

Thi T. Tran, DO, FAOCD, FAAD
Board Certified Dermatology
Board Certified Mohs Micrographic Surgery



Skin Cancer and Mohs Surgery Specialist

Dear New Patient:

Welcome to Village Dermatology & Cosmetic Surgery! We are pleased that you have chosen us to care for your dermatologic needs. Our goal is to provide you with compassionate, accessible and quality dermatologic care for your skin, hair, and nails. Dr. Tran specializes in derma-surgery and the diagnosis and treatment of skin cancer.

Your skin care is important to us. Dr. Tran and his team of Physician Assistants and Nurse Practitioners will take their time to address your concerns both medically and surgically. Each member of our staff is dedicated to making your visit a positive and educational experience. However, emergencies and unexpected delays during patient care may occur. We will do our best to minimize such delays. Thank you very much for your understanding and patience.

Please help us to provide you with the best of care by taking the time to review and complete the enclosed new patient forms.

Once you have completed the above forms, **please send the forms back by mail, drop them off at our office or bring them with you on your first visit.** In addition, Village Dermatology & Cosmetic Surgery requires all patients to bring 2 forms of identification: please bring your (1) **STATE/GOVERNMENT ISSUED DRIVER'S LICENSE** or **NON-DRIVER IDENTIFICATION CARD** and (2) **CURRENT INSURANCE CARD(S).**

Should you have any questions regarding the enclosed forms, please do not hesitate to call us. We look forward to seeing you in our office so that we can get to know you better.

Your appointment date and time: _____.

Note: When you come for your appointment, please do not wear any fragrances such as perfume, lotion, or aftershave.

Thank you.

Sincerely,

Dr. Thi Tran and Staff

1950 Laurel Manor Drive, Suite 224 | The Villages, FL 32162 | **tel** 352.751.6565 | **fax** 352.205.7777

www.villagederm.com

Revision: 11/2016

VILLAGE DERMATOLOGY AND COSMETIC SURGERY, L.L.C.

***** PLEASE FILL OUT THIS FORM AS COMPLETELY AND ACCURATELY AS POSSIBLE*****

*****Please refrain from wearing perfume after-shave and strong-smelling lotions to the office. People who have allergies and illnesses, especially those undergoing chemotherapy, cannot tolerate strong scents. Several patients have complained of sneezing, itchy and teary eyes and having to change seats due to heavy perfume scents*****

Patient's Full Name as it Appears on Insurance Card:			
Date of Birth:		Social Security Number:	
Marital Status:	Single Married Widow(er) Divorced	Sex:	Male Female
Driver's License:		Issuing State:	
Mailing Address:			
City:		State and Zip Code:	
Out-of-State Mailing Address:			
City:		State and Zip Code:	

PATIENT'S CONTACT INFORMATION

Cell Phone No.:		Home Phone No.:	
Work Phone No.:		Email Address:	

PATIENT'S EMERGENCY CONTACT INFORMATION

Name (Relation):		Contact Number:	
Name (Relation):		Contact Number:	
Name (Relation):		Contact Number:	

PATIENT'S EMPLOYMENT INFORMATION

Occupation:		Employer:	
Work Address:			

PATIENT'S OTHER HEALTHCARE PROVIDERS

Primary Doctor:		Phone Number:	
Referring Doctor:		Phone Number:	

Verified by (Initials)/Date: _____/_____

MRN: _____

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PRIMARY INSURANCE INFORMATION	
Insurance Company/Carrier:	
Policy Holder's Name:	
Policy Holder's Relationship with Patient:	
Policy Holder's Date of Birth:	
Policy or Member ID Number:	
Policy Group Number:	

SECONDARY INSURANCE INFORMATION	
Insurance Company/Carrier:	
Policy Holder's Name:	
Policy Holder's Relationship with Patient:	
Policy Holder's Date of Birth:	
Policy or Member ID Number:	
Policy Group Number:	

TERTIARY INSURANCE INFORMATION	
Insurance Company/Carrier:	
Policy Holder's Name:	
Policy Holder's Relationship with Patient:	
Policy Holder's Date of Birth:	
Policy or Member ID Number:	
Policy Group Number:	

PATIENT'S INITIALS	ACKNOWLEDGEMENT
	I authorize Village Dermatology & Cosmetic Surgery, LLC to bill my insurance(s).
	Authorization to release information: I hereby authorize Village Dermatology & Cosmetic Surgery, LLC to release any information required in the course of my examination or treatment, which could include pictures, HIV, communicable disease, drug abuse information or a letter regarding the care I have received with Village Dermatology & Cosmetic Surgery, LLC to any of my referring doctors listed on page 1.
	Authorization to pay: I hereby authorize payment directly to Village Dermatology & Cosmetic Surgery, LLC for the surgical and/or medical benefits, if any, otherwise payable to be for services.
	I understand that I am financially responsible for the charges NOT COVERED by my insurance.

Patient's Signature:		Date:	
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Verified by (Initials)/Date: _____ / _____

MRN: _____

BILLING PROCEDURE STATEMENT

Patient Name:		Date of Birth:	
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Thank you for choosing Village Dermatology & Cosmetic Surgery, LLC for your healthcare needs. Along with providing you with quality service, Village Dermatology would also like to assist you with your billing questions and needs.

It is the patient's responsibility to understand his/her benefits, coverages, and if Village Dermatology & Cosmetic Surgery, LLC is in-network with his/her insurance, prior to receiving any service. Copayments and/or outstanding balances are due at the time of check-in.

1.	MEDICARE ONLY. Village Dermatology & Cosmetic Surgery, LLC is a contracted specialty provider of Medicare. We will file claims for Medicare for you. Village Dermatology & Cosmetic Surgery, LLC accepts Medicare assignments; however, you will still be responsible for the 20% that Medicare does not cover at the time services are rendered.
2.	MEDICARE + SUPPLEMENT. Village Dermatology & Cosmetic Surgery, LLC is a contracted specialty provider of Medicare. We will file claims with both insurance for you. However, claims denied, rejected or partially paid by your supplemental carrier will be your responsibility in 30 days, without prior arrangement.
3.	FEDERAL BLUE CROSS & BLUE SHIELD. Village Dermatology & Cosmetic Surgery, LLC is a contracted specialty provider of Federal BCBS. We will file claims with Federal BCBS for you. However, claims denied due to non-coverage will be your responsibility in 30 days, without prior arrangement.
4.	TRICARE STANDARD & TRICARE FOR LIFE. Village Dermatology & Cosmetic Surgery, LLC is a contracted specialty provider of Tricare Standard and Tricare for Life. We will file claims with Tricare Standard and Tricare for Life for you. However, claims denied due to non-coverage will be your responsibility in 30 days, without prior arrangement.
5.	CHAMPVA & VA COMMUNITY CARE NETWORK. Village Dermatology & Cosmetic Surgery, LLC is a contracted specialty provider of ChampVA and VA Community Care Network. We will file claims with ChampVA and VA Community Care Network for you. However, claims denied due to non-coverage will be your responsibility in 30 days, without prior arrangement.
6.	PRIVATE HEALTHCARE INSURANCE/MEDICARE ADVANTAGE PLAN (IN-NETWORK). Village Dermatology & Cosmetic Surgery, LLC is a contracted specialty provider of the following listed insurance carriers. We will file claims with the insurance for you. However, claims denied due to non-coverage will be your responsibility in 30 days, without prior arrangement. • Florida Blue Cross & Blue Shield Commercial PPO Only; <i>Except Florida BlueSelect</i> • United Healthcare Commercial & Medicare Advantage Plans • Humana Medicare Advantage Plans • Aetna Commercial & Medicare Advantage Plans • Freedom Health & Optimum Health Medicare Advantage HMO Plans • Cigna Commercial PPO Only • BCBS of Michigan Medicare Advantage PPO (Retired School Employees)
7.	PRIVATE HEALTHCARE INSURANCE/MEDICARE ADVANTAGE PLAN (OUT-OF-NETWORK). <u>Full payment is due at the time services are rendered</u> , unless prior arrangements have been made. As a courtesy, Village Dermatology & Cosmetic Surgery, LLC will file claims with the insurance for you. Claims denied, for any reason, will be the patient's responsibility in 30 days, without prior arrangement. Any payment received by Village Dermatology & Cosmetic Surgery, LLC from the insurance will be reimbursed to the patient, if he/she has paid in full at the time of visit.
8.	UNINSURED & SELF PAY. Patients may request a good faith estimate prior to receiving services. Note that the final invoice may be different from the issued good faith estimate, depending on the services rendered during the visit. <u>Full payment is due at the time services are rendered</u> , unless prior arrangements have been made. Village Dermatology & Cosmetic Surgery, LLC will provide you with an invoice for services rendered during your healthcare visit.
HMO Plans	Certain HMO plans may REQUIRE REFERRAL and/or PRIOR AUTHORIZATION prior to receiving services from a specialty provider. It is the patient's responsibility to understand this requirement, as this may cause delayed care. Please contact your Primary Care Physician, to help with expediting the process.
Bank Fees	Foreign checks will be subjected to an additional \$10.00 fee, per check, as the patient's responsibility. Any returned checks due to insufficient funds, stopped payment, and closed accounts will result in a \$15.00 fee as the patient's responsibility.

ACKNOWLEDGMENT

I have been informed, and I understand the billing procedures of Village Dermatology & Cosmetic Surgery, LLC.

I agree to pay any balances that are my responsibility. Balance unpaid will result in collection actions.

I also understand that all laboratory charges are billed separately from the physician's office services and it is my responsibility to pay.

Patient's Signature:		Date:	
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Verified by (Initials)/Date: _____ / _____

MRN: _____

PATIENT NOTICE OF PRIVACY PRACTICES

Patient Name:		Date of Birth:	
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This notice describes how medical information about you may be disclosed. Please review it carefully. Village Dermatology & Cosmetic Surgery, LLC will use your medical information for the following:	
1.	TREATMENT: Including providing your medical records to consulting clinicians and insurance companies.
2.	PAYMENT: We will file necessary claims to insurance companies in your name to obtain payment. They may request part or all of your medical record to pay the claim.
3.	HEALTHCARE OPERATIONS: Any others involved in your healthcare.
The entire PRIVATE POLICY NOTICE of Village Dermatology & Cosmetic Surgery, LLC is posted in the waiting room for your perusal.	

In conjunction with these privacy practices, you will need to provide us with the following information:	
Name of person(s) and telephone number(s) who we may speak to regarding your healthcare (i.e. spouse, family member, etc.).	
May we communicate with you by mail or leave a message on your answering machine regarding your healthcare or an upcoming appointment?	
Yes	No
May we send you text (SMS) messages on your cell phone and/or email messages for updates and information, including appointment reminders?	
Yes	No

INFORMED CONSENT

I understand that during my course of treatment, unforeseen conditions may occur that necessitate a skin biopsy(s) to be taken by shave, punch, and/or excision. In addition, I also give permission to have minor surgical procedures, and any subsequent treatments as deemed necessary as long as the risks and complications are discussed with me prior to the said procedure. These risks include, but are not limited to scarring, bleeding, swelling, pain, deformity, infection, and/or ulceration. I will also inform the practitioner of any possible contradictions to the planned procedure, including medications, such as anticoagulants, aspirin, cardiac, infections or psychotropic.

I recognize that every surgical procedure involves uncertainty, and no result can be guaranteed. I also recognize that the practitioner is not responsible for natural complications that may occur. If any postoperative complications occur, it is my responsibility to contact the practitioner as soon as possible.

To document and follow the course of my treatment, I give permission to have photographs taken. Photographs are part of my medical record and confidential in nature. I also grant permission for judicious use for medical education purposes if my identity is withheld.

I also consent to the disposal of any tissue, which is removed in accordance with accustomed practice and procedure. I give my permission to have any tissue removed during the procedure sent for histological examination.

I understand that any controversy or claim arising out of medical care provided will be resolved through mandatory binding arbitration under the rules of the Florida Arbitration Code.

I have been informed and understand both the Patient Notice of Privacy Practices and Informed Consent listed above by Village Dermatology & Cosmetic Surgery, LLC. I read and signed a copy of the Summary of the FL Patient's Bill of Rights and Responsibilities. I read and signed a copy of the Individuals' Right under HIPAA to Access their Health Information.

Patient's Signature:		Date:	
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Verified by (Initials)/Date: _____ / _____

MRN: _____

PATIENT HISTORY (Medical, Surgical, Social, and Family)

Patient Name:		Date of Birth:	
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PAST MEDICAL HISTORY:

1. Heart Disease, such as:

- Heart attack ☐ Y ☐ N
Dates: _____
Angina/Chest Pain ☐ Y ☐ N
Abnormal rhythm ☐ Y ☐ N
Coronary disease ☐ Y ☐ N
High blood pressure ☐ Y ☐ N
Heart failure ☐ Y ☐ N
Pacemaker ☐ Y ☐ N
Implantable
Defibrillator ☐ Y ☐ N
Heart valve ☐ Y ☐ N

2. Lung Disease, such as:

- Asthma/wheezing ☐ Y ☐ N
Emphysema ☐ Y ☐ N
Bronchitis ☐ Y ☐ N
Chronic cough ☐ Y ☐ N
History of TB (self) ☐ Y ☐ N
History of TB (family) ☐ Y ☐ N
Shortness of breath ☐ Y ☐ N
Sleep Apnea ☐ Y ☐ N

3. Genital/Urinary:

- Kidney/Renal disease ☐ Y ☐ N
Dialysis ☐ Y ☐ N
Last date of dialysis _____

4. Skin:

- Basal Cell Nevus
Syndrome ☐ Y ☐ N
Chronic Scar ☐ Y ☐ N
Squamous Cell
Carcinoma ☐ Y ☐ N
Basal Cell Carcinoma ☐ Y ☐ N
History of Melanoma ☐ Y ☐ N

5. Joints:

- Prosthesis ☐ Y ☐ N

6. Reproductive

- Are you or might you
be pregnant? ☐ Y ☐ N

7. Gastro-intestinal:

- Liver disease ☐ Y ☐ N
Jaundice ☐ Y ☐ N
Hiatal hernia/Reflux ☐ Y ☐ N

8. Blood & Coagulation:

- AIDS/HIV ☐ Y ☐ N
Hepatitis/type ☐ Y ☐ N
If yes, what type? _____
Anemia ☐ Y ☐ N
Bleeding after surgery ☐ Y ☐ N

9. Nervous System:

- Strokes ☐ Y ☐ N
Seizures/Epilepsy ☐ Y ☐ N
Head/Neck injury ☐ Y ☐ N

10. Endocrine:

- Diabetes ☐ Y ☐ N
Thyroid disease ☐ Y ☐ N

11. Other:

- Arsenic Exposure ☐ Y ☐ N
Immunosuppression ☐ Y ☐ N

12. Prosthesis

- ☐ Y ☐ N

13. Are you or might be pregnant?

- ☐ Y ☐ N

14. Do you have problems with bleeding after a biopsy or a surgical procedure?

- ☐ Y ☐ N

15. Dentures

- ☐ Upper ☐ Lower ☐ None

16. Contact Lenses

- ☐ Y ☐ N

17. Other Medical Problem(s) Not Listed:

PAST SURGICAL HISTORY:

FAMILY HISTORY:

- History of Melanoma (family) ☐ Y ☐ N

SOCIAL HISTORY:

1. History of Sun Exposure

- Or Sun Burns ☐ Y ☐ N

2. Tanning Bed Use

- ☐ Y ☐ N

3. Sunscreen Use

- ☐ Y ☐ N

4. Self-Skin Exams

- ☐ Y ☐ N

FUNCTIONAL HISTORY:

Are you deaf or do you have serious difficulty hearing?

- ☐ Y ☐ N

DRUG ALLERGIES AND REACTIONS:

Allergic to local anesthetics ☐ Y ☐ N

Allergic to topical

antibiotics ☐ Y ☐ N

Allergic to latex ☐ Y ☐ N

Sensitive to tape/bandages ☐ Y ☐ N

MA's Signature and Date:

Provider's Signature and Date:

MEDICATION LIST

Patient Name:		Date of Birth:	
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Please PRINT clearly. You may attach additional page(s) or a copy of your current medication list.

Medication Name (Inc. OTC and Supplements)	Dosage	Frequency (i.e. Once a day)	How You Take/Use The Medication (i.e. Orally)

CURRENT LOCAL PHARMACY:

Pharmacy Name:		Phone Number:	
Location:		Fax Number:	

CURRENT MAIL-ORDER PHARMACY:

Pharmacy Name:		Phone Number:	
Location:		Fax Number:	

PATIENT'S INITIALS	ACKNOWLEDGMENT
	Incomplete Record. Patient is unable to provide some/all of the following information: dosage, frequency, and/or route of administration.
I hereby certify that all information listed above and/or attached to this form is correct and provided to the best of my knowledge.	

Patient's Signature:		Date:	
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Verified by (Initials)/Date: _____ / _____

MRN: _____

Patient Name:		Date of Birth:	
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How did you hear about us?

Thank you for choosing Village Dermatology & Cosmetic Surgery, LLC. We would appreciate your taking the time to complete this form.	
Did you hear about us in one of the following ways?	
☐	Social media: Facebook _____ Instagram _____
☐	Google Search
☐	Yelp
☐	Vitals.com
☐	Healthgrades.com
☐	Nextdoor.com
☐	RateMDs.com
☐	Villages-News.com
☐	Newspaper Advertisement: The Villages Daily Sun
☐	Magazine Advertisement: The Villages Magazine
☐	Radio Advertisement: The Villages Radio
☐	The Villages Phonebook
☐	The Villages Newcomers Guide
☐	Community Seminar/Event Where/When:
☐	Other:
Whom may we thank for referring you to our practice?	
☐	Village Dermatology Employee:
☐	Employer:
☐	Friend/Neighbor:
☐	Family:
☐	Insurance Provider:
☐	Physician Referral:
Yes No	Have you visited our website – www.villagederm.com ?

Summary of the Florida Patient's Bill of Rights and Responsibilities

Florida law (Florida Statute 381.026) requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

Patient Rights:

1.	A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
2.	A patient has the right to prompt and reasonable response to questions and requests.
3.	A patient has the right to know who is providing medical services and who is responsible for his or her care.
4.	A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
5.	A patient has the right to bring any person of his or her choosing to the patient-accessible areas of the health care facility or provider's office to accompany the patient while the patient is receiving inpatient or outpatient treatment or is consulting with his or her health care provider, unless doing so would risk the safety or health of the patient, other patients, or staff of the facility or office or cannot be reasonably accommodated by the facility or provider.
6.	A patient has the right to know what rules and regulations apply to his or her conduct.
7.	A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
8.	A patient has the right to refuse any treatment, except as otherwise provided by law.
9.	A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
10.	A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
11.	A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
12.	A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
13.	A patient has the right to impartial access to medical treatment or accommodation, regardless of race, national origin, religion, handicap, or source of payment.
14.	A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
15.	A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
16.	A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

Patient Responsibilities:

1.	A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
2.	A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
3.	A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
4.	A patient is responsible for following the treatment plan recommended by the health care provider.
5.	A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
6.	A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
7.	A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
8.	A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

I read and understand the Summary of the Florida Patient's Bill of Rights and Responsibilities.

Patient's Signature:		Date:	
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Individuals' Right under HIPAA to Access their Health Information (45 CFR 164.524)

1.	Records disclosure (authorization for release or to obtain) must be in writing <u>AND</u> signed by patient (or his/her personal representative authorized under the State*).
2.	Per our office policy, a NEW disclosure form must be signed by the patient at each request .
3.	Please allow 5 to 7 business days from the date we receive your signed form to complete your request.
	Under the HIPAA Privacy Rule, a covered entity must act on an individual's request for access no later than 30 days after receipt of the request, see 45 CFR 164.524(b)(2).
For more information on Individuals' Right under HIPAA to Access their Health Information (45 CFR 164.524), please visit the U.S. Department of Health and Human Services website at www.hhs.gov .	

*Must provide a legitimate copy of an individual's personal representative authorization under State (i.e. POA).

I read and understand the Individuals' Right Under HIPAA to Access their Health Information.

Patient's Signature:		Date:	
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