LC/DERM
LEGENDS DERMATOLOGY, LLC
IULIA FUNIERU, MD
Diplomat of the AAPS

1497 LEGENDS BLVD.
CHAMPIONS GATE, FL 33896
PHONE (407) 479-2924
FAX (407) 479-2999

PATIENT REGISTRATION FORM

Name: _____ ☐ Jr. ☐ Sr.
First Middle Last

Prefer to be called: _____ Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Address: _____
Street # Street Name Apartment #

_____
City State Zip Code

Employer: _____
Name Address Phone

Home Phone: ( )_____ Date of Birth: ____/____/____
Month Day Year
Cell Phone ( )_____
Work Phone: ( )_____

Social Security Number: _____ Sex: ☐ Male ☐ Female

Where should statements of your account be sent if different from above? Single___ Married___

_____
Name Address Apt # City State Zip

In case of Emergency, who should be notified?_____ Phone ( )_____

Primary Care Physician: _____ Who Referred You? _____

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT ALL MAJOR CREDIT CARDS FOR YOUR CONVENIENCE. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the release of medical information to your primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. You herein authorize payment of medical benefits to the physician.

_____ _____
Signature of patient or legal guardian Date

Name of policy owner if other than patient: _____ Date of Birth: _____

Patient relationship to policy owner: ☐ Self ☐ Child ☐ Other: _____

Please present Insurance Cards and photo ID to the receptionist so copies may be made.

Do we have your permission to: Leave a message or Text on your cell phone. Yes ☐ YES No ☐ NO

Leave a message on your answering machine at home? ☐ YES ☐ NO

Leave a message at your place of employment? ☐ YES ☐ NO

Discuss your medical condition and/or financial information with any member of your household? ☐ YES ☐ NO

If yes, whom? _____ Relationship: _____

_____ _____
Patient Signature Date

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
Fibromyalgia
GERD
Hearing Loss
Heart
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Kidney
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stomach
Stroke
Thyroid
Valve Replacement
None

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement within last 2 years
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None

Other _____

Name_____ Date_____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer__Date_____
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma____ Date_____
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer__ Date____
None
Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Any other family history: _____

Pharmacy Name/Number_____
Race _____

Reason for visit_____

Medications: (Please enter all current medications)

_____
_____
_____

Allergies: (Please enter all allergies) _____

Name_____Date_____

Social History: (Please circle all that apply)

Cigarette Smoking:

Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

Sexual History:

Not sexually active
Sexually active with one partner
Sexually active with more than one partner
Same sex partner

Illicit Drug Use:

Drug Use
IV Drug Use

Alcohol Use:

Alcohol: none
Alcohol: less than 1 drink a day
Alcohol: 1-2 drinks a day
Alcohol: 3 or more drinks a day

Are you pregnant? Yes_____ No_____
If yes, Due Date: _____

Other_____

None

Name_____Date_____

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FINANCIAL POLICY

We are committed to providing you with the best possible medical care. If you have medical insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance, and your understanding of our payment policy.

Please be aware that it is your responsibility to know your insurance policy and coverage in relation to Dermatology. We do not acknowledge responsibility for each individual plan. Laboratory charges are not included in the cost of the procedure and all billing for laboratory services is handled by the lab.

Co-payments (the amount a patient is responsible to pay every time they see a primary doctor or a specialist) and **Deductibles** (the fixed amount of money patients are required to pay before the insurance starts to pay, based on contracted rates with your insurance and the type of service is provided), as well as **Co-insurances** (the portion of your medical bill patients pay, for certain services, after the deductible is met) **must be paid at the time services are rendered**. Once the insurance has processed the claims the payments made at the office will be applied towards the deductible or the out of pocket maximum established by each individual insurance plan.

In case of an overpayment the office will refund the overpaid amount AFTER the EOB (explanation of benefits) from the insurance is received. This may take 30 to 45 days. You can opt to leave the overpaid amount in the account here as a credit for future visits.

In case of an underpayment we will bill you after the EOB from insurance is received.

New patients need to provide us with **Photo ID and Insurance** card, or just photo ID if no insurance available. Established patients please notify the front desk of any change of address, telephone number or insurance.

All cosmetic services will require $50.00 deposit at the time the appointment is made, except cosmetic laser procedures and dermal fillers which require $100.00 deposit. The deposit will be credited towards the cosmetic procedure.

Returned checks are subject to **$35.00 charge**. Unpaid accounts that are more than 90 days old will be sent to a Collection Agency after due notice is served to the patient with a fee **of $12.00**

I have read and understood the Financial Policy of Legends Dermatology and agree to comply with its terms

Signature_____ Date_____/_____/_____

Print name_____

PATIENT RECEIPT OF PRIVACY NOTICE
EXHIBIT 1
Review date January 2, 2017

LEGENDS DERMATOLOGY
1497 LEGENDS BLVD
CHAMPIONS GATE, FL 33896
PHONE (407) 479-2924
FAX (407) 479-2999

WRITTEN ACKNOWLEDGEMENT FORM

RECIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (1) have received a copy of the Notice of the Privacy Practices

OR

(2) have been offered a copy of the Notice of the Privacy Practices but declined to accept a copy

_____ _____

Signature of patient **DATE**

FOR OFFICE USE ONLY

WRITTEN ACKNOWLEDGEMENT OF PAITENT REFUSAL TO SIGN A RECEIPT OF NOTICE OF PRIVACY PRACTICES

On the _____day of_____2017 the notice of Privacy Polices was offered

or given to _____
Print name

_____The patient accepted a copy of the Notice of Privacy Practices but refused to sign an acknowledgement that it was given to the patient

_____The patient refused to accept a copy of the Notice of Privacy Practices and refused to sign an acknowledgement that it was offered to the patient

_____ _____

Signature of employee DATE

Exhibit 1
Review Date January 2, 2017
WRITTEN ACKNOWLEDGEMENT FORM
RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ _____ _____ _____

Witness signature DATE Patient/agent/guardian signature DATE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on 6/15/2017 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, IULIA FUNIERU MD. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $0.25 for each page and the staff time charged will be $ 10 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Iulia Funieru, M.D.
Legends Dermatology, LLC.
1497 Legends Blvd.
Champions Gate, FL 33896

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.)
We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $0.25 for each page and the staff time charged will be $ 10 per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. **HOW TO CONTACT US:**

Practice Name: LEGENDS DERMATOLOGY, LLC Privacy Officer: IULIA FUNIERU MD

Telephone: (407)479-2924 Fax: (407)479-2999

Email: legendsderm@gmail.com

Address: 1497 Legends Blvd, Champions Gate, FL 33896