



New Image Dermatology

www.newimagederm.com

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Welcome to New Image Dermatology!

We are pleased that you have chosen New Image Dermatology for your dermatologic care. We are dedicated to providing our valued patients with outstanding medical care.

Enclosed or attached are the patient registration forms that will assist us in preparing your chart quickly. Please complete the forms and sign where indicated and return them to the office via email or bring with you when you arrive for your appointment. It is necessary for you to arrive 15 minutes early for your initial visit to allow time for preparation of your medical chart.

To ensure fast service, please have the following available for your visit:

- Completely filled out information packet
- Signed privacy statement
- Copy of your current insurance card and
- Copy of your current Driver's License or Photo ID

It is important that you have valid insurance information with you in order for benefits to be verified. You will be responsible for any co-payment and/or deductible amounts according to your insurance policy payable at the time services are rendered. We will file your primary insurance and as *a courtesy, we will also file your secondary insurance once*. If you do not provide all pertinent insurance information prior to being seen you will be considered a self-pay patient and payment will be due in full when services are rendered.

We look forward to providing you with outstanding patient care.

Yours truly,

Laura J. Richards
Office Manager

NEW IMAGE DERMATOLOGY
PATIENT REGISTRATION

PERSONAL INFORMATION

TODAYS DATE: _____

Last Name: _____ First Name: _____ M.I. : _____

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

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

Home Phone: _____ Cell Phone: _____

Sex: Male Female Marital Status: Single Married Divorced Widowed

Patient's Employer: _____ Occupation: _____

Spouse's Employer: _____ Occupation: _____

EMERGENCY CONTACT

Name of Spouse or Close Relative or Friend: _____

Phone Number: _____ Relationship: _____

GUARANTOR PARENT, SPOUSE OR RESPONSIBLE PARTY (if different from patient)

Last Name: _____ First Name: _____ M.I. : _____

Social Security Number: _____ Date of Birth: _____

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

Relationship of Patient to Insured: Spouse Mother Father Legal Guardian

PRIMARY & SECONDARY INSURANCE

Please present insurance card(s) and drivers license at time of check-in.

POLICY HOLDER (if different from patient)

Policy Holder Name: _____ Social Security #: _____

Date of Birth: _____

Relationship of Patient to Insured: Spouse Mother Father Legal Guardian

REFERRAL INFORMATION, PATIENT FINANCIAL POLICY & SIGNATURE ON FILE

REFERRING INFORMATION

Whom may we thank for referring you to us: _____

Are there any members of your family who are or have been a patient of either Dr. Myers or Dr. Fotopoulos?

Yes No If yes, name and relationship: _____

HIPAA PRIVACY

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations and test results, diagnosis, treatment, and any plans for future care or treatment. This information serves as:

- A basis for planning your care treatment
- A means to communicate with health professionals who contribute your care
- A source for applying your diagnosis and treatment information for payment purposes

As part of your treatment, payment or healthcare operations, it may become necessary to disclose health information to other healthcare providers (referrals or consultation), laboratories, insurance companies for payment and/or other individuals or agencies as permitted or required by state or federal law.

Do you give our office permission to discuss your medical information with family members? Yes No

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

May we leave personal medical information on your answering machine at home? Yes No

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician’s Notice of uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature _____ *Date* _____

PAYMENT POLICY

MEDICARE, HMO, PPO or other managed care patients You will be responsible for paying your annual deductible and/or co-payment or charges for any non-covered service and any cosmetic services. Cash, check, or credit card will be accepted for payment.

NON-PROVIDER: The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

In the event that you’re account must be turned over to collections a collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

PATIENT SIGNATURE

DATE

NEW IMAGE DERMATOLOGY
PATIENT MEDICAL INFORMATION

PATIENT NAME: _____

Family physician: _____

Physician Telephone #: () _____

Drug allergies: _____

Current medications: _____

Do you have a personal history of the following illnesses?

Skin cancer: Yes No Location: _____

Other cancer: _____

diabetes: Yes No

high blood pressure: Yes No

kidney disease: Yes No

hepatitis Yes No

bleeding disorder: Yes No

ulcers: Yes No

eczema: Yes No

psoriasis: Yes No

heart disease: Yes No

rheumatic fever: Yes No

tuberculosis: Yes No

asthma: Yes No

hay fever Yes No

liver disease: Yes No

abnormal moles: Yes No

excessive scarring: Yes No

Other illnesses: _____

Do you have a heart valve replacement? Yes No

Do you have a joint replacement? Yes No

X _____
Patient signature

_____/_____/_____
Date

Due to the prevalence of skin cancer, a full-body examination is an important preventative measure.

Do you wish to have this full-body examination? Yes No

INFORMATION FOR PATIENTS & THEIR FAMILIES

The following is provided to inform you about Florida law regarding Health Care Advance Directives. The Patient's Right to Decide.

All adult individuals in health care facilities such as hospitals, nursing homes, hospice, home health agencies & health maintenance organizations have rights under Florida Law.

You have the right to fill out a paper known as "Advance Directive". The paper says in advance what kind of treatment you want or do not want under special, serious medical conditions that would stop you from telling the doctor how you want to be treated. For example, if you were taken to a health care facility in a coma, would you want the facility's staff to know your specific wishes about decisions affecting your treatment?

QUESTIONS COMMONLY ASKED ABOUT ADVANCE DIRECTIVES:

1. WHAT IS AN ADVANCE DIRECTIVE?

An advance directive is a written or oral document that is made & witnessed in advance of serious illness or injury, about how you want medical decisions made. Two forms of advance directives:

"Living Will" & "Health Care Surrogate Designation"

An advance directive allows you to state your choices for you if you become unable to make decisions about your medical treatment. An advance directive can enable you to make decisions about your future medical treatment.

2. WHAT IS A LIVING WILL?

A living will generally states the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living. Florida law provides a suggested form for a living will. You may use it or some other form. You may wish to speak to an attorney or physician to be certain you have completed the living will in a way that your wishes will be understood.

3. WHAT IS A HEALTH CARE SURROGATE DESIGNATION?

A "Health Care Surrogate Designation" is a signed, dated & witnessed paper naming another person such as husband, wife, son or close friend as your agent to make medical decisions for you, if you should be unable to make them for yourself, you can include instructions about any treatment you want or wish to avoid. Florida law provides a suggested form for the designation of a health care surrogate. You may use it or some other form. You may wish to name a second person to stand for you, if your choice is not available.

PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

PLEASE FILL OUT THIS FORM FOR COMPLIANCE WITH THE PATIENT SELF DETERMINATION ACT PASSED BY THE STATE OF FLORIDA.

You cannot remove all uncertainty about your future healthcare needs but by having on advance directive you can have the peace of mind that comes from making your wishes known in advance!

Declaration to Decline Life-Prolonging Procedures (Living Will)

- I have made a living will
- I do not have a living will

Health Care Surrogate

- I have designated a Health Care Surrogate
- I have not designated a Health Care Surrogate

Durable Power of Attorney

- I have appointed a Durable Power of Attorney for Health Care Decisions.
- I have not appointed a Durable Power of Attorney for Health Care Decisions.

Signature of Patient or Representative

Printed Name

Date

If you have any further questions, you can contact your family attorney, local hospital or local medical association for additional information.

OMNIBUS REGISTRATION RECONCILIATION ACT OF 1990 (PATIENT SELF-DETERMINATION ACT)
CHAPTER 765, FLORIDA STATUTES

SUBMIT