NEW PATIENT INTAKE SHEET

Thomas S. Breza MD
Thomas S. Breza JR., MD
Stacey McFadden PA-C
Catherine Arias, PA-C

Patient Name
Circle Which Applies
MR. MRS. MS. Dr. (First, MI, Last) _____

Date of Birth:

Primary Address

Street _____

City _____ State _____ Zip Code _____

Cell Phone: _____ Work Phone: _____

Email Address: _____

Emergency Contact

Name: _____ Relationship to patient: _____

Cell Phone: _____ Work Phone: _____

Pharmacy

Name: _____ Phone Number: _____

Address _____

To whom should the account be addressed if the patient is a child:

Name: _____ Date of Birth:

Signature of Patient: _____ Date:

Dermatology by the Sea
4341 Bougainvilla Drive
Lauderdale by the Sea, Fl 33308
P:954-492-8866 F:954-492-8865
dermatologybythesea.com

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MEDICAL INFORMATION

Please list any allergies to medications: ☐ No known allergies

_____

_____

_____

Immunizations: ☐ Pneumococcal (pneumonia) ☐ Influenza ☐ Covid

Please check any relevant past medical/surgical history:

☐ Mohs Procedure
☐ High Blood Pressure
☐ Diabetes
☐ High Cholesterol
☐ Cancer
☐ Heart Disease
☐ Stroke
☐ Blood clots
☐ Asthma
☐ Pacemaker
☐ Epilepsy
☐ Depression / Anxiety

Other illness/surgery _____

Please list current medications:

_____

_____

_____

_____

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Disclosure of Medical Records

Patient Name: _____ Date of Birth:

In addition to the patient AND treating doctors, such as family members and/or friends, please indicate whom we may give test results and/or medical record information to:

Name(s) of whom we may give results to:

_____

Phone Number:_____

☐ Please **DO NOT** discuss my healthcare with anyone but myself.

Signature of Patient _____ Date:

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we 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. We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

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This notice is effective as of January 1, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office. You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer Jamie Milano for more information, in person or in writing.

Patient Name: _____ Signature: _____

Date: Relationship to patient SELF PARENT OTHER

Acknowledgement of Patient Responsibility

Please be aware that we do our best to verify your eligibility and benefits prior to your appointment time, but it is ultimately the patient's responsibility to know what your benefits are and whether we are in or out of network with your insurance policy. If there is any remaining balance after your insurance company processes your claim, it is patient responsibility. It is also the patient's responsibility to inform us of any demographic changes as well as insurance changes (including Obamacare) since your last appointment. Thank you for your cooperation.

Please be aware that you are responsible for the cost of the appointment on the day of your appointment, including but not limited to your deductible, out of pocket, co insurance, and copay.

I acknowledge my responsibilities as a patient in the practice.

Signature of Patient _____ Date:

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment + Patient Responsibility, but was unable to do so as documented below:

Date: Initials: Reason:

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