

**Cynthia Rogers, M.D.**

**CONSENT FOR RELEASE OF USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

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 (HIPAA).

**The patient understands that:**

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a 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 Practices.
- 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 receipt of treatment upon the execution of this Consent.

**This Consent was signed by:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name (Patient or Representative)      Date

\_\_\_\_\_  
Relationship to Patient (if other than patient)

**Witness:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name (Practice Representative)      Date

**Minor Patient Registration Form**

\_\_\_\_\_  
First                      Middle                      Last                      Social Security Number

Date of Birth: \_\_\_\_\_ Male  Female

Legal Guardian or Parent Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street

\_\_\_\_\_  
City                                      State                                      Zip

Home Phone: (      ) \_\_\_\_\_ Mobile Phone: (      ) \_\_\_\_\_

Preferred Contact Method: Home / Mobile      Email Address: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Provider: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy Location: \_\_\_\_\_

Preferred Language: \_\_\_\_\_

**ETHNICITY:** Hispanic/Latino    Non-Hispanic/Latino    Prefer Not to Answer

**RACE:** American Indian    Asian    Black/African American    White    Native Hawaiian/Pacific Islander    Other

**I DO / DO NOT consent to the office leaving a detailed message containing medical information at any of the phone numbers listed above. (CIRCLE ONE)**

**I DO / DO NOT consent to the office discussing my medical information with: (CIRCLE ONE)**

Person: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Person: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**Emergency Contact Information:**

In case of Emergency, whom should we notify? \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone#: (      ) \_\_\_\_\_

**Insurance Information:** Do you have health insurance?    Yes  No

Primary Insurance Carrier: \_\_\_\_\_

Name of Insured (Guarantor): \_\_\_\_\_ Guarantor Date of Birth: \_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_

Name of Insured (Guarantor): \_\_\_\_\_ Guarantor Date of Birth: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## TREATMENT TO MINORS

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Many times parents/guardians find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

I hereby grant Dr. Cynthia Rogers permission to treat my child when they arrive at the office unaccompanied or accompany by \_\_\_\_\_.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

### AUTHORIZATION TO CHARGE SERVICES TO MAJOR CREDIT CARD

This agreement is required if you wish your child to be seen.

My minor child will be coming to the office for regular treatment of his/her dermatological condition; I authorize the above physician to charge to my major credit card (listed below) under the following circumstances:

#### Initials

\_\_\_\_\_

I understand that I am responsible for payment of my account at this time of service for deductibles, non-covered services, medically unnecessary services, copayments and insurance balances, should my primary insurance be with a company with which the physician(s) are contracted. If my insurance company is not one with which the physician is contracted, I am responsible for the entire amount at the time of service.

\_\_\_\_\_

A receipt for charges will be mailed to my address.

VISA       MasterCard       Discover

Credit Card Number: \_\_\_\_\_ Exp Date: \_\_\_\_\_

Name as it appears on the credit card: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

## Office Financial Policy

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

### **Medicare:**

We are Medicare participating providers. We will bill Medicare and Medigap carriers. You will be responsible at the time of service for payment of:

- a. The annual deductibles
- b. Copayments
- c. Charges for cosmetic services

If you have Medicare, as well as secondary coverage with a commercial plan that is not Medigap or is an insurance company with which we have no contract, we will file a claim to your secondary/supplemental carrier. If no payment is received from your secondary/supplemental carrier within 60 days after we file a claim, you will be sent a bill and will be responsible for the balance.

### **Non-Medicare/Commercial Plans:**

If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for all covered, medically necessary services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible at the time of service for payment of :

- a. The annual deductibles
- b. Copayments
- c. Charges for uncovered or cosmetic services

In the event that you, as the patient, or we, as the physician, are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.

For non-Medicare patients who have insurance coverage with an insurance carrier with which we do not have a contractual relationship, please note the following:

- a. We will file both your primary and secondary insurance. If we do not receive payment from your primary carrier within 45 days of filing, you will be billed for the entire amount. Payment is due 10 days after receipt of the statement.
- b. If we receive payment from the primary, we will file a claim with your secondary. If we do not receive payment from your primary carrier within 45 days of filing, you will be billed for the entire amount. Payment is due 10 days after receipt of the statement.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Out of Network Waiver Form

Date of Service: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Physician Name: Cynthia Rogers, M.D.

Name of Insurance: \_\_\_\_\_

### **Your signature below signifies that you clearly understand that**

Dr. Cynthia Rogers is NOT a member of your managed care plan. Because the doctor is NOT on your plan, the expenses for today's visit will be your responsibility. This means you will have to pay the doctor's charges in full at the end of today's visit.

Our office will file a claim to your carrier as a courtesy.

Certain types of plans will not reimburse any money if the patient requests and seeks services from a physician that is NOT part of the plan or network.

Do not sign this form unless you positively understand the consequences of your visit, the charges you will have to pay, and the fact that you may not receive any of the money back from your insurance carrier.

**I understand all of the above and still want to receive services from the non-participating physician today.**

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

## Medical History Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### MEDICAL HISTORY.

Please check if you have ever had any of the following diseases or conditions?

|                                |                          |  |                          |
|--------------------------------|--------------------------|--|--------------------------|
| Cardiovascular                 |                          | Cancers  |                          |
| High blood pressure            | <input type="checkbox"/> | Breast   | <input type="checkbox"/> |
| Pacemaker                      | <input type="checkbox"/> | Ovarian  | <input type="checkbox"/> |
| Defibrillator                  | <input type="checkbox"/> | Lung   | <input type="checkbox"/> |
| Irregular heartbeat            | <input type="checkbox"/> | Colon  | <input type="checkbox"/> |
| Heart Attack                   | <input type="checkbox"/> | Prostate   | <input type="checkbox"/> |
| Blood clots                    | <input type="checkbox"/> | Bladder  | <input type="checkbox"/> |
| Stent                          | <input type="checkbox"/> | Other _____                                      | <input type="checkbox"/> |
| Coronary artery disease        | <input type="checkbox"/> | Psychiatric/Neurologic                           |                          |
| Stroke                         | <input type="checkbox"/> | Epilepsy/seizure disorder                        | <input type="checkbox"/> |
| Respiratory                    |                          | Alzheimer's                                      | <input type="checkbox"/> |
| Emphysema/COPD                 | <input type="checkbox"/> | Parkinson's                                      | <input type="checkbox"/> |
| Asthma                         | <input type="checkbox"/> | Other dementia                                   | <input type="checkbox"/> |
| Gastrointestinal/Genitourinary |                          | Depression/anxiety                               | <input type="checkbox"/> |
| Reflux/GERD                    | <input type="checkbox"/> | Musculoskeletal                                  |                          |
| Kidney failure                 | <input type="checkbox"/> | Rheumatoid                                       | <input type="checkbox"/> |
| Endocrine                      |                          | Osteoarthritis                                   | <input type="checkbox"/> |
| Diabetes                       | <input type="checkbox"/> | Artificial joint                                 | <input type="checkbox"/> |
| Hyperthyroidism                | <input type="checkbox"/> | Skin   |                          |
| Hypothyroidism                 | <input type="checkbox"/> | Skin cancer                                      | <input type="checkbox"/> |
| Head/Eyes/Ear/Nose/Throat      |                          | <input type="checkbox"/> Basal cell carcinoma    |                          |
| Cataracts                      | <input type="checkbox"/> | <input type="checkbox"/> Squamous cell carcinoma |                          |
| Glaucoma                       | <input type="checkbox"/> | <input type="checkbox"/> Malignant melanoma      |                          |
| Hearing Loss                   | <input type="checkbox"/> | Actinic keratosis                                | <input type="checkbox"/> |
| Infections                     |                          | Abnormal (dysplastic) moles                      | <input type="checkbox"/> |
| MRSA                           | <input type="checkbox"/> | Other _____                                      | <input type="checkbox"/> |
| HIV / AIDS                     | <input type="checkbox"/> |  |                          |
| Tuberculosis                   | <input type="checkbox"/> |  |                          |
| Hepatitis: A / B / C           | <input type="checkbox"/> | <b>NONE</b>                                      | <input type="checkbox"/> |

Family history of Melanoma: Yes No

Mother     Father     Brother     Sister     Daughter     Son  
 Grandmother     Grandfather     Aunt     Uncle

### SURGICAL HISTORY.

Please list any surgeries you have had:

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**MEDICATIONS.**

Please list any prescription medications (or aspirin) that you are taking (including topicals):

| <u>Name</u> | <u>Strength</u> | <u>How Often</u> |
|-------------|-----------------|------------------|
| _____       | _____           | _____            |
| _____       | _____           | _____            |
| _____       | _____           | _____            |
| _____       | _____           | _____            |
| _____       | _____           | _____            |
| _____       | _____           | _____            |
| _____       | _____           | _____            |
| _____       | _____           | _____            |
| _____       | _____           | _____            |
| _____       | _____           | _____            |
| _____       | _____           | _____            |
| _____       | _____           | _____            |
| _____       | _____           | _____            |
| _____       | _____           | _____            |
| _____       | _____           | _____            |
| _____       | _____           | _____            |

**Are you allergic to any medications: Yes / No**

**If yes, please list:** \_\_\_\_\_

- |                         |     |    |                       |     |    |
|-------------------------|-----|----|-----------------------|-----|----|
| Allergy to adhesive?    | YES | NO | Allergy to latex?     | YES | NO |
| Allergy to epinephrine? | YES | NO | Allergy to lidocaine? | YES | NO |
| History of MRSA?        | YES | NO |                       |     |    |

**SOCIAL HISTORY.**

Smoking Status:    FORMER SMOKER                      CURRENT SMOKER                      NEVER SMOKER  
Alcohol: NONE    LESS THAN 1 DRINK PER DAY    1-2 DRINKS PER DAY    3 OR MORE DRINKS PER DAY  
Occupation: \_\_\_\_\_  
Year-round Florida resident? YES    NO            If not, where else do you live? \_\_\_\_\_  
Hobbies: \_\_\_\_\_

**QUALITY MEASURES.**

Have you received a Pneumonia vaccination? Yes / No

Do you have a health care proxy? Yes / No

Who? \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have a living will? Yes / No

Have you received an Influenza vaccination? Yes / No

Are you interested in the Patient Portal? Yes / No

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**FAMILY MEDICAL HISTORY.**

|               | Mother                   | Father                   | Brother                  | Sister                   |
|---------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Cancer        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Melanoma      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**REVIEW OF SYSTEMS.**

**Please check if you are currently experiencing any of the following symptoms?**

|                                |                          |                           |                          |
|--------------------------------|--------------------------|---------------------------|--------------------------|
| Cardiovascular                 |                          | Head/Eyes/Ear/Nose/Throat |                          |
| Chest pain                     | <input type="checkbox"/> | Change in vision          | <input type="checkbox"/> |
| Palpitations                   | <input type="checkbox"/> | Ringing in ears           | <input type="checkbox"/> |
| Respiratory                    |                          | Headache                  | <input type="checkbox"/> |
| Shortness of breath            | <input type="checkbox"/> | Sore throat               | <input type="checkbox"/> |
| Cough                          | <input type="checkbox"/> | Musculoskeletal           |                          |
| Gastrointestinal/Genitourinary |                          | Joint pain                | <input type="checkbox"/> |
| Abdominal pain                 | <input type="checkbox"/> | Muscle pain               | <input type="checkbox"/> |
| Nausea/vomiting/diarrhea       | <input type="checkbox"/> | Muscle weakness           | <input type="checkbox"/> |
| Pain with urination            | <input type="checkbox"/> | Systemic                  |                          |
| Psychiatric/neurologic         |                          | Fever/chills/night sweats | <input type="checkbox"/> |
| Depression                     | <input type="checkbox"/> | Unexplained weight loss   | <input type="checkbox"/> |
| Anxiety                        | <input type="checkbox"/> |                           |                          |
| Numbness/tingling              | <input type="checkbox"/> | <b>None</b>               | <input type="checkbox"/> |

**PATIENT SIGNATURE (or name of person completing this form)**

**DATE**