HELLER DERMATOLOGY CENTER
JEFFREY J. HELLER, D.O., F.A.A.D.
511 N. CLYDE MORRIS BLVD.
DAYTONA BEACH, FL 32114
OR
790 DUNLAWTON AVE., SUITE H
PORT ORANGE, FL 32127

PHONE (386) 239-8700
FAX (386) 239-7070

www.hellerdermcenter.net

ADULT

(TO HANDOUT, FAX, MAIL, OR E-MAIL)

DEAR PATIENT:

THANK YOU FOR CHOOSING OUR CENTER FOR YOUR DERMATOLOGICAL NEEDS.

YOUR APPOINTMENT IS SCHEDULED FOR: _____

IN THE: _____: DAYTONA BEACH OFFICE

_____: PORT ORANGE OFFICE

ENCLOSED ARE THE PATIENT INFORMATION SHEETS THAT YOU REQUESTED.

PLEASE BRING THESE FULLY COMPLETED FORMS, ALONG WITH YOUR INSURANCE CARD (S), AND DRIVER'S LICENSE (OR PHOTO ID) WITH YOU TO YOUR SCHEDULED APPOINTMENT.

PLEASE ARRIVE AT LEAST 10 MINUTES BEFORE YOUR APPOINTMENT.

IT IS IMPORTANT THAT YOU NOT WEAR ANY COLOGNE (OR PERFUME) TO OUR OFFICE.

YOU WILL BE RESPONSIBLE FOR ANY CO-PAY OR DEDUCTIBLE AT THE TIME OF THE SERVICE (CASH, DEBIT OR CREDIT CARD). **WE DO NOT ACCEPT CHECKS**.

ALL MINORS MUST BE ACCOMPANIED BY A PARENT FOR THEIR INITIAL VISIT. IF A LEGAL GUARDIAN, THEN WE MUST HAVE A COPY OF THE LEGAL PAPERS AND/OR POWER OR ATTORNEY (POA) PAPERS AT THE TIME OF THE SERVICE.

IF YOU HAVE ANY QUESTIONS, PLEASE CALL.

THANK YOU.

HELLER DERMATOLOGY CENTER

PATIENT INFORMATION SHEET

PLEASE PRINT CLEARLY AND COMPLETE IN FULL

PATIENT NAME:_____ TODAY'S DATE:_____

(FIRST) (MI) (LAST)

DATE OF BIRTH:_____AGE:_____SEX:_____DRIVER'S LICENSE STATE & #_____

RACE:_____ ETHNICITY:_____ PREFERRED LANGUAGE:_____

MAILING ADDRESS:_____

CITY:_____STATE:_____ZIP CODE:_____

HOME PHONE: (_____)_____CELL PHONE: (_____)_____SOCIAL SECURITY#_____

WORK PHONE: (_____)_____EXT#_____ EMPLOYER NAME:_____

MARITAL STATUS: MARRIED_____ SINGLE_____ OTHER:_____ E-MAIL ADDRESS:_____

SPOUSE'S NAME_____SS#_____DATE OF BIRTH:_____

PRIMARY CARE PHYSICIAN:_____PHONE NUMBER#_____

REFERRING SOURCE:_____PHONE NUMBER#_____

IF YOU ARE A STUDENT, CHECK ONE: FULL TIME_____ PART TIME_____

NAME OF YOUR SCHOOL:_____

STUDENT'S PERMANENT / PARENT'S NAME AND ADDRESS:_____

FOR EMERGENCY CONTACT, WE NEED THE NAME AND PHONE NUMBER OF SOMEONE WHO **DOES NOT** LIVE WITH YOU.

NAME:_____RELATIONSHIP:_____PHONE NUMBER: (_____)_____

ADDRESS:_____CITY:_____STATE:_____ZIP CODE:_____

NEAREST RELATIVE NOT LIVING WITH YOU. NAME:_____

RELATIONSHIP:_____PHONE: (_____)_____

ADDRESS:_____CITY:_____STATE:_____ZIP CODE:_____

PRIMARY INSURANCE INFORMATION. WE WILL NEED TO MAKE COPIES OF ALL OF YOUR HEALTH INSURANCE ID CARDS, PRIMARY AND SECONDARY (IF APPLICABLE). **PLEASE COMPLETE THE FOLLOWING ALSO.**

NAME OF PRIMARY INSURANCE COMPANY:_____

INSURANCE ID#_____POLICY OR GROUP#_____

NAME OF INSURED **(IF DIFFERENT FROM PATIENT)**:_____RELATIONSHIP:_____

INSURED'S DATE OF BIRTH:_____SS#_____SEX:_____

INSURED'S ADDRESS:_____CITY:_____STATE:_____ZIP CODE:_____

INSURED'S EMPLOYER:_____WORK PHONE: (_____)_____EXT:_____

EMPLOYER'S ADDRESS:_____CITY:_____STATE:_____ZIP CODE:_____

DO YOU HAVE A SECONDARY INSURANCE? YES_____ NO_____

******* IF YOU PROVIDE US WITH INCORRECT OR INVALID INSURANCE INFORMATION AND WE NEED TO RE-ENTER AND RE-SUBMIT YOUR CORRECTED INSURANCE INFORMATION, THERE WILL BE A $20.00 ADMINISTRATIVE CHARGE FOR EACH CLAIM REFILED***** _____**

(PATIENT'S INITIALS)

FINANCIAL POLICY OF THE HELLER DERMATOLOGY CENTER

As your physician, we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance, and your understanding of our payment policy.

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. We accept cash, debit cards and credit cards (Visa, MasterCard, Discover & American Express). In some cases, we will accept a check with prior approval. Returned checks are subject to a service charge of $35.00 (or 5% of the face value of the check, whichever is greater), any bank fees and you will lose your privilege to write checks in our office.

PRIVATE INSURANCE COMPANIES THAT WE "ARE" A PROVIDER WITH. Co-payment, co-insurance and deductible must all be paid at the time of service. If we are unable to verify your insurance coverage, you will responsible for payment in full today and we will give you the appropriate papers to file for possible reimbursement. Because we are under contract with your current insurance company, we will file your insurance claim. If payment is not received from your insurance company within a reasonable time (90 days), the full balance will be transferred to the responsibility of the patient (or guardian).

PRIVATE INSURANCE COMPANIES THAT WE "ARE NOT" A PROVIDER WITH. You will be responsible for payment in full at the time of service and our office will give you the necessary forms so that you may file for reimbursement.

MEDICARE. Your deductible and 20% of the allowable charges are due at the time of service. Since we are a Medicare provider we will file your Medicare. If we do not know the Medicare allowable charge for a specific service, we will bill you after Medicare processes the claim. Please bring your Medicare Explanation of Benefits (EOB) showing you have met your deductible.

CHILDREN OF DIVORCED PARENTS. Payment will be due from the parent that is with the child today no matter who is responsible by order of the divorce decree.

MISSED APPOINTMENTS. We ask for 24 hours notice to cancel an appointment. Failure to call may result in a charge to your account ($25 as of 10/1/2013) and /or loss of any deposit for that appointment. Patients who do not call to cancel appointments may be discharged from the practice after the third no-show.

FINANCIAL AGREEMENT. We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer (possibly), and the insurance company. We are not party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (such as yearly physicals, cosmetic procedures, etc.).

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.** On any balance on your account after 90 days, **including those that your insurance has not paid,** collection action will be taken. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account.

If it becomes necessary to collect any sum due through an attorney (or collection agency), then the patient agrees to pay all reasonable costs of collections ($25 monthly fee as of 2013), including attorney's fees, whether suit is filed or not. Returned checks are subject to a service charge of $35.00 (or 5% of the face value of the check, whichever is greater), any bank fees and you will lose your privilege to write checks in our office.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

METHOD OF PAYMENT: CASH____, DEBIT____, CREDIT CARD____. VISA, MASTERCARD, DISCOVER, AMEX

NO CHECKS ARE ALLOWED.

I have read and understand the Financial Policy.

_____ _____

Signature (Patient, Guardian, or Power of Attorney) Date

_____ _____

Witness Date

Revised NP form April 2018 **HELLER DERMATOLOGY CENTER**

PATIENT QUESTIONNAIRE AND HISTORY

TODAY'S DATE:_____

1: PATIENT NAME:_____

2: DATE OF BIRTH:_____ **HEIGHT:**_____ **WEIGHT:**_____

3: LIST ALL THE NAMES OF ANY MEDICATIONS YOU CURRENTLY TAKE OR USE (EVEN IF ONLY AS NEEDED):

*** CHECK HERE IF YOU'VE GIVEN US A "CURRENT LIST OF MEDICATIONS" TODAY.**_____

*** (IF YOU TAKE NO MEDICATIONS, CHECK HERE:**_____**)**

_____ _____ _____

_____ _____ _____

4: PHARMACY:_____ **PHONE#**_____**LOCATION:**_____

5: LIST ALL DRUG ALLERGIES: (IF YOU HAVE NO KNOWN ALLERGIES, CHECK HERE:_____**)**

_____ _____ _____ _____ _____

6: HAVE YOU HAD A: FLU SHOT? (CIRCLE ONE) YES / NO IF YES, WHAT YEAR:_____

7: HAVE YOU HAD A: PNEUMONIA VACCINE? (CIRCLE ONE) YES / NO IF YES, WHAT YEAR_____

8: DO YOU HAVE A LIVING WILL / CARE PLAN? (CIRCLE ONE) YES / NO

(IF YES, NAME OF SURROGATE / RELATIONSHIP:_____ **PHONE :**_____

9: SOCIAL HISTORY:

	CURRENTLY	PREVIOUSLY	
CIGARETTES	Yes___ No___	Yes___ No___	(IF YES, HOW MUCH_____)
ALCOHOL	Yes___ No___	Yes___ No___	HOW MANY TIMES IN A YEAR DO YOU DRINK MORE THAN 5 DRINKS A DAY?_____

10: PLEASE LIST PAST SURGICAL HISTORY AND ANY CHRONIC ILLNESSES:

(IF YOU HAVE NO PAST SURGICAL HISTORY OR CHRONIC ILLNESSES, CHECK HERE:_____**)**

_____

_____

11: PLEASE CHECK BELOW ONLY IF IT APPLIES TO EITHER YOURSELF OR A RELATIVE (Father/Mother/Brother/Sister):

	Self	Relative
A) SKIN CANCER: MELANOMA?____OTHER?____	___	___
B) JOINT REPLACEMENT / YOURSELF ONLY		
PLEASE CIRCLE AND GIVE YEAR OF PROCEDURE		
RT HIP _____, LT HIP_____, RT KNEE_____, LT KNEE_____		
OTHER AREA AND YEAR_____		
C) Bleeding Disorder_____	___	___
D) Anemia_____	___	___
E) Blood Transfusion_____	___	___
F) HIV history_____	___	___
G) Hepatitis B?___ C?____ Other Liver Disease?___	___	___
H Alcohol / Drug Abuse_____	___	___
I) RHEUMATIC FEVER:_____	___	___
J) HEART VALVE DISORDER?_____	___	___
K) Stroke_____	___	___
L) Heart Attack_____	___	___
M) Angina / Chest Pain_____	___	___
N) High Blood Pressure_____	___	___
O) High Cholesterol_____	___	___

	Self	Relative
P) Hearing Disorder_____	___	___
Q) Recent Weight Loss_____	___	___
R) Migraine Headache_____	___	___
S) Osteoporosis_____	___	___
T) Arthritis_____	___	___
U) Eye Disease_____	___	___
V) Cataracts?_____Glaucoma?____	___	___
W) Nose Bleeds_____	___	___
X) Sinus / Throat Infection_____	___	___
Y) Depression_____	___	___
Z) Mental Illness_____	___	___
A1) Lung Disease_____	___	___
A2) Stomach Disorder_____	___	___
A3) Bowel Problems_____	___	___
A4) Kidney / Bladder_____	___	___
A5) Neurological_____	___	___
A6) Convulsions_____	___	___
A7) Diabetes_____	___	___

OTHER:_____

12: FOR WOMEN ONLY:

LAST MENSTRUAL PERIOD:_____ **ARE YOU CURRENTLY PREGNANT? YES_____ NO_____**

TAKING BIRTH CONTROL? Yes____ No____ TUBAL LIGATION?_____ **HYSTERECTOMY?**_____

13. PATIENT (OR PARENT / GUARDIAN) SIGNATURE:_____

HELLER DERMATOLOGY CENTER
LIFETIME AUTHORIZATION, INSURANCE ASSIGNMENTS
AND AUTHORIZATION TO RELEASE INFORMATION

I. RELEASE IN INFORMATION - I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payer (such as an insurance company or governmental agency, example: Blue Cross/Blue Shield or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. PHYSICIAN INSURANCE ASSIGNMENT - I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

III. MEDICARE - Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL THAT IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for my insurance or third payor within a reasonable period of time not to exceed 90 days.

If this account is assigned to any attorney for collections and/or suit, the patient (or parent/guardian) agrees to pay all reasonable attorneys' fees and costs of collection.

Date:_____

Signature of Patient (Parent/Guardian/Subscriber):_____

Original Signature on File at Physician's Office

SECONDARY INSURANCE SIGNATURE

I request that payment of authorized secondary (Medigap for Medicare patients) benefits be made on my behalf to Heller Dermatology Center for any services furnished to me by Dr. Heller. I authorize any holder of medical information about me to release to Dr. Heller any information needed to determine benefits or the benefits payable for related services.

Date:_____

Signature of Patient (Parent/Guardian/Subscriber):_____

Heller Dermatology Center
Jeffrey J. Heller, D.O.

NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

A: I, _____, feel I have complete understanding
(**PRINT** Patient Name or Parent/Guardian or POA)

and/or received a copy (***) of Jeffrey J. Heller's Notice of Privacy Practices regarding

patient:_____ / _____
(**PRINT** Patient Name) (**Patient's Date of Birth**)

Patient or Parent/Guardian or POA **SIGNATURE**_____

Date signed:_____

***** Our privacy practices booklet is available to read in the reception area <u>or</u> you may ask the front desk personnel for a copy *****

B: **I give permission** to Heller Dermatology Center to obtain my prescriptions from the pharmacy.

My initials:_____

C: **I authorize** Jeffrey J. Heller, D. O. to release my (patient's) medical information to:

<u>Please print</u>

Primary Care / Family Doctor:_____**Phone#**_____
I don't have one:_____ **Refused:**_____
(initial) **(initial)**

Name & relationship to patient:_____**Phone#**_____

Name & relationship to patient:_____**Phone#**_____

Name & relationship to patient:_____**Phone#**_____

<u>MYSELF ONLY:</u> Initial here:_____ Phone#_____

(This authorization will expire one (1) year after the date on which the authorization was signed)

HELLER DERMATOLOGY CENTER
COSMETIC INTEREST QUESTIONNAIRE

Patient name:_____ E-mail address:_____

Today's date:_____

Health issues and procedures or products of interest to you (please check all that apply).

__ BOTOX Cosmetic (Botulinum Toxin Type A)
__ AHA and Glycolic Peels
__ Thinning Lips
__ Skin Rejuvenation
__ Retin-A or Renova
__ Micro-Dermabrasion
__ Acne
__ Chemical Peels
__ Skin Wrinkle Fillers
__ I.P.L. Treatments (Intense Pulse Light)
__ Skin Care Advice
__ Skin Care Products
__ Aging Skin
__ Liver Spots / Age Spots
__ Sunscreen Advice
__ Removing Leg Veins
__ Facials and Eye Treatments
__ Hair Removal
__ Spider Vein Treatments
__ Removing Facial Veins

__ Other, Please Specify:_____

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		True Age		Older Than
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		Somewhat Concerned		Very Concerned
1	2	3	4	5

DIRECTIONS TO DAYTONA OFFICE

HELLER DERMATOLOGY CENTER
511 NORTH CLYDE MORRIS BLVD.
DAYTONA BEACH, FL 32114
386-239-8700

FROM I-95
GET OFF 95 AT THE ISB / US92 EXIT (EXIT # 87). HEAD EAST TO CLYDE MORRIS BLVD. AND TURN LEFT. WE ARE JUST PAST THE THIRD LIGHT (DUNN AVENUE) ON THE RIGHT.

FROM SOUTH DAYTONA / PORT ORANGE:
TAKE CLYDE MORRIS NORTH. GO PAST "ISB" AND CONTINUE PAST ANOTHER 3 LIGHTS. WE ARE JUST PAST DUNN AVENUE (3RD LIGHT) ON THE RIGHT.

FROM INTERNATIONAL SPEEDWAY BLVD (ALSO KNOWN AS "ISB" OR US92):
TURN NORTH ON CLYDE MORRIS BLVD. AND GO PAST THREE LIGHTS. WE ARE JUST PAST THE 3RD LIGHT (DUNN AVENUE) ON THE RIGHT.

FROM BEACHSIDE (DAYTONA):
TAKE MASON AVENUE WEST TO CLYDE MORRIS BLVD. AND TURN LEFT (SOUTH). WE ARE JUST BEFORE THE NEXT LIGHT (DUNN AVENUE) ON YOUR LEFT.

FROM NEW SMYRNA BEACH / EDGEWATER (SOUTH OF DAYTONA):
TAKE US1 (RIDGEWOOD AVE) TO ISB AND TURN LEFT. GO TO CLYDE MORRIS BLVD. AND TURN RIGHT. WE WILL BE JUST PAST THE THIRD LIGHT (DUNN AVENUE) ON THE RIGHT.

DIRECTIONS TO PORT ORANGE OFFICE

HELLER DERMATOLOGY CENTER
790 DUNLAWTON, SUITE H
PORT ORANGE, FL 32127
386-239-8700

WE ARE IN PORT ORANGE ONLY ON WEDNESDAY AFTERNOONS, BY APPOINTMENT

FROM I-95
GET OFF OF 95 AT THE PORT ORANGE EXIT (I DON'T KNOW THE EXIT #). TURN LEFT (HEADING EAST). GO ACROSSED NOVA ROAD. WE WILL BE APPROX 4/10TH OF A MILE ON THE RIGHT (PORT ORANGE MEDICAL CENTER) PAST NOVA.

FROM DAYTONA / ORMOND:
TAKE NOVA ROAD SOUTH TO DUNLAWTON AND TURN LEFT (EAST). WE ARE IN THE PORT ORANGE MEDICAL CENTER WHICH IS APPROX. 4/10TH OF A MILE FROM NOVA. THE OFFICE IS ON THE RIGHT.

FROM NEW SMYRNA BEACH / EDGEWATER:
TAKE US1 (AKA RIDGEWOOD AVENUE) NORTH TO DUNLAWTON AVENUE AND TURN LEFT. GO PAST THE POST OFFICE (THAT IS ON YOUR RIGHT). WE ARE ON THE LEFT SIDE OF THE ROAD (SOUTH SIDE) IN THE PORT ORANGE MEDICAL CENTER.

INTERNATIONAL SPEEDWAY BLVD (ALSO KNOWN AS "ISB" OR US92)