JUDITH CROWELL, M.D.
DERMATOLOGY & COSMETIC ENHANCEMENT

Intake Form

Nombre: _____ Fecha:_____

(Edit patient) (photo of patient)

Fecha de Nacimiento: _____ **Edad:** _____ **Sexo:** ❑F ❑M **Numero de Social:** _____

Domicilio: _____

Estado Civil: (Marque Una) ☐ Soltero ☐ Casado ☐ Otro

Employment Status (Marque Una)

☐ Empleado ☐ Estudiante de tiempo completo ☐ Estudiante a tiempo parcial

☐ Otro ☐ Jubilado ☐ Trabajadores por cuenta propia

Correo Electrónico: _____,_____

(Al proporcionar dirección de correo electrónico, autorizo a la oficina de ponerse en contacto conmigo a través de la dirección de correo electrónico proporcionada)

Teléfono de su casa: _____ **Móril:** _____

Preferred Contact Method (Marque Una) ☐ Teléfono de su casa ☐ Célula ☐ Email

Farmacia Preferida: _____ **Derección:** _____

Estas preguntas se incluyen para cumplir con las nuevas normas federales de salud - tenemos la obligación de solicitar esta información

Etnicidad (Marque Una) ☐ Hispánico or Latino ☐No Hispánico or Latino ☐ Elijo no especificar

☐ Americano Indian/Alaskan Native ☐Asian ☐ Negro/African Americano

Raza (Marque Una) ☐ Native Hawaiian/Other Pacific Island ☐ Blanco ☐ Elijo no especificar

☐ Otro _____

Idioma Preferido (Marque Una) ☐ Inglés ☐ Español ☐ Lenguaje por señas

☐ Elijo no especificar ☐ Otro _____

Historial del Paciente

Historial Médico: (marque todas las que correspondan)

☐ Ansiedad
☐ Artritis
☐ Asma
☐ Fibrilación Auricular
☐ Transplante de médulla ósea
☐ BPH (Porblemas de la prostate)
☐ Cáncer del Seno
☐ Cáncer de Colon
☐ EPOC (Enfermedades Pulmonarias)
☐ Enfermedad de las Arteria Coronarias
☐ Depresión
☐ Diabetes
☐ Enfermedad renal terminal
☐ ERGE (Reflujo Gastrico)
☐ Pérdida del odio
☐ Hepatitis
☐ Presion alta
☐ VIH/SIDA
☐ Colesterol alto
☐ Tiroides alta
☐ Tiroides baja
☐ Leucemia
☐ Cáncer de pulmón
☐ Linfoma
☐ Cáncer de Próstata
☐ Tratamiento de radiación
☐ Convulsiones
☐ Derrame Cerebral
☐ Ninguno
☐ Otro_____

Historial Médico: (marque todas las que correspondan)

☐ Apéndice (apendicetomía)
☐ La vejiga (cistectomía)
☐ Mastectomía (derecha, izquierda, Bilateral)
☐ Tumorectomía (derecha, izquierda, Bilateral)
☐ Biopsia de seno (derecha, izquierda)
☐ Reducción de senos
☐ Los implantes de senos
☐ Colon (colectomía): La resección del cancer del colon
☐ Colon (colectomía): Diverticulitis
☐ Colon (colectomía): Enfermedad Inflamatoria intestinal
☐ La vesícula biliar (colecistectomía)
☐ Corazón: cirugía de revascularización coronaria
☐ Corazón: dilatacion de las arterias/anyplastia
☐ Corazón: El reemplazo de la válvula mecánica
☐ Corazón: El reemplazo de la válvula biológica
☐ Corazón: Trasplante de Corazón
☐ Testículos:(orquiectomía)(derecha, izquierda, Bilateral)
☐ Reemplazo de rodilla (derecha, izquierda, Bilateral)
☐ Reemplazo de cadera (derecha, izquierda, Bilateral)
☐ Riñón: La biopsia renal
☐ Riñón: Nefrectomía (derecha, izquierda)
☐ Riñón: Estripación de una piedra riñón
☐ Renal: Trasplante de riñón
☐ Ovarios (ooforectomía): Endometriosis
☐ Ovarios (ooforectomía): Quiste de ovario
☐ Ovarios (ooforectomía): El cáncer de ovario
☐ Próstata (prostatectomia):Cáncer del la próstata
☐ Próstata (prostatectomia):Biopsia del la próstata
☐ Próstata (prostatectomia): RTU
☐ La piel: Biopsia de la Piel
☐ La piel: carcinoma basocelular
☐ Piel: Carcinoma del epitelio escamoso
☐ La piel: el melanoma
☐ Vaso (esplenectomía)
☐ Útero (histerectomía): Fibromas
☐ Útero (histerectomía): Cáncer Uterino
☐ Ninguno
☐ Otro _____

Piel historia de la enfermedad: (marque todas las que correspondan)

☐ Acné
☐ Descamación o picazón del cuero cabelludo
☐ Cáncer del la piel basocelular
☐ Quemaduras solares con ampollas
☐ Cáncer de piel del epitelio escamoso
☐ Eczema
☐ Queratosis actínica
☐ Fiebre del Heno/Alergias
☐ Melanoma
☐ Alerjia a plantas venenosas
☐ Lunares precancerosas
☐ Soriasis
☐ Piel reseca
☐ Ninguno
☐ Otro ___ _____

¿Usa crema protectora solar? ☐ Sí ☐ No

En caso afirmativo, ¿qué SPF?_____

¿Usas un salón de broncear? ☐ Sí ☐ No

¿Tiene antecedentes familiares de melanoma? ☐ Sí ☐ No

En caso afirmativo, que relativo (s)?_____

☐ Madre	☐ Hija	☐ Sobrino	☐ Nieto
☐ Padre	☐ Hijo	☐ Sobrina	☐ Nieta
☐ Hermana	☐ Tío	☐ Abuela	
☐ Hermano	☐ Tía	☐ Abuelo	☐ Otro

Medicamentos: (Que toma actualmente)

_____

_____

_____

_____

_____

_____

Alergias:

_____

_____

_____

_____

_____

_____

Historia Social: (marque todas las que correspondan)

☐ No esta sexualmente activa	☐ Consumo de alcol: ninguno
☐ Relaciones sexuales con una pareja	☐ Consumo de alcol: menos de 1 bebida al dia
☐ Relaciones sexuales con más de una pareja	☐ Consumo de alcol: 1-2 bebidas por dia
☐ Pareja del mismo sexo	☐ Consumo de alcol: 3 o más bebidas por dia
☐ Consume drogas	☐ Ninguno
☐ Usa drogas intravenosas	

☐ Otro _____

el Consumo de Tabaco: (Por favor marque una)

☐ Fumada diario	☐ Nunca ha fumado
☐ Fumador ocasional	☐ Estado actual del fumadares desconocido
☐ Ex fumador	

Cautions/Alerts: (marque todas las que correspondan)

☐ Alergia al adhesive: erupción
☐ Alergia a la lidocaína: picazón
☐ Alergia a la lidocaína: palpitaciones
☐ Alergia a la lidocaína: sudorou sudoración
☐ Alergia a los antibiótic tópicos
☐ Valvula cardiaca artificial
☐ Articulaciones artificiales en últimos dos años
☐ Anticoagulantes de sangre
☐ Defibrilador
☐ MRSA: infección resistente a antibioticos
☐ Marcapasos
☐ Vasovagal Episodio's/de desmayo
☐ Antecedentes personales de melanoma maligno
☐ Medicamentos antes de procedimientos
☐ Latidos cardiacos rapidos
☐ Embarazo o planea un embarazo

Opinión de los Síntomas:

¿Está usted experimenta alguno de los siguientes? (marque todas las que correspondan)

☐ Nuevo crecimiento del pelo en la cara, el pecho o abdomen
☐ Nuevos Lunares
☐ Problemas con sangramientes o moretones
☐ Problemas con la cicatrización
☐ Problemas con cicatrices (queloides)
☐ Erupción
☐ Sensibilidad a la luz solar
☐ Cambio notable en los lunares existentes
☐ Pérdida de cabello significativo
☐ Ardor persistente o intermitente de la piel
☐ Picazon persistente o intermitente de la piel
☐ Nuevo crecimiento del pelo en la cara, pecho o abdomen
☐ Actualmente tiene cicolos menstruales
☐ Ciclo menstrual irregular
☐ Fiebre alergica
☐ Inmunosupresión
☐ Dolor en el pecho
☐ Palpitaciones, ritmo cardiaco irregular
☐ Fiebre o escalofríos
☐ Sudores nocturnos
☐ Pérdida de peso involuntaria
☐ Problemas de la tiroides
☐ Visión borrosa
☐ Dolor de garganta
☐ Dolor abdominal
☐ Sangre en las heces fecales
☐ Sangre en la orina
☐ Dolor en las articulaciones
☐ Debilidad muscular
☐ Rigidez en el cuello
☐ Dolores de cabeza
☐ Convulsiones
☐ Tos
☐ Dificultad para respirar
☐ Silido del pulmon
☐ Ansiedad
☐ Depresión
☐ Otro_____

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 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:_____

7800 SW 87th Avenue • Suite C-300 • Miami, FL 33173 • Phone: 305.274.0221 • Fax: 305.274.7275

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. (Revised 9/13)

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.
- If you have paid for services "out of pocket" in full and in advance, and you request we do not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

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

Revised September 2013

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.

7800 SW 87th Avenue • Suite C-300 • Miami, FL 33173 • Phone: 305.274.0221 • Fax: 305.274.7275

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 (____) _____
(Patient's Initials)

Cell (____) _____

_____Leave a message with anyone answering my phone.

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

_____
Name

_____
Relationship

Telephone (____) _____

_____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: _____