JUDITH CROWELL, M.D.
DERMATOLOGY & COSMETIC ENHANCEMENT

Intake Form

Name: ____ Date:____________

(Edit patient) (photo of patient)

Date of Birth: ____________ **Age:** ______ **Sex:** ☐F ☐M **Social Security:** ____/___/_____

Address: ____

Marital Status: (check one) ☐ Single ☐Married ☐ Other

Employment Status (check one)

☐ Employed ☐FT Student ☐ PT Student ☐ Other ☐ Retired ☐ Self Employed

Preferred Email: ____,________________

(By providing email address, I authorize your office to contact me via the email address provided)

Home Phone: ________________________ **Cell Phone:** _________________________

Preferred Contact Method (check one) ☐ Home Phone ☐Cell Phone ☐ Email

Preferred Pharmacy: ______________________________ **Zip Code:** _______________

These questions are included to comply with new Federal Health guidelines – we are required to ask for this information

Ethnicity (check one) ☐ Hispanic or Latino ☐Not Hispanic or Latino ☐ I choose not to specify

Race (check one) ☐ American Indian/Alaskan Native ☐Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Island ☐ White ☐ I choose not to specify ☐ Other _____________________________

Preferred Language (check one) ☐ English ☐ Spanish ☐ American Sign Language ☐ I choose not to specify ☐ other ______________

Patient History

Past Medical History: (please check all that apply)

☐ Anxiety	☐ Depression	☐ Hypothyroidism
☐ Arthritis	☐ Diabetes	☐ Leukemia
☐ Asthma	☐ End Stage Renal Disease	☐ Lung Cancer
☐ Atrial fibrillation	☐ GERD (Gastric Reflux)	☐ Lymphoma
☐ Bone Marrow Transplantation	☐ Hearing Loss	☐ Prostate Cancer
☐ BPH	☐ Hepatitis	☐ Radiation Treatment
☐ Breast Cancer	☐ High Blood Pressure	☐ Seizures
☐ Colon Cancer	☐ HIV/AIDS	☐ Stroke
☐ COPD (Emphysema)	☐ High Cholesterol	
☐ Coronary Artery Disease	☐ Hyperthyroidism	☐ None

☐ Other ____

Past Medical History: (please check all that apply)

☐ Appendix Removed
☐ Bladder Removed
☐ Mastectomey (Right, Left, Bilateral)
☐ Lumpectomy (Right, Left, Bilateral)
☐ Breast Biopsy (Right, Left, Bilateral)
☐ Breast Reduction
☐ Breast Implants
☐ Colectomy: Colon Cancer Resection
☐ Colectomy: Diverticulitis
☐ Colectomy: IBD
☐ 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)
☐ Joint Replacement within last 2 years
☐ Kidney Biopsy
☐ Kidney Removed (Right, Left)
☐ Kidney Stone Removed
☐ Kidney Transplant
☐ Ovaries Removed: Endometriosis
☐ Ovaries Removed: Cyst
☐ Ovaries Removed: Ovarian Cancer
☐ Prostate Removed: Prostate Cancer
☐ Prostate Biopsy
☐ TURP-Prostatectomy
☐ Skin Biopsy
☐ Basal Cell Cancer Surgery
☐ Squamous Cell Carcinoma Surgery
☐ Melanoma Surgery
☐ Spleen Removed
☐ Testicles Removed (Right, Left, Bilateral)
☐ Hysterectomy: Fibroids
☐ Hysterectomy: Uterine Cancer
☐ None
☐ Other ____

Skin Disease History: (please check all that apply)

☐ Acne
☐ Actinic Keratoses
☐ Basal Cell Skin Cancer
☐ Blistering Sunburns
☐ Dry Skin
☐ Eczema
☐ Flaking or Itchy Scalp
☐ Hay Fever/Allergies
☐ Melanoma
☐ Poison Ivy
☐ Precancerous Moles
☐ Psoriasis
☐ Squamous Cell Skin Cancer
☐ None
☐ 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)? ____

Medications: (Please enter all current medications)

____

____

____

____

____

____

Allergies: (Please enter all allergies)

____

____

____

____

____

____

Social History: (Please check all that apply)

☐ Not sexually active
☐ Sexually active with one partner
☐ Sexually active with more than one partner
☐ Same sex partner
☐ Drug use
☐ IV Drug use
☐ Other ____

☐ Alcohol consumption: None
☐ Alcohol consumption: Less than 1 drink per day
☐ Alcohol consumption: 1-2 drinks per day
☐ Alcohol consumption: 3 or more drinks per day
☐ None

Smoking Status: (Please check one)

☐ Current every day smoker
☐ Current some day smoker
☐ Former smoker

☐ Never smoked
☐ Smoker current status unkown
☐ Unkown if ever smoked

Cautions/Alerts: (Please check all that apply)

☐ Allergy to adhesive: rash
☐ Allergy to Lidocaine: itching
☐ Allergy to Lidocaine: palpitations
☐ Allergy to Lidocaine: sweating
☐ Allergy to topical antibiotic ointments
☐ Artificial heart valve
☐ Artificial joints within past two years
☐ Blood thinners

☐ Defibrillator
☐ MRSA
☐ Pacemaker
☐ Patient vasovagal
☐ Personal history of malignant melanoma
☐ Premedication prior to procedures
☐ Rapid heartbeat with epenephrine
☐ Pregnancy or planning a pregnancy

Review of Systems:

Are you currently experiencing any of the following? (Please check all that apply)

- ☐ New hair growth on face, chest or abdomen
- ☐ New Moles
- ☐ Problems with bleeding/easy bruising
- ☐ Problems with healing
- ☐ Problems with scarring (hypertrophic or keloid)
- ☐ Rash
- ☐ Sensitivity to sunlight
- ☐ Significant change in existing moles
- ☐ Significant hair loss
- ☐ Significant persistent or intermittent burning of the skin
- ☐ Significant persistent or intermittent itching of the skin
- ☐ Currently having menstrual periods
- ☐ Irregular menstrual cycle
- ☐ Hay fever
- ☐ Immunosuppression
- ☐ Chest Pain
- ☐ Palpitations, irregular heart beat
- ☐ Fever or chills
- ☐ Night sweats
- ☐ Unintentional weight loss
- ☐ Thyroid problems
- ☐ Blurry vision
- ☐ Sore throat
- ☐ Abdominal pain
- ☐ Bloody stool
- ☐ Bloody urine
- ☐ Joint aches
- ☐ Muscle weakness
- ☐ Neck stiffness
- ☐ Headaches
- ☐ Seizures
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Anxiety
- ☐ Depression

SKIN AND CANCER ASSOCIATES / CENTER FOR COSMETIC ENHANCEMENT®

Today's date:

PATIENT INFORMATION

Patient's last name: | First: | Middle: | ❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms ❑ Dr. | Marital status (circle one) Single / Mar / Div / Sep / Wid

Date of Birth: / / | Age: | Sex: ❑ M ❑ F | Social Security No.: - - | Driver's License No. & State

Home Phone No: ( ) | Work Phone No: ( ) | Cell Phone No: ( ) | Email Address:

Local Street Address: | City: | State: | ZIP Code:

Permanent Street Address: | City: | State: | ZIP Code:

Occupation: | Employer:

Name of Parent (for Minor Patient): | Name of Parent Employer: | Parent Work Phone No: ( )

Parent Address (if different) | City: | State: | ZIP Code:

Referred to practice by: ❑ Dr. | ❑ Insurance Plan | ❑ Yellow Pages/Advertising:

❑ Family/Friend: | ❑ Web Site: | ❑ Other:

INSURANCE INFORMATION

Person responsible for bill: | Birth date: / / | Address (if different): | Home Phone No.: ( )

Occupation: | Employer: | Employer address: | Employer Phone No.: ( )

Primary Insurance: | Address: | Phone No: ( )

Insured's name: | Insured's S.S. No.: | Birth Date: / / | Sex: ❑ M ❑ F | Group No.: | Policy No.:

Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other

Secondary Insurance (If Any): | Address: | Phone No: ( )

Insured's name: | Insured's S.S. No.: | Birth Date: / / | Sex: ❑ M ❑ F | Group No.: | Policy No.:

Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( )

AUTHORIZATION TO PAY / FOR MEDICARE, LIFETIME AUTHORIZATION

The above information is true to the best of my knowledge. I authorize any holder of medical or other information about me to release to my insurance company, and, for Medicare/Blue Cross/Blue Shield to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers or to the billing agent of Blue Cross/Blue Shield of Florida, any information needed for this or a related insurance or claim. I permit a copy of this authorization to be used in place of the original. I further authorize payment of medical and/or surgical insurance benefits, otherwise payable to me, to the party who accepts assignment. I understand that I am financially responsible for those charges not paid by my insurance.

Patient Signature ______________________ Date

Other Signature if Patient Unable to Sign ______________________ Date

Judith E. Crowell,MD.-Aton Holzer,MD.-Maureen Masse,MD.

SKIN AND CANCER ASSOCIATES

Insurance Assignment Agreement/Privacy Notice Acknowledgment

****PLEASE SIGN THE RELEASE(S) BELOW THAT PERTAINS TO YOUR TYPE(S) OF INSURANCE****

COMMERCIAL INSURANCE

I, the undersigned, certify that I (or my dependent) have insurance coverage through ____________________

________________________, and assign directly to Skin and Cancer Associates (SCA) all

Name of Insurance Company(ies)

Insurance benefits, if any, otherwise payable to me, for services rendered. I hereby authorize SCA to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____________________	____________________	____________________
Beneficiary/Patient Signature	**Relationship**	**Date**

MEDICARE and/or MEDICAID *Lifetime Authorize. Medicare and Medicaid patient certifications. Patient certification authorization to release information and payment request.*

I certify that the information given by me in applying for payment under Title XVIII and or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its authorized benefits me made on my behalf. I assign the benefits payable for physicians (s) services. I understand that I am responsible for my health insurance deductibles and co-insurance.

____________________	____________________	____________________
Patient Signature	**Print Patient Name**	**Date**

MEDIGAP NOTE: IF YOU SIGN HERE YOU SHOULD ALSO SIGN FOR MEDICARE ABOVE.

Beneficiary Signature Authorization.

I request that payment of authorized Medigap benefits be made on my behalf to SCA for services furnished to me by the physician(s) of SCA. I authorize any holder of medical information about me to release to my Medigap carrier any information needed to determine these benefits or the benefits payable for related services.

____________________	____________________
Beneficiary/ Patient Signature	**Print Beneficiary/ Patient Name**
HIC (Medicare) Number	**Medigap Number**
Name if Medigap Insurance Company	**Date**

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I was provided a copy of the Notice of Privacy Practiced and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

____________________	____________________	____________________
Patient Signature	**Print Patient Name**	**Date**

Parent or Authorized representative (if applicable)

7800 SW 87th Avenue, Suite C300 * Miami, Fl. 33173 * (305) 274-0221 * Fax (305) 274-7275

JUDITH CROWELL, M.D.
DERMATOLOGY & COSMETIC ENHANCEMENT

No-Show Policy

Dear Patient:

We understand that there are legitimate reasons for having to cancel an appointment. We ask you to show consideration by calling well in advance if you are unable to keep an appointment so we have the option of offering that appointment to another patient who needs to see the doctor. Please let this letter serve to notify you that if you fail to give us a 24 hour notice of cancellation, there will be a $25.00 cancellation fee billed to your account that cannot be filed to your insurance.

Thank you for understanding,

Judith E. Crowell, M.D. and Aton Holzer, M.D.

Signature of Patient:______________________________ Date:_______________

When patient is under age 18 or unable to affix signature:

Patient's name: ____

Signature of guardian:____

Printed name of guardian:____

Witness Signature:__________________________________ Date:______________

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THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Skin and Cancer Associates, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective 04-15-03 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Skin and Cancer Associates, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating heath professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Skin and Cancer Associates the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Request we amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of certain disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Skin and Cancer Associates is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post a revised notice.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We may also provide other physicians or subsequent health care providers with copies of various reports that should assist him or her in treating you.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Your information may be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do to protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location, and general condition. We may call to confirm appointments and communicate lab results.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the practice's Privacy Officer, Darlene Tomlinson at 1-888-479-6415 Ext 636.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

NOTICE OF PRIVACY POLICIES

FOR

Skin and Cancer Associates

JUDITH CROWELL, M.D.
DERMATOLOGY & COSMETIC ENHANCEMENT

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider; we are committed to your treatment being successful. Please understand the payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment.

All patients must complete our Registration Form before seeing the physician.

Payments are due at the time of service. We accept cash, checks, and credit cards. If needed, a payment plan can be established with prior credit approval.

If you have insurance, which will pay our physicians directly, and which we can verify, we still require that you pay all co-payments, deductibles, Co-insurance and charges for non-covered services at the time of service.

If you are a member of an HMO or PPO, which requires a **referral form** from your primary care physician, **you are responsible to bring this form with you for your visits.**

If you have any questions or concerns about your bill, you may speak with our Patient Accounts Office at either:

Patient Accounts Office (305) 625-8025 or Toll Free 1-888-479-6415

Missed Appointments: If you are unable to keep your appointment, kindly give 24-hour notice. Please help us serve you better by keeping scheduled appointments.

Thank you for your understanding Our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X______________________________ ______________________

Signature of Responsible Party Date

X_____________________________ ______________________

Signature of Co-Responsible Date

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JUDITH CROWELL, M.D.
DERMATOLOGY & COSMETIC ENHANCEMENT

Request for Confidential Communications

I, _______________________________authorize the staff and Dr. Crowell/Dr. Holzer to notify
(Patient's Name)
me of my diagnostic or lab results. Please check one or more of the following options:

_______Speak with me only

_______Leave a message at my phone number designated below if I am not available.

Home (___) _________________

Work (___) _________________

Cell (___) _________________

____
(Patient's Initials)

_______Leave a message with anyone answering my phone.

_______Name of other person(s) authorized to accept results for me:

____
Name

____
Relationship

Telephone (___) _______________

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________Other

________**Don't call me with any results.** I will call the office if I want test results.

Complete address for communication

Local ______________________________________
____
____

Permanent ______________________________________
____
____

Patient Signature: ___________________________________ Date: _______________

Witness Signature: ___________________________________ Date: _______________