DR. ROBERT A. NORMAN, DO, MPH, MBA
Dermatology

NEW PATIENT INFORMATION

(PLEASE FILL OUT COMPLETELY AND CLEARLY)

Patient's Name: _____ Sex: ☐ M ☐ F

Date of Birth: _____/_____/_____ Marital Status: ☐ Single ☐Married ☐ Divorced ☐ Widowed

Social Security: _____ Driver's License or ID #: _____

Parent/Guardian's name if patient is under 18yrs old: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Primary Care Doctor: _____ Phone: _____

Primary Care Doctor Address: _____

Patient's Employer: _____ Occupation: _____

Current Pharmacy (Name_____, Address:_____ & Ph #):_____ ____

Employer's Address: _____

How did you hear about us?: _____

PRIMARY INSURANCE

☐ Medicare ☐ Avmed ☐ Sunshine ☐ Staywell ☐ Molina ☐ Healthease ☐ WellCare ☐ Aetna ☐ BCBS

☐ Cigna☐ United Health ☐ Multiplan ☐ Humana ☐ Beechstreet ☐ Tricare ☐ integral quality ☐ Great West

☐ Prestige ☐ Better Health ☐ Hillsborough Health Care ☐ Pinellas Care ☐ Tampa Care

☐ OTHER: _____Policy Number: _____

Insured's Name: _____ Insured's Date of Birth: _____/_____/_____

Relationship to Patient: _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Work Phone: _____

MEDICAL HISTORY **(PLEASE FILL OUT COMPLETELY AND CLEARLY)**

Name of Patient: _____ Date: _____

Please describe the reason for visiting the office today &(((KSQR@CDGJJCBGL(((': _____]

Current Medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you allergic to any medications? †Yes †No | If YES please list:

_____

Do you have now or have you ever had the following diseases or conditions**:**

Dermatological:
Acne ☐ Yes ☐ No
Eczema ☐ Yes ☐ No
Hives ☐ Yes ☐ No
Psoriasis ☐ Yes ☐ No
Other Skin Issues ☐ Yes ☐ No

Mental:
Anxiety ☐ Yes ☐ No
Depression ☐ Yes ☐ No
Psychiatric Care ☐ Yes ☐ No

Respiratory:
Bronchitis ☐ Yes ☐ No
Emphysema ☐ Yes ☐ No
Asthma ☐ Yes ☐ No
Chronic Cough ☐ Yes ☐ No

Vascular:
High Blood Pres. ☐ Yes ☐ No
Chest Pain ☐ Yes ☐ No
Heart Attack ☐ Yes ☐ No
Heart Murmur ☐ Yes ☐ No
Irreg. Heart Rate ☐ Yes ☐ No
Pacemaker ☐ Yes ☐ No
Phlebitis ☐ Yes ☐ No

Other Conditions:
Diabetes ☐ Yes ☐ No
Thyroid ☐ Yes ☐ No
Kidney ☐ Yes ☐ No
Bladder ☐ Yes ☐ No
Stomach ☐ Yes ☐ No
Bowel ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No
Convulsion ☐ Yes ☐ No
Fainting ☐ Yes ☐ No
Joint ☐ Yes ☐ No
Deformity ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Epilepsy, Seizures ☐ Yes ☐ No
HIV (AIDS) ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No | If YES, how many per day? _____
Do you take IV drugs? ☐ Yes ☐ No | If YES, which one? _____ How much? _____
Have you ever had dental anesthesia (Novocain)? ☐ Yes ☐ No
Any bad reaction to anesthesia? ☐ Yes ☐ No

Skin:
When expose to sun do you: ☐ Tan ☐ Tan & Burn ☐ Burn
Have you ever had skin cancer? ☐ Yes ☐ No
Has anyone in your family ever had skin cancer? ☐ Yes ☐ No
Do you have any history of skin disease? ☐ Yes ☐ No
If YES, please list: _____
List any other disease or condition we should know about: _____
List surgical procedures you have had in the last 6 months: _____

Please answer the following questions:
Do you Smoke? ☐ Yes ☐ No | If YES, how much? _____
Do you bleed easily? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No
Do you have artificial joint(s)? ☐ Yes ☐ No

What are your hobbies?_____

Completed by:
☐ Patient: _____ ☐ Medical Assistant: _____

☐ Doctor: _____ Date: _____/_____/_____

DR. ROBERT A. NORMAN, DO, MPH, MBA
Dermatology

FINANCIAL AGREEMENT & AUTHORIZATION FOR TREATMENT

(PLEASE FILL OUT COMPLETELY AND CLEARLY)

PAYMENT POLICY

We take Cash, Checks, Money Orders, Debit Cards, and Visa and Mastercard Credit cards. Patients without insurance are required to pay in full at the time of service. We require insurance co-payments to be paid at the time of service. Since insurance deductibles and co-insurance are often not known at the time of service, we will bill you for these after your insurance has paid. However, we reserve the right to collect known deductibles and co-insurance at the time of service.

We will process insurance claims for office procedures or surgery, however, please be aware that you, the patient, are responsible for the bill. Prompt payment of any amounts due after your insurance has paid is necessary to remain a patient of this practice. In addition, any patient who files bankruptcy and lists Dr. Robert A. Norman, DO, MPH, MBA & Associates as a debtor will no longer be seen by this office.

Accounts that are delinquent after 90 days may be subject to collection and all costs involved, including, but not limited to, attorney fees, court costs, and judgment interest, and will be considered patient responsibility. Any legal action will be filed in the Hillsborough County Court system.

I hereby authorize payment of medical benefits to Dr. Robert A. Norman, DO, MPH, MBA & Associates for services furnished to me by my provider. I further agree to pay all co-pays, deductibles, non-covered services or charges considered above usual and customary (non-contracted carriers only) by my insurance company.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Dr. Robert A. Norman, DO, MPH, MBA & Associates to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Dr. Robert A. Norman, DO, MPH, MBA & Associates' Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Robert A. Norman, DO, MPH, MBA & Associates reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Robert A. Norman, DO, MPH, MBA & Associates' Privacy Officer at 8002 Gunn Hwy. Tampa, FL 33626.

With this consent, Dr. Robert A. Norman, DO, MPH, MBA & Associates may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls, pertaining to my clinical care, including laboratory results among others. Dr. Robert A. Norman, DO, MPH, MBA & Associates may also mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient information.

I have the right to request that Dr. Robert A. Norman, DO, MPH, MBA & Associates restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Dr. Robert A. Norman, DO, MPH, MBA & Associates' use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Robert A. Norman, DO, MPH, MBA & Associates may decline to provide treatment to me. (Patients under 18 years of age will need a parent or guardian signature authorizing treatment and consenting to financial responsibility.)

_____	_____	_____
Name of Patient or Legal Guardian	Signature of Patient or Legal Guardian	Date

DR. ROBERT A. NORMAN, DO, MPH, MBA
Dermatology

HIPAA - PATIENT CONSENT FORM

(PLEASE FILL OUT COMPLETELY AND CLEARLY)

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 healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosure 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 healthcare operations
- The Practice has a Notice of Privacy Practice 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:

_____	_____	_____/_____/_____
Patient or Representative's Name	Signature	Date
_____	_____	_____/_____/_____
Relationship to Patient	Witness/Practice Representative Signature	Date

DR. ROBERT A. NORMAN, DO, MPH, MBA
Dermatology

DOCTOR-PATIENT ARBITRATION AGREEMENT **(PLEASE FILL OUT COMPLETELY AND CLEARLY)**

This agreement is made between Robert A. Norman D.O., P.A., their agents, employees or any of the foregoing, referred to herein after as "Doctor" and referred to herein after as the patient. It is the intention of the parties to this agreement to bind not only themselves, but also their heirs, personal representatives, guardians, *children, spouses* or any person deriving their claims or on behalf of *the* patient.

It is understood by the patient that he or she is not required to use Dr. Norman and Associates, nor any of the foregoing referred to us "doctor" for dermatology services and that there are numerous other physicians in the Tampa Bay area who are qualified to perform dermatology services.

For and in consideration of the mutual benefits flowing one to the other, it is understood and agreed that *in the* event of any controversy, dispute or claims which might arise between the doctor and the patient, regardless of whether the dispute concerns the medical care rendered, or payment of surgical or other fees, or any other matter whatsoever, the dispute shall be resolved by arbitration as provided In the Florida Arbitration Code, Chapter 682, Laws of Florida. IT IS UNDERSTOOD THAT THIS ARBITRATION SHALL BE IN LIEU OF AND INSTEAD OF ANY TRIAL BY JUDGE OR JURY. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. The arbitrators shall be licensed physicians certified by the American Board of Dermatology and actively engaged in the practice of Dermatology in the State of Florida. The panel of arbitrators shall hear and decide the controversy, dispute or claim, and the decision shall be binding on all parties.

It is further understood and agreed by the parties hereto that the arbitration of any controversy, dispute or claim pursuant to this agreement shall be commenced within the time prescribed by the applicable Florida Statue of Limitations. An action pursuant to this agreement shall be deemed to commence upon the receipt of a written claim notifying the Doctor or Patient, whichever the case may be, of the nature of the controversy, dispute or claim, and demanding that the parties proceed with arbitration in accordance with the terms or this agreement. The maximum recoverable damages under the agreement are limited to $150,000.

_____	_____	_____/_____/_____
Patient or Representative's Name	Signature	Date
_____	_____	_____/_____/_____
Doctor or Authorized Representative's Name	Signature	Date
_____	_____	_____/_____/_____
Witness Name	Witness Signature	Date

DR. ROBERT A. NORMAN, DO, MPH, MBA
Dermatology

PATHOLOGY PAYMENT GUIDELINES **(PLEASE FILL OUT COMPLETELY AND CLEARLY)**

In order to determine the laboratory that any specimens taken will go to, please ask a front desk receptionist for an updated list of payers and corresponding laboratories. All specimens not read within Dr. Robert A. Norman's office will be sent to a third-party laboratory, based on payer, and the patient or responsible party will receive a bill from that third-party laboratory.

Self-pay patient specimens are read within Dr. Robert A. Norman's office. Self-pay patients must pay a Pathology Fee per specimen. Pathology is NOT included in the price of the Biopsy. Pathology Self-Pay fee is $85 per biopsy specimen. Specimens associated with any other payer are sent out to the corresponding laboratory.

_____ _____ _____/_____/_____

Patient or Responsible Party's Name Signature Date

No Show Fee Policy:

Patients must contact our office during business hours from 9 a.m. to 5 p.m., Monday through Friday, 48 hours in advance, to cancel their appointment. Failure to contact our office will result in a charge to the patient.

The fees are:

New patient visit: $100.00 Follow-up visit: $50.00

The fee must be paid in full before your next appointment can be scheduled.

_____ _____ _____/_____/_____

Patient or Representative's Name Signature Date

To Our Patients:

If we are providers for your insurance company, you will be asked for a credit or debit card number all information will be held securely until your insurances have paid their portion and notified us of your financial responsibility. At that time, any remaining balance due will be charged to your credit card. If we are NOT providers for your insurance plan, the office policy remains the same: you will pay in full at the time of your visit; we will file your medical claim to your insurance company as a courtesy. After receiving an Explanation of Benefits (EOB) from your insurance company any credits will be refunded to you by your insurance plan or **our** office. ***It is in your best interest to understand your insurance plan*.**

This credit card policy will be an advantage to you as you will no longer have to prepare and mail us check. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and post in the mail. All fees due can be taken care of without trips to office. This policy benefits everybody by keeping the cost of health care down, and by allowing us to concentrate first and foremost on your medical needs.

Our Credit card on account policy in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays, co-insurances and deductible amounts will, of course, still be due at the time of your visit. Any outstanding balances over 90 days will be charged to your credit card or patient will be sent to our collection agency.

PLEASE NOTE: **Any charges over $ 100 will receive a courtesy call to advise we will be charging this to your credit card on file**.

++

I authorize _____ to charge the outstanding balances on my account to the following credit card. If the billing address for this credit card differs from your home address, please advise the billing address. Thank You.

Visa ____ MC ____ AmEx ____ Disc ____ Care Credit ____

Account Number _____ Exp Date _____

Name on card (PRINT) _____

Patient Name _____ Date of Birth _____

Signature _____ Date _____

1. Is my credit card Secure?

This office has adopted an electronic medical record. These are no paper records. All Medical offices and institutions will be required to comply with this federal mandate in the near future. Your Credit card information will be entered into the computer adjacent to your social security number. The system is completely secure and there will be no paper copy of your credit card number floating around.

2. Why am I being asked to leave this information?

This credit card will be used to cover any expenses not reimbursed by your insurance. Unfortunately, "incidentals" are often unexpected until your insurer sends out an explanation of benefits. Unlike some offices, Dermatology offices often provide services not included in a regular office visit. (Biopsies, Destruction, etc.) These services are evaluated individually by your insurance, and may result in addition patient responsibility. Leaving this information in advance cuts down expenses significantly, and saves paper. These services are evaluated individually by your insurance; any may result in additional patient responsibility.

Leaving this information in advance cuts down expenses significantly, and saves paper. There are 4 steps in collection that this policy will save. Printing a statement, mailing the statement, writing a check (or printing your CC number) and sending the statement back.

Everyone is looking for ways to cut expenses, and simple process and provide significant savings to everyone.

3. I know my insurance and co-pay, why do I need to leave the information?

If you have ever tried to call your insurance company, you can understand this completely. Despite our best efforts at calling insurance companies to verify benefits, we are frequently given incorrect information. We have been told individuals were eligible when their plan had actually expired. We have been told co-pays were $25, when they are actually $50. All of this adds up quickly.

4. Do I have any other options?

Yes. You may pay our fees in full at the time of service. We will then refund you promptly when your insurance company determines payment.

5. May I revoke my number at any time?

Yes. Once your insurance has paid your claim (you will receive a copy of your explanation of benefits in the mail from your insurer). You may call us, and we will delete the information.

Medical Records Release

I, _____, request a copy or summary of the following medical records regarding the following patient:

Patient's Name: _____ Patient's Date of Birth: _____

TO BE SENT FROM

Dr. Robert A. Norman and Associates
8002 Gunn Hwy
Tampa, FL 33626
Phone: 813-880-7546, Fax: 813-249-5210

TO BE SENT TO

_____
_____
_____

__ Complete Medical Record
__ Biopsy Report(s)
__ Lab Report(s)
__ Consultation Reports
__ Medication Allergies
__ Allergy Test/Treatment
__ Surgical Procedures
__ Other: _____

For dates of service from _____ to _____

Additional Comments:
_____
_____
_____

_____ _____
Patient's Signature Date

_____ _____
Parent's or Guardian's Signature Date

_____ _____
Witness Date