HELLER DERMATOLOGY CENTER
JEFFREY J. HELLER, D.O., F.A.A.D.
511 N. CLYDE MORRIS BLVD.
DAYTONA BEACH, FL 32114

MINOR

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

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

www.hellerdermcenter.net

DEAR PATIENT, PARENT AND/OR GUARDIAN:

THANK YOU FOR CHOOSING OUR CENTER FOR YOUR DERMATOLOGICAL NEEDS.

YOUR APPOINTMENT IS SCHEDULED FOR: _____

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

MINOR PATIENT INFORMATION SHEET

PLEASE PRINT CLEARLY AND COMPLETE IN FULL TODAY'S DATE:_____

CHILD'S NAME:_____ NICKNAME?_____
FIRST MI LAST

RACE:_____ ETHNICITY:_____ PREFERRED LANGUAGE:_____

CHILD'S DATE OF BIRTH:_____ AGE:_____ SEX_____ SS#_____

PRIMARY CARE PHYSICIAN:_____PHONE NUMBER:_____

REFERRING PHYSICIAN:_____PHONE NUMBER:_____

******* PARENT / GUARDIAN INFORMATION*******

PARENT/GUARDIAN FULL NAME:_____DOB:_____RELATIONSHIP:_____

MAILING ADDRESS_____CITY:_____ST:_____ZIP:_____

HOME PH# (____)_____ WORK PH# (___)_____ CELL PH#(___)_____

DRIVER'S LICENSE STATE AND #_____SS#_____

EMPLOYER NAME AND COMPLETE ADDRESS:_____

MARITAL STATUS: MARRIED____ SINGLE____ OTHER_____ E-MAIL ADDRESS:_____

SPOUSE'S NAME:_____ DOB:_____ SS#_____

HOME PHONE # (____)_____ WORK PHONE # (____)_____ CELL PHONE#(____)_____

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

NAME:_____RELATIONSHP:_____PHONE:(____)_____

ADDRESS:_____CITY:_____ST:_____ZIP:_____

NEAREST RELATIVE NOT LIVING WITH THE CHILD.

NAME:_____RELATIONSHIP:_____PHONE: (___)_____

ADDRESS:_____CITY:_____ST:_____ZIP:_____

NAME OF INSURANCE COMPANY:_____

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

INSURED'S DATE OF BIRTH:_____ SS#_____ SEX:_____

INSURED'S ID#_____GROUP#_____

ADDRESS **(IF DIFFERENT FROM ABOVE)**_____CITY:_____ST:____ZIP:_____

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

EMPLOYER'S ADDRESS:_____CITY:_____ST:_____ZIP:_____

DOES THE CHILD HAVE A SECONDARY INSURANCE? YES____ NO____

***** OUR OFFICE WILL NEED TO MAKE COPIES, TODAY, OF ALL INSURANCE CARDS APPLICABLE*****

DIVORCED PARENTS: IT IS THE POLICY OF THIS OFFICE THAT THE PARENT ACCOMPANYING ANY CHILD FOR TREATMENT WILL BE HELD RESPONSIBLE FOR ALL BILLS.

I AUTHORIZE TREATMENT BY HELLER DERMATOLOGY CENTER. I AGREE TO ADVISE MY PHYSICIAN OF ALL INFORMATION POSSIBLE TO ENABLE APPROPRIATE DECISIONS REGARDING CARE OF THE INVOLVED MINOR. I AGREE TO BE RESPONSIBLE FOR ALL BILLS AND ANY REASONABLE ATTORNEY AND/OR COLLECTIONS FEES INCURRED AS A RESULT OF NON-PAYMENT OF THE MEDICAL BILL(S). I AUTHORIZE DISCLOSURE OF THE MINOR'S MEDICAL RECORD TO THE SOCIAL SECURITY ADMINISTRATION (UNDER TITLE XVII OR ITS INTERMEDIARIES), INSURANCE COMPANIES, OTHER THIRD PARTY PAYORS, BENEFITS DUE ME UNDER MY HEALTH INSURANCE FOR SERVICES RENDERED BY HELLER DERMATOLOGY CENTER TO ME OR MY DEPENDENTS. I AGREE TO PAY A $35 SERVICE CHARGE (OR 5% OF THE FACE VALUE OF THE CHECK WHICHEVER IS GREATER) IF MY CHECK IS RETURNED FOR ANY REASON WHATSOEVER. I UNDERSTAND I WILL ALSO BE RESPONSIBLE FOR ANY BANK CHARGES RELATED TO THAT CHECK.

PARENT/GUARDIAN SIGNATURE:_____RELATIONSHIP TO PATIENT:_____

******* 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***** _____

(PARENT'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 ACCEPTED.

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'S
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 or 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:

Please print

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#**_____

MYSELF ONLY: Initial here:_____ Phone#_____

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

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****

I, _____,
(PLEASE PRINT - PARENT OR LEGAL GUARDIAN WITH DOCUMENTATION)

HEREBY GIVE **HELLER DERMATOLOGY AND SKIN THERAPY CENTER'S** MEDICAL PERSONNEL PERMISSION TO TREAT MY MINOR CHILD AS DEEMED NECESSARY DURING MY ABSENCE.

MY HM # (_____) _____, WK # (_____) _____, CELL # (_____) _____

NAME OF CHILD:_____DATE OF BIRTH_____

IN MY ABSENCE, I AUTHORIZE THE FOLLOWING ADULT(S) TO BRING MY CHILD IN FOR TREATMENT. THIS BEING MY PRIORITY LIST.

STEPPARENT:_____
(FULL NAME)

GRANDPARENT:_____
(FULL NAME)

ADULT BROTHER OR SISTER:_____
(FULL NAME)

ADULT AUNT OR UNCLE:_____
(FULL NAME)

OTHER: _____
(FULL NAME AND RELATIONSHIP TO THE PATIENT)

IN CASE OF EMERGENCY (AND I CANNOT BE REACHED), PLEASE CONTACT:

_____
(PLEASE PRINT - NAME AND RELATIONSHIP TO CHILD)

_____
SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

_____
WITNESS DATE

ALL SURGICAL PATIENTS

SURGERY PROCEDURE CANCELLATION AGREEMENT

Heller Dermatology Center would like to inform you of our new cancellation policy effective May 22, 2019.

A specific length of time is being reserved for your surgical procedure / appointment. We would greatly appreciate that any cancellations or rescheduling be done **at least 24 hours** before that appointment time. **Failure to contact us within 24 hours before your surgical appointment will result in a $50 fee being charged to your personal account (not to be billed to an insurance company). (This includes "no shows" for a surgical appointment).**

Thank you for your cooperation as we try to operate efficiently.

Patient's printed name:_____

Patient's or guardian's signature:_____

Witnessed by:_____

Date:_____

HELLER DERMATOLOGY CENTER

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.