Palm Beach Dermatology

Lara Kelley, M.D.
Mohs Surgeon
FELLOW AMERICAN COLLEGE OF MOHS SURGERY
DIPLOMATE OF THE AMERICAN BOARD OF DERMATOLOGY
FELLOW OF THE AMERICAN ACADEMY OF DERMATOLOGY

Our Office Address Is:

3401 PGA Blvd

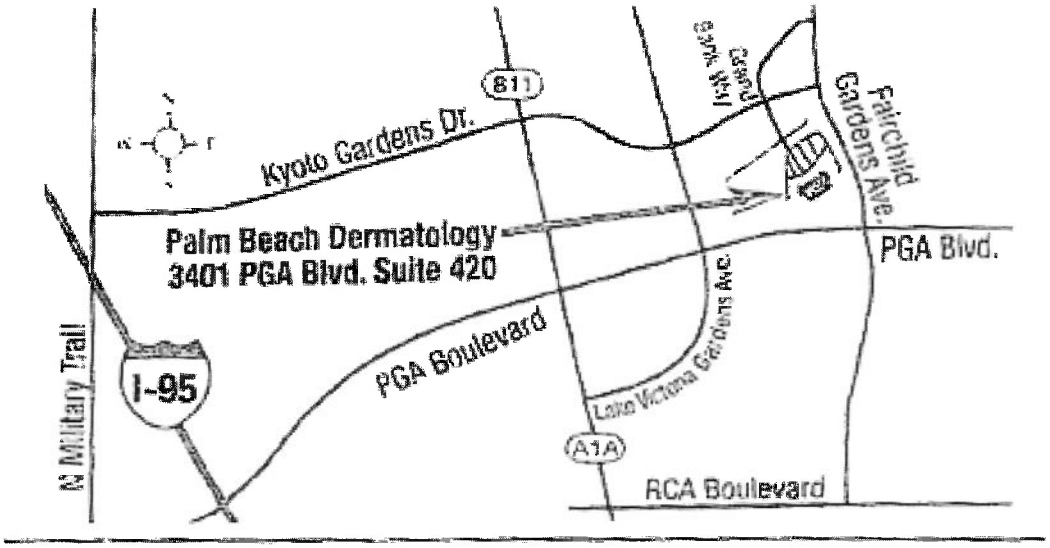
Suite 420

Palm Beach Gardens, Florida 33410

Phone: 561-471-1808

Fax: 561-471-1603

We Look Forward to Seeing You!



LARA KELLEY, MD
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Name _____ Date_____

Local Address_____

Local City, State, Zip Code_____

Seasonal Address_____

Seasonal City, State, Zip Code_____

SS#_____Date of Birth_____Age_____

Circle One – Male / Female

Circle One – Caucasian / African American / Asian / Native American / Hispanic

Email_____

Primary Telephone Number with area code_____

Secondary Telephone Number with area code_____

Who referred you to our office?_____

Primary Care Physician_____Phone#_____

Employer_____Phone#_____

Spouse Name:_____Phone#_____

Emergency Contact Name_____Phone#_____

Pharmacy Name_____Phone#_____

Pharmacy Street Address with Crossroads_____

Have you had Mohs surgery before?_____What area of the body?_____

Past Medical History: please circle all that apply

Anxiety	Diabetes	Hyperthyroidism / Hypothyroidism
Arthritis	Lung Cancer	Leukemia
Atrial Fibrillation	End Stage Renal Disease	Lymphoma
Bone Marrow Transplant	GERD	Prostate Cancer
Breast Cancer	Hearing Loss	Radiation Treatment
Colon Cancer	Hepatitis – What type?	Seizures
COPD	High Blood Pressure	Stroke
Coronary Artery Disease	HIV/AIDS	Heart Attack
Depression	High Cholesterol	Other:

Past Surgical History: please circle all that apply

Appendix Removed	Kidney Biopsy
Bladder Removed	Kidney Removed – right / left
Mastectomy – right / left / bilateral	Kidney Stone Removal
Lumpectomy – right / left / bilateral	Kidney Transplant
Breast Biopsy / Breast Implants	Endometriosis
Colon Cancer Resection	Ovarian Cancer
Diverticulitis / IBD	Prostate Cancer / Prostate Biopsy
Gallbladder Removed	Transurethral resection of the prostate (TURP)
Coronary Artery Bypass	Spleen Removed
Heart Valve Replacement–Mechanical / Tissue	Testicle Removed – right / left / bilateral
Heart Transplant	Hysterectomy
Joint Replacement – Knee right / left / bilateral	Uterine Cancer
Joint Replacement – Hip right / left / bilateral	Other:

Skin Disease History: please circle all that apply

Acne	Dry Skin
Actinic Keratosis	Eczema / Psoriasis
Basal Cell Cancer	Seborrheic Keratosis
Squamous Cell Cancer	Seborrheic Dermatitis
Melanoma	Blistering Sunburn

Do you use sunscreen? YES / NO SPF#_____

Family History of Melanoma? Yes / No Who in the family? _____

Medications - Please Include Dosage and Frequency:

_____

_____

_____

_____

Medication Allergies:

_____

_____

Social History: please circle all that apply

Current Some Day Smoker	Alcohol Use : none
Current Everyday Smoker	Alcohol Use: less than one drink daily
Former Smoker	Alcohol Use: 1 - 2 drinks daily
Never Smoked	Alcohol Use: 3 or more drinks daily
Men: How many times in the past year have you had 5 or more drinks a day? _____ **Women**: How many times in the past year have you had 4 or more drinks a day?_____	

ALERTS: please circle all that apply

Allergy to Adhesive	Heart Defibrillator
Allergy to Lidocaine	MRSA
Allergy to Topical Antibiotics	Pacemaker
Artificial Heart Valve	Rapid Heartbeat with Epinephrine
Blood Thinners	Premedication prior to surgical procedures
Joint Replacement	Pregnant / Nursing

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THESE QUESTIONS ARE REQUIRED BY YOUR HEALTH INSURANCE COMPANY

Advance Care Plan: If 65 and older, please complete all that apply

Do you have a health care proxy in the event you are unable to make your own medical decisions?	YES / NO
Designee's Name:	Designee's Telephone Number:
Do you have a living will?	YES / NO

☐ Patient Refused to Answer

Women 65 and older, please select all that apply:

Do you have urinary incontinence?	YES / NO
	If you have answered yes, we recommend you follow up with your primary care physician.

Patient Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

Palm Beach Dermatology

Lara Kelley, M.D.

Patient Financial Responsibility

Thank you for choosing Dr. Kelley to treat your skin cancer. We are committed to providing quality care and service to all of our patients. The following is a statement of our patient financial policy, which we ask that you please read and agree to prior to any surgery.

- The patient is ultimately responsible for the payment for treatment and care
- We will bill your insurance. However, he/she is required to provide the most correct and updated information regarding insurance
- Patients are responsible for payment of co-pays, co-insurance and deductibles
- Co-pays, co-insurance and deductibles are due at the time of service
- If we have a contract with your insurance company we will bill your insurance company first, less any co-pays, co-insurance and deductibles, and then bill you for any amount determined to be your financial responsibility. This process generally takes (6) weeks from the time the claim is received by your insurance company

I have read the patient financial responsibility policy contained above, and my signature below serves as acknowledgment of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all charges in full.

_____ _____

Signature Date

_____ _____

Printed Name Date

Receipt of Notice of Privacy Practices

Written Acknowledgment

PBD & P, Inc.

I _____ have been given the opportunity to read a copy of PBD & P, Inc. notice of patient privacy practice.

_____ _____

Signature Date

If you would like this office to be able to discuss your health information (PHI) with another person or family member, please list the name and relationship below.

_____ _____

Name of authorized person Relationship

_____ _____

Name of authorized person Relationship

_____ _____

Name of authorized person Relationship

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information.

Protected health information (PHI), about you, is maintained as a written and /or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information that may identify you and relates to your past, present and future physical or mental health condition related healthcare services.

Our Practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professional involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

The following is a statement of your rights, under the Privacy Rule, in reference to your PHI.

You have the right to receive, and we are required to provide you with, a copy of the Notice of Privacy Practices. We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice and if such is maintained by the practice, on its website.

You have the right to authorize other use and disclosure. This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intend to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication. This means you have the right to ask us to contact you about medical matters using an alternative method and to a destination requested by you. You must inform us in writing using a form provided by our practice how you wish to be contacted if other than the address and phone number we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI. This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in an electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state or federal guidelines.

You have the right to request a restriction of your PHI. This means you may ask us in writing not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction we will abide by it except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing that we restrict communication to your health plan regarding a specific treatment or service that you or someone on your behalf has paid for in full out of pocket.

You have the right to request an amendment to your protected health information. This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases we may deny your request.

You have the right to request a disclosure accountability. You have the right to receive written notification if the practice discovers a breach of your unsecured PHI and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights please feel free to contact our HIPAA Compliance Officer. Contact information is provided on the following page.

How We May Use or Disclose Protected Health Information

The following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - we may use and disclose your PHI to provide, coordinate or manage your healthcare and any related services. This includes coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special notices - we may use and disclose your PHI as necessary to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that described or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health related benefits and services offered by our office for fund raising activities or with respect to a group health plan to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - we may use or disclose as needed your PHI in order to support the business activities of our practice. This includes but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Operations - The practice may elect to use a health information organization or other such organizations to facilitate the electronic exchange of information for the purposes of treatment payment or healthcare operations.

To Others Involved In Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member or personal representative or any other person that is responsible for your healthcare or your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI then your healthcare provider, may using professional judgment, determine where the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - we are also permitted to use or disclose your PHI without your written authorization for the following purposes; as required by law; for public health activities; health oversight activities; in case of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activities; military action ; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us or directly to the Secretary of the Department of Health and Human Services if you believe if your privacy rights have been violated by us. You may file a complaint with us by notifying the HIPAA Compliance Officer at 561-471-1808.

We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with out HIPAA Compliance Officer in person or by phone.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the "Acknowledgment" form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.