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

Village Dermatology & COSMETIC SURGERY, LLC

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 and Dr. Tran will take his 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 is requiring all patients to bring 2 forms of identification: please bring your (1) **STATE/GOVERNMENT ISSUED DRIVER'S LICENSE** or **NON-DRIVER IDENTFICATION 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

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***** 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. A number of patients have complained of sneezing, itchy and teary eyes and having to change seats due to heavy perfume scents*****

NP____ CONSULT____ DATE _____ TIME_____

Patient's Full Name: _____

Marital Status: S____ M ____ W ____ D ____ **Social Security #** _____

Date of Birth: _____ **Age:** _____ **Sex:** F ____ M ____

Driver's License # _____ **Issuing State**: _____

Mailing Address: _____

City: _____ **State**: _____ **Zip**: _____

Alternate Address: _____

City: _____ **State**: _____ **Zip**: _____

To respect your privacy please tell us which of the following numbers we should call to communicate with you regarding **APPOINTMENT REMINDERS, LAB RESULTS,** etc. **Only** list the phone number, or numbers, you want us to call.

Home Phone # _____ **Work Phone #** _____

Cell (Alternate) Phone # _____ **Email:** _____

Please list any family members or any other person that the staff can communicate with regarding your medical or insurance issues.

Name: _____ **Phone #**: _____

Occupation: _____ Employer _____

Employer's Address: _____

Spouse's name: _____ Spouse phone # _____

Person to contact in case of an emergency: _____

Emergency contact phone # _____

Your referring physician: _____ Phone # _____

Your primary care physician: _____ Phone # _____

Verified by (Initials)/Date: _____/_____ MRN: _____

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Primary Insurance _____

Insured: (SUBSCRIBER) _____

Insured's relationship to patient: _____

Insured's Date of Birth: _____

POLICY # _____

GROUP # _____

Secondary Insurance_____

Insured: (SUBSCRIBER) _____

Insured's relationship to patient: _____

Insured's Date of Birth: _____

POLICY # _____

GROUP # _____

_____**Initial**: I authorize **Village Dermatology & Cosmetic Surgery, L.L.C.** to bill my insurance.

_____**Initial: Authorization to release information**: I hereby authorize **Village Dermatology & Cosmetic Surgery, L.L.C**. 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, L.L.C**. to any of my referring doctors listed on **page 1.**

_____**Initial: Authorization to pay**: I hereby authorize payment directly to **Village Dermatology & Cosmetic Surgery, L.L.C.** 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 Signature: _____ Date: _____

Verified by (Initials)/Date: _____/_____ MRN: _____

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BILLING PROCEDURE STATEMENT

Patient Name: _____ **Date of Birth:** _____

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. Please read the following provisions and initial the billing class that best represents you:

1. **Medicare only** – Village Dermatology & Cosmetic Surgery, LLC will file Medicare for you. Village Dermatology & Cosmetic Surgery, LLC accepts assignment; 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 will file both insurances for you. However, claims denied, rejected or partially paid by your supplemental carrier will be your responsibility in 30 days.

3. **Medicare Advantage/Complete Plan** – Village Dermatology & Cosmetic Surgery, LLC will file insurance for you. However, claims denied or rejected will be your responsibility in 30 days.

4. **BC/BS – PPO Only** - Village Dermatology & Cosmetic Surgery, LLC will file insurance for you. However, claims denied or rejected will be your responsibility in 30 days.

5. **Private Healthcare Insurance** – Full payment is due at the time services are rendered unless prior arrangements have been made. Village Dermatology & Cosmetic Surgery, LLC will provide you with an invoice for services rendered during your healthcare visit so that you may submit to your healthcare insurance company for reimbursement.

6. **Self-Pay** – Full payment is due at the time services are rendered unless prior arrangements have been made. Village Dermatology & Cosmetic Surgery, LLC will provide you with an invoice for services rendered during your healthcare visit.

I have been informed and understand the billing procedures of Village Dermatology & Cosmetic Surgery, LLC. I agree to pay any balances that are my responsibility. Balances unpaid will result in collection actions.

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

_____ _____

Signature of the patient **OR** legal representative and relationship to patient Date

Verified by (Initials)/Date: _____/_____ MRN: _____

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PATIENT NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

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:

1. Name of person(s) and telephone number(s) who we may speak to in regards to your healthcare (i.e. spouse, family member, etc.).

   _____

   _____

2. May we communicate with you by mail or leave a message on your answering machine in regards to your healthcare or an upcoming appointment? YES _____ NO _____

INFORMED CONSENT

I understand that during my course of treatment, unforeseen conditions may occur that necessitates 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 complication 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 the 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 histologic 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 received a copy of Summary of the FL Patient's Bill of Rights and Responsibilities.

_____ _____

Signature of the patient **OR** legal representative and relationship to patient Date

Verified by (Initials)/Date: _____/_____ MRN: _____

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HISTORY (Medical, Social, Family) AND MEDICATION

Patient Name: _____ **Date of Birth:** _____

Have you in the past or present had:

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 (self) □ Y □ N
History of Melanoma (family) □ Y □ N
History of Sun Exposure Or Sun Burns □ Y □ N
Tanning Bed Use □ Y □ N
Sunscreen/Sun block Use □ Y □ N
Self Skin Exams □ 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
Problems bleeding after surgical procedure □ Y □ N

9. Nervous System:
Strokes □ Y □ N
Seizures/Epilepsy □ Y □ N
Head/Neck injury □ Y □ N

10. Endocrine:
Diabetes □ Y □ N
Insulin □ Y □ N
Thyroid disease □ Y □ N

11. Smoker □ Y □ N
Stop Smoking Counseling □ Y □ N
Pkg/day _____
# of years _____

12. Alcohol □ Y □ N
Qty./Frequency _____

13. Have you or anyone in your family had high fever/complications during or after surgery? □ Y □ N
If yes, reaction:
_____

14. Other:
Arsenic Exposure □ Y □ N
Immunosupression □ Y □ N

15. Previous Surgeries/Other Medical Problems
_____
_____
_____
_____

Dentures ☐ upper ☐ lower ☐ none
Contact Lenses □ Y □ N
Drug allergies/reactions:
_____
_____
_____
_____

Allergic to local anesthetics □ Y □ N
Allergic to topical antibiotics □ Y □ N
Allergic to latex □ Y □ N
Sensitive to tape/bandages □ Y □ N
Blood thinning agents □ Y □ N

Vitamins/Herbal treatments
☐ Vitamin E
☐ Multivitamin
☐ Ginko
☐ Garlic tablet
☐ Other _____
☐ None

PLEASE LIST ALL MEDICATIONS, DOSES AND FREQUENCY ON THE NEXT PAGE (MEDICATION LIST).

Do you take NSAIDS? □ Y □ N
☐ Self prescribed
☐ Dr. prescribed

Do you take aspirin? □ Y □ N
☐ Self prescribed
☐ Dr. prescribed

Doctor _____

Why? _____

Patient interviewed: ☐ **in person** ☐ **by phone** **Date:** _____

NURSE'S NOTES:
_____
_____
_____

Reviewed

Nurse's/MA's signature/Date: _____ **Provider's signature/Date:** _____

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MEDICATION LIST

Patient Name: _____ **Date of Birth:** _____

Please PRINT clearly.

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

IMMUNIZATION RECORD:

Pneumonia Vaccine: □ Yes □ No Date of Last Dose: _____

Flu Vaccine: □ Yes □ No Date of Last Dose: _____

CURRENT PHARMACY:

Pharmacy Name: _____ Location: _____

Phone Number: _____ Fax Number: _____

Incomplete Record

_____ Patient is unable to provide some/all of the following information: dosage, frequency, and/or route of administration.

Patient Certification

I hereby certify that all information listed above and/or attached to this form is correct and provided to the best of my knowledge.

_____ _____

Signature of the patient **OR** legal representative and relationship to patient Date

Verified by (Initials)/Date: _____/_____ MRN: _____

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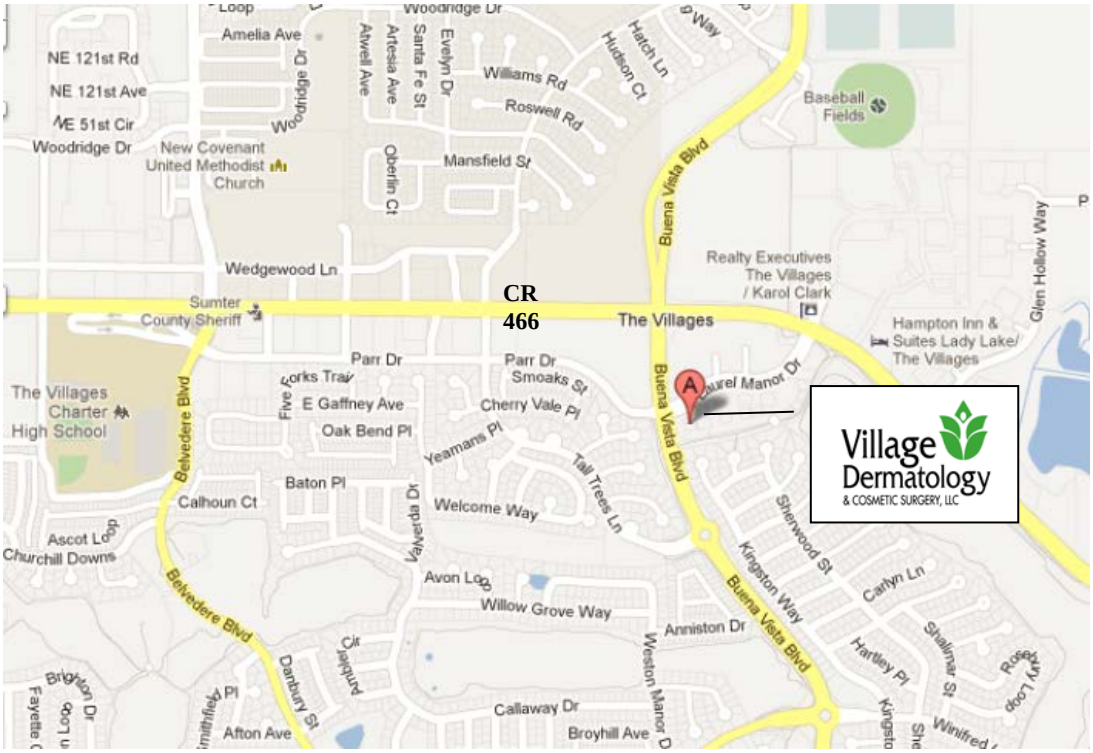
DIRECTIONS TO VILLAGE DERMATOLOGY & COSMETIC SURGERY, LLC



From I-75

Take Wildwood Exit (#329) East on Hwy 44. At US 301, head North (left). Follow US 301 North for approximately 8 miles (through Wildwood). At CR 466, turn right into the Villages. Follow CR 466 for approximately 2 miles to Buena Vista Boulevard. Turn right on to Buena Vista Boulevard. Make the first left off of Buena Vista into the Laurel Manor Professional Park. Village Dermatology & Cosmetic Surgery, LLC is on the first right in Building 220, Suite 224.

From Ocala/Belleview/Summerfield

Head South on US 301. At CR 466, head East (left) in to the Villages. Follow CR 466 for approximately 2 miles to Buena Vista Boulevard. Turn right (traffic light) on to Buena Vista Boulevard. Make the first left off of Buena Vista into the Laurel Manor Professional Park. Village Dermatology & Cosmetic Surgery, LLC is on the first right in Building 220, Suite 224.

From Leesburg/Fruitland Park

Head north on US 27. At CR 466, head West (left) in to the Villages. Follow CR 466 to Buena Vista Boulevard. Turn left (traffic light) on to Buena Vista Boulevard. Make the first left off of Buena Vista into the Laurel Manor Professional Park. Village Dermatology & Cosmetic Surgery, LLC is on the first right in Building 220, Suite 224.

Village Dermatology & COSMETIC SURGERY, LLC

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 a 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 accommodations, 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.

Village Dermatology & COSMETIC SURGERY, LLC

Patient Name: _____ Date: _____

How did you hear about us?

Thank you for choosing Village Dermatology & Cosmetic Surgery, LLC. We would appreciate you 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
- ☐ RateMDs.com
- ☐ Villages-News.com
- ☐ Newspaper Advertisement: Publication: _____
- ☐ Magazine Advertisement: Publication: _____
- ☐ Radio Advertisement: Station: _____
- ☐ The Villages Residential Directory
- ☐ The Villages Newcomers Guide
- ☐ Community Seminar/Event: Where/When: _____
- ☐ Other: _____

Whom may we thank for referring you to our practice?

- ☐ VDCS' Employee Name: _____
- ☐ Employer Name: _____
- ☐ Friend/Neighbor Name: _____
- ☐ Family Name: _____
- ☐ Insurance Provider Name: _____
- ☐ Physician Referral Name: _____

Have you visited our website – www.villagederm.com? Please circle: Yes No