

HIPAA PRIVACY CONSENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has the right to request and review our Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

This Consent was signed by:

Signature - Patient, Parent/Guardian/Personal Representative

Date

Print Name - Patient, Parent/Guardian/Personal Representative

Relationship to Patient



Skin & Laser Medical Center

DR. DYAN HARVEY-DENT
Phone(813)684-9600 Fax(813)662-9777

4325 Lynx Paw Trail
Valrico, FL 33596

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Patient's Name: _____ **Patient's DOB:** _____

As a patient, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit. Not all services are covered in all insurance contracts. If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges. To find out what your insurance plan covers and what your financial obligation may be, call the customer service or member services department of your insurance company (the phone numbers are on your insurance card). Your employer's human resources department may also be a source of information and assistance.

While you may have insurance coverage to pay your medical bills, you are ultimately responsible for all charges. You are responsible to notify us of your insurance and to provide the necessary information about your insurance plan; therefore, please have your current insurance card with you at all times, as well as a photo ID such as a driver's license, military ID, or government issued ID.

Make sure the physician is listed as a participating provider with your insurance company. If not listed, contact your plan's customer service department. It is your responsibility to know your insurance company's patient responsibilities and procedures. If proper procedures are not followed, you may be liable for full payment of the services rendered.

Benefit and coverage rules and policies differ among insurers and even between different plans of the same insurer. If you go to an out-of-network provider, your insurance company may only pay a percentage of the rates they determine are usual, customary, and reasonable (UCR) rates. You will be responsible for the amount of charges over the insurer's UCR plus your usual deductible and co-payment. Your insurance company can assist you in finding an in-network provider to limit the expense you will have to pay for care.

I have read and understand the above statements. I accept full financial responsibility and will be responsible for settlement of this account.

Signature - Patient, Parent/Guardian/Personal Representative

Date

Print Name - Patient, Parent/Guardian/Personal Representative

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****APPOINTMENT POLICY****

TO AVOID EXCESSIVE WAIT TIME FOR YOU AND OTHER PATIENTS SCHEDULED, WE ASK THAT YOU PLEASE ARRIVE ON TIME. PLEASE BE ADVISED THAT WE RESERVE THE RIGHT TO RESCHEDULE AN APPOINTMENT IF A PATIENT IS MORE THAN 15 MINUTES LATE.

****CANCELLATION POLICY****

IN AN EFFORT TO MAINTAIN PATIENT SATISFACTION AND EFFICIENT PATIENT SCHEDULING, THIS OFFICE HAS A CANCELLATION POLICY THAT REQUIRES AT LEAST 24 HOURS NOTIFICATION OF A SCHEDULED APPOINTMENT. IF A PATIENT FAILS TO KEEP HIS/HER APPOINTMENT, HE/SHE WILL BE CHARGED \$35. THIS COST WILL BE THE RESPONSIBILITY OF THE PATIENT AND IS NOT COVERED BY INSURANCE.

PLEASE NOTE: WE REQUIRE AT LEAST 48 HOURS NOTIFICATION OF CANCELLATION FOR SATURDAY APPOINTMENTS OR APPOINTMENTS WITH MORE THAN AN HOUR TIME SLOT. IF A PATIENT FAILS TO KEEP HIS/HER APPOINTMENT, HE/SHE WILL BE CHARGED \$50.

I CERTIFY THAT I HAVE READ THE FINANCIAL AND CANCELLATION POLICIES OF SKIN AND LASER MEDICAL CENTER AND AGREE TO ABIDE BY THEM.

Signature: _____ Date: _____

****CONSENT FOR PHOTOGRAPHY****

I, THE UNDERSIGNED, DO HEREBY AGREE TO THE FOLLOWING. I AM ALLOWING DR. HARVEY-DENT, OR A STAFF MEMBER, TO TAKE PHOTOS OF MY TREATMENT AND/OR TREATED AREAS TO BE USED FOR THE PURPOSE OF MONITORING MY PROGRESS AND/OR EDUCATION.

AT MY REQUEST MY IDENTITY WILL REMAIN ANONYMOUS. _____ (PLEASE INITIAL)

***MAY WE USE YOUR PHOTOS FOR OUR BEFORE AND AFTER BOOK FOR IN OFFICE USE ONLY?**

Print Patient Name

Patient Signature

Witness

Date



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MEDICAL HISTORY

Please complete the following: Date: _____ SS#: _____ DOB: _____

Name: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: (____) _____ Cell: (____) _____

Employer: _____ Work Number: (____) _____

Marital Status: Married Widowed Single Divorced Separated Living Alone

Do you have a Living Will? Yes No Healthcare Surrogate/Proxy Yes No

Emergency contact Person(s): _____ Phone# _____

Reason for today's Visit? _____

Are you under a physician's care Yes No If yes, Physician's Name: _____

Are you allergic to any medications? Yes No If yes, Please specify: _____

List all medications with doses that you are currently taking: _____

Hospitalizations, Operations, Illnesses, Injuries, & Medications

Were you hospitalized within the past year? Yes No If yes, list reason(s) and date(s): _____

Have you had any surgeries/operations? Yes No If yes, list type of procedure(s) and date(s): _____

List any other past accidents, injuries, or major illnesses not mentioned above. Also include dates: _____

Have you ever had any blood transfusion? Yes No If yes give date(s) _____

Do you have now, or have you ever had diseases or conditions of (Check YES or NO):

Arthritis/Joint Deformity	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart Murmur	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Artificial Joint	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bladder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Immunodeficiency Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Blood Clots	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Irregular Heartbeat	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Kidney	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cataracts/Glaucoma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Liver or Gallbladder Diseases	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Convulsions, Epilepsy, Seizure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Mitral Valve Prolapse	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Pacemaker	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Emotional/Psychiatric	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Phlebitis (inflammation of veins)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Gastrointestinal Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Polycystic Ovaries	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hearing Loss	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Thyroid	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Attack	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Tuberculosis or Lung Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Venereal Diseases	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Do you have a family history of any of the conditions listed below? (Check YES or NO, if yes which member):

M-Mother, F-Father, B-Brother, S-Sister

- Cancer Yes No (Circle: M, F, B, S) Type _____
- Diabetes Yes No (Circle: M, F, B, S) _____
- Heart Disease Yes No (Circle: M, F, B, S) _____
- High Blood Pressure Yes No (Circle: M, F, B, S) _____
- Mental Illness Yes No (Circle: M, F, B, S) _____
- Thyroid Disease Yes No (Circle: M, F, B, S) _____

Social History:

How many days per week do you drink? Liquor _____ Beer _____ Wine _____ Don't Drink Alcohol _____

Do you or have you ever smoked? Yes No If yes, # of cigarettes/day _____ for how many years _____
If you are an ex smoker, what year did you quit? _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

Please print the name of Patient, Guardian, or Personal Representative Relationship to Patient

Reviewed and Updated paperwork on: _____



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DERMATOLOGY MEDICAL HISTORY

Acne: My skin is: oily dry combination

Yes No

- Do you have a history of breakouts? If so, what is the frequency of your breakouts? Frequent Occasional Rarely
- Do you have any scarring as a result from your acne?
- Have you been on Accutane in the last 6 months?

Skin Background:

Yes No

- Have you ever had skin cancer?
- Has anyone in your family had skin cancer? If yes, what type? _____
Whom? _____
- Do you have a history of any specific skin diseases? If yes, please explain.

- Do you bleed easily?
- Do you develop keloid scars after surgery?
- Do you use tanning beds?
- Do you use sunscreen on a regular basis?
- Are you prone to cold sores/fever blisters?
- Do you have rosacea?
- Do you use Retin-A, Glycolic acid, Hydroquinone (skin bleaching agent) products? If yes, please specify. _____

What type of skin care products do you use? _____

Please list any medications that make you sensitive to light: _____

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Guardian or Personal Representative

Relationship to Patient

Skin and Laser Medical Center

Dyan J. Harvey-Dent, D.O.

Patient Registration Sheet 2010

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

Mailing Address: _____ **City:** _____ **ST:** _____ **Zip:** _____

Marital Status: _____ **SSN:** _____ **Driver's License:** _____ **ST:** _____

Home Phone: _____ **Work:** _____ **Cell:** _____

Email : _____ **Occupation:** _____ (Please indicate if student)

Spouse/Parent Name if Minor: _____ **SSN:** _____

Spouse/Parent DOB: _____ **Employer:** _____

Emergency Contact (Other than spouse or parent): _____

WOULD YOU LIKE YOUR MEDICAL INFORMATION RELEASED TO ANY FAMILY MEMBERS?	YES / NO
IF YES, WHOM? _____	Relationship: _____
Would you like messages left on your answering machine?	YES / NO
Primary Insurance: _____	Additional Insurance: _____
Policy Holder Name: _____	Policy Holder Name: _____
Member ID: _____	Member ID: _____
Policy Holder DOB: _____	Policy Holder DOB: _____
Primary Insurance Annual Deductible: _____	Met: _____ COPAY: _____
Other Insurance Annual Deductible: _____	Met: _____ COPAY: _____
Please be prepared to show proof of your deductible being met if you met it in another office. Your insurance can provide you with this.	

I understand that I am responsible for all fees regardless of insurance coverage, and that charges are due at time of service unless other arrangements have been made in advance of treatment. If Skin and Laser Medical Center does bill my insurance, I authorize them to release any or all of my medical records to my insurance companies for assigned payment of medical benefits. I also understand that I will be billed separately by the laboratory for any lab tests that are sent out for testing. Consent is hereby given to the treating physician or nurse practitioner to administer treatment and to perform such medical and/or surgical procedures that are deemed necessary for treatment.

Signature: _____ **Printed Name:** _____

Date: _____ **Updated:** _____ / _____ / _____



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HEALTH MAINTENANCE LOG

ADULT

Patient Name: _____

DOB: _____

HEALTH MAINTENANCE	DATE	DATE	DATE	DATE	DATE	DATE	DATE
Annual PE							
Pelvic / PAP / Breast Exam							
Skin Cancer Screening							
Mammogram							
Bone Density							
Prostate / PSA							
EKG							
Cholesterol Screen / LDL							
Thyroid Function / TSH							
Colonoscopy Age 50 >							
Tetanus							
PPD							

DIABETES MELLITUS MANAGEMENT (Yearly)	DATE	DATE	DATE	DATE	DATE	DATE	DATE
HgbA1c							
Lipids							
Serum K+							
Serum Creatinine							
Urine – Microalbum: Creatinine ratio							
Eye Exam							
Influenza Vaccine							
Pneumo. Vaccine							



Skin & Laser
Medical Center
DR. DYAN HARVEY-DENT

AUTHORIZATION TO PROVIDE MEDICAL CARE TO A MINOR

I, _____, AS PARENT/LEGAL GUARDIAN FOR THE PATIENT, _____, AUTHORIZE DR. DYAN HARVEY-DENT AND HER ASSOCIATES, TO TREAT AND/OR PROVIDE ANY NECESSARY MEDICAL CARE TO THE ABOVE PATIENT WITHOUT MY PRESENCE AT THE TIME MEDICAL CARE IS RENDERED.

THIS AUTHORIZATION IS GOOD:

___ FOR TODAY'S DATE ONLY

___ INDEFINITELY OR UNTIL WRITTEN NOTICE IS RECEIVED VOIDING THIS AUTHORIZATION

PRINTED NAME OF PATIENT (MINOR) _____

PRINTED NAME OF PARENT/LEGAL GUARDIAN _____

SIGNATURE OF PARENT/LEGAL GUARDIAN _____

TODAY'S DATE _____

PLEASE HAVE MINOR BRING IN THIS FORM OR FAX BACK TO (813) 662-9777

ADULT IMMUNIZATION RECORD

Always carry this record with you and have your healthcare professional or clinic keep it up to date.

Last name M.I.

Birthdate: (mo.) - (day) - (yr.)

First name M.I.

Printed by Immunization Action Coalition, Saint Paul, MN
www.immunize.org • www.vaccineinformation.org

Vaccine	Type of vaccine	Date given mo/day/yr	Healthcare professional or clinic	Date next dose due
Hepatitis B (HepB, HepA-HepB)				
Hepatitis A (HepA, HepA-HepB)				
If combo				
Measles, Mumps, Rubella (MMR)				
Varicella (VAR) (chickenpox)				
Zoster (shingles)				
Tetanus, Diphtheria, (Pertussis) (Td, Tdap)				

Last name First name M.I.

Medical notes (e.g., allergies, vaccine reactions):

Item # R2005 (8/09)

Vaccine	Type of vaccine	Date given mo/day/yr	Healthcare professional or clinic	Date next dose due
Pneumococcal (PPSV23, PCV13)				
Influenza (TIV, LAIV)				
Human Papillomavirus (HPV4, HPV2)				
Meningococcal (MCV4, MPSV4)				
Other				

To learn more about vaccines, visit www.vaccineinformation.org & www.immunize.org