent Mailing Address _____
Street City/State Zip Code

Are you a full time Florida resident? No Yes (If part time Florida resident, please provide alternate address)

Alternate Address: _____
Street City/State Zip Code

WHAT IS BEST WAY FOR US TO CONTACT YOU?		**PREFERRED**	**EMERGENCY**
Home Phone Number:	(___) _____	_____	_____
Cellular Phone:	(___) _____	_____	_____
Work Number:	(___) _____	_____	_____
May we leave a message with a member of your household? Yes / No	**If yes, with whom?** _____		
EMAIL:	_____@_____.COM	_____	_____

Patient Occupation: _____ **Employer:** _____

Spouse's Name: _____ **Employer:** _____

Emergency Contact: _____ **Contact Number:** _____

If the patient is under the age of 18, both parent's names and employers must be given:

Guarantor (Responsible Party): Name: _____ Relationship: _____

Social Security Number: _____ **Date of Birth:** _____

Release of Information
(All patients must sign)

I authorize the release of medical information to my primary care or referring doctor, Laboratories, and as necessary to insurance companies to process insurance claims, insurance applications and prescriptions. I understand that I am ultimately responsible for any and all services to me at the time of service.

Patient or Guarantor Signature _____ Date _____

11.25.2014 mmb

Please fill out the following information regarding any results calls. Thank You!

Date: _____ Name: _____ Date of Birth: _____

What is the best way for us to contact you?

Home Phone Number: _____

Cell Phone Number: _____

Work Number: _____

If we are calling with Biopsy/Lab Results:

May we leave a message with the results with a member of your household? Yes / No If Yes with whom? _____

May we leave a message with the results on your voicemail/answering machine? Yes / No

If you choose No to the above we will leave a message asking you to call our office back.

Medical History

Primary care/Family Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

PLEASE PROVIDE PHARMACY INFORMATION FOR ELECTRONIC PRESCRIPTIONS:

PHARMACY: _____

LOCATION: _____

PHONE NUMBER: _____

FAMILY & PAST MEDICAL HISTORY.....PLEASE MARK ANY CONDITIONS THAT APPLY NONE ☐

	PERSONAL	*FAMILY*		PERSONAL	FAMILY
ANXIETY			HYPERTENSION		
ARTHRITIS			HIV/AIDS		
ASTHMA			HYPERCHOLESTEROLEMI		
BPH			HYPERTHYROIDISM		
COPD			HYPOTHYROIDISM		
DEPRESSION			LEUKEMIA		
DIABETES			LYMPHOMA		
RENAL DISEASE			RADIATION TREATMENT		
GERD			SEIZURES		
HEARING LOSS			STROKE		
HEPATITIS					
CANCER			_____		
TRANSPLANTS			_____		
HEART ISSUES			_____		

SURGICAL HISTORY NONE ☐

_____ DATE:_____ COMMENTS: _____

_____ DATE:_____ COMMENTS: _____

_____ DATE:_____ COMMENTS: _____

SKIN DISEASE HISTORY.....PLEASE MARK ANY CONDITIONS THAT APPLY NONE ☐

	PERSONAL	*FAMILY*		*PERSONAL*	*FAMILY*
ACNE			HAY FEVER/ALLERGIES		
ACTINIC KERATOSES			MELANOMA		
BASAL CELL CARCINOMA			POISON IVY		
DRY SKIN			PRECANCEROUS MOLES		
ECZEMA			PSORIASIS		
FLAKING OR ITCHY SCALP			SQUAMOUS CELL CARCINOMA		

_____ DATE:_____ COMMENTS: _____

_____ DATE:_____ COMMENTS: _____

_____ DATE:_____ COMMENTS: _____

DO YOU TAN IN A TANNING SALON? YES NO

(PLEASE FINISH ON PAGE 2)

Medical History Continued

MEDICATION HISTORY

Please list you current medications, dosage, and frequency, encluding blood thinners.

NONE ☐

_____ _____

_____ _____

_____ _____

Do you have any allergies to medication or medical supplies? YES NO

If yes, please list the medication in the box and circle your reaction

Anaphylaxis Angioedema Diarrhea Dizziness Fatigue GI upset Hives Liver toxicity

Nausea Rash Shortness of breathe Swelling Weal Other

_____

_____

_____

SOCIAL HISTORY

SMOKING STATUS:

Current everyday smoker occassional rare

started smoking date: _____

quit smoking date: _____

number of packs per day: _____

total years smoked: _____

Date of last flu vaccination _____

Date of last pneumonia vaccination _____

_____ drug use

_____ iv drug use

_____ Do you feel safe at home?

_____ Do you feel unsafe at home?

How often do you exercise? _____

How often do you use caffeine? _____

INSURANCE INFORMATION

(PLEASE FILL OUT IF THE POLICY HOLDER IS SOMEONE OTHER THAN THE PATIENT.)

Policy Holders Name:_____ **Policy Holders DOB:**_____/_____/_____

Policy Holders address: _____**City** _____**State**_____ **Zip**_____

Policy Holders Social Security # _____-_____-_____ (Required for filing insurance claims)

Patient's Relationship to Policy Holders (please circle one): Spouse or Child

I authorize Fort Myers Dermatopathology to release to my insurance company any information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to Fort Myers Dermatopathology.

Patient Signature: _____ **Date**_____/_____/_____

IS THE PATIENT IN A SKILLED NURSING FACILITY, NURSING HOME, OR HOSPICE? _____

IF YES, PLEASE PROVIDE INFORMATION: _____

_____

CONTACT PERSON: _____

MEDICARE PATIENTS

I authorize Fort Myers Dermatopathology to release to the Social Security Administration and Health Care Finance, or its intermediaries, any information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to
Fort Myers Dermatopathology.

Signature _____ Date_____/_____/_____

Secondary insurance to Medicare
(Copy of insurance card must be given.)

Company name _____ Policy # _____

Address _____ Phone # _____

Policy Holders Name _____ DOB _____/_____/_____

Social Security # _____-_____-_____

11.25.2014mmb

ADVANCED DERMATOLOGY SPECIALTIES

FORT MYERS DERMATOPATHOLOGY, P.A

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for FORT MYERS DERMATOPATHOLOGY, P.A / ADVANCED DERMATOLOGY SPECIALTIES (ADS) to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Notice of Privacy Practice provides a more complete description of such uses and disclosures.

I have the right to view the Notice of Privacy Practices prior to signing the consent. ADS 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 ADVANCED DERMATOLOGY SPECIALTIES 12580 University Drive Suite # 200 Fort Myers, FL 33907.

With this consent, ADS may call my home or other alternative locations and leave a message on the 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 calls pertaining to my clinical care, including laboratory results among others.

With this consent, ADS may mail to my home or other alternative 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 this consent, ADS may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards patient statements. I have the right to request that ADS 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 for FORT MYERS DERMATOPATHOLOGY, P.A / ADVANCED DERMATOLOGY SPECIALTIES use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, for FORT MYERS DERMATOPATHOLOGY, P.A / ADVANCED DERMATOLOGY SPECIALTIES may decline to provide treatment to me.

_____ _____ _____

Signature of Patient, Legal Guardian **Patient Name** **Date**

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of FORT MYERS DERMATOPATHOLOGY, P.A / ADVANCED DERMATOLOGY SPECIALTIES (ADS) Notice of Privacy Practices, and a copy of the consent for **Use and Disclosure of Protected Health Information,** which details how my information may be used and disclosed under state federal laws. I understand the consent of these notices.

_____ _____ _____

Signature of Patient, Legal Guardian **Patient Name** **Date**

ADVANCED DERMATOLOGY SPECIALTIES FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. ***ADVANCED DERMATOLOGY SPECIALITIES*** accepts cash, personal checks, Visa, MasterCard, American Express and Discover. There is a service charge for returned checks of $20.00.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments. We realize that financial difficulty is a reality. In such circumstances, we may advise you to speak with our billing office to make arrangements for payment.

PATIENT RESPONSIBILITY

It is the patient's responsibility to provide ***ADVANCED DERMATOLOGY SPECIALITIES*** the current insurance coverage information at the time of the visit. We are not responsible for benefits subject to the deductible or non-covered benefits.

INSURANCE

We bill participating Insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 60 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

For self-pay patients, with NO insurance coverage, we have self-pay rates that must be paid in full at time of service.

We do not bill secondary insurance companies unless it is Medicare, or prior authorization has been made with our billing office.

If you need assistance or have questions, please contact the Billing Office between 8:00AM and 4:30 PM, Monday through Friday at 239-274-0228.

MANAGED CARE

If you are enrolled in a managed care insurance plan (i.e., HMO), you will need to obtain a referral and or authorization from your PCP office before seeing a specialist. Retroactive referrals are not guaranteed.

I have read and understand the ***ADVANCED DERMATOLOGY SPECIALITIES*** financial policy. I agree to assign insurance benefits to ***ADVANCED DERMATOLOGY SPECIALITIES*** wherever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for the costs of collections.

Patient Name: _____ ***DOB:*** _____

Signature of Patient/Guarantor: _____ ***Date:*** _____

Authorized Representative: _____ ***Date:*** _____

Updated 3.7.2017