Welcome to Alliant Dermatology, PA!

We would like to thank you for giving us the opportunity to be your skin care provider. Our goal is to provide you with excellent care that you can trust. We would like to welcome you and help prepare you for your visit to our office. Below are some forms you can complete at home, to help expedite the check-in process. As part of our record keeping system, your file will be created upon receiving your completed forms the day of your scheduled appointment. Please note that new patient forms will not be accepted prior to your scheduled appointment. If you are unable to complete these forms at home before your appointment, please arrive 45 minutes ahead of your scheduled appointment.

To be prepared for your visit with us, please understand the following things:

- Please do not wear any make-up, concealer, sunscreen, lotions, jewelry, perfume or cologne.
- For a full body skin check, be prepared that you will be asked to remove all clothing including your socks and shoes. If you prefer, you may leave on your under garments.

In addition, you will need the following items for your first appointment:

- Insurance card(s) and Driver's license
- List of any medications and dosages currently taking
- Any medical records or test results pertaining to your skin condition or history of skin cancers
- Form of payment for co-pays and/or deductibles (we accept cash, checks, VISA, or MasterCard)
- Please be knowledgeable about your insurance plan and benefits

These items will help make your visit with us smooth and easy. If you are unable to make your scheduled appointment, please call us as soon as possible.

After your appointment, you will be receiving an email to access your patient portal which has all of your records. You can expect to receive the email 24 to 48 hours after your appointment.

For more information about Alliant Dermatology, please visit our website at: **www.alliantdermatology.com** or call us at **352-399-7295**, or email us at **mail@alliantdermatology.com**

We look forward to meeting with you shortly.

Sincerely,

Alliant Dermatology Providers and Staff

ALLIANT DERMATOLOGY
Medical | Surgical | Cosmetic | Vein
Established 2012
(352) 399-7295

Dermatology
Mohs Surgery
Plastic Surgery
Vein Therapy
Cosmetic Dermatology
Radiation Oncology

Dear Patient –

- Please be aware that we now have the capability to process our biopsy lab specimens in house.
- Dr. L. Frank Glass, MD is our Dermatopathologist.
- There will be a separate lab charge which will be billed directly by us.
- If you would like more information, or for us to use a different laboratory for your biopsy specimen, please let us know. Thank you for your understanding.

Sincerely,

Alliant Dermatology Providers and Staff

www.alliantdermatology.com
Santa Fe Crossing
8620 E County Road 466
The Villages, FL 32162

Fax: (352) 399-7294
Creekside Medical Plaza
1050 Old Camp Rd, Bldg. 150
The Villages, FL 32162

mail@alliantdermatology.com
Colony Professional Plaza
340 Heald Way, Ste. 216
The Villages, FL 32163

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Please circle your pharmacy. If you use Medco, Express Scripts, Caremark, or any other mail order pharmacy please indicate below.

CVS Pharmacy 5208 E CR 466, The Villages, FL 32162 (352) 751-4700	**CVS Pharmacy** 860 Avenida Central, Lady Lake, FL 32159 (352) 750-1118	**CVS Pharmacy** 17817 SE 109th Ave, Summerfield, FL 34491 (352) 347-6616	**CVS Pharmacy** 1235 North 14th Street, Leesburg, FL 34748 (352) 787-7800
Walgreens 400 Colony Blvd, The Villages, FL 32162 (352) 205-7010	**Walgreens** 890 N US Highway 441, Lady Lake, FL 32159 (352) 753-3257	**Walgreens** 1581 Bella Cruz Drive, Lady Lake, FL 32159 (352) 750-9959	**Walgreens** 2235 Parr Drive, The Villages, FL 32162 (352) 391-9457
Walgreens 8591 SE 165th Mulberry Lane, The Villages, FL 32162 (352) 753-5034	**Walgreens** 2010 Citrus Blvd, Leesburg, FL 34748 (352) 326-0735	**Walgreens** 901 South 14th Street, Leesburg, FL 34748 (352) 787-3506	**CVS Pharmacy** 901 S Main St, Wildwood, FL 34785 (352) 748-0588
Publix Pharmacy 1566 Bella Cruz Drive, Lady Lake, FL 32159 (352) 750-9863	**Publix Pharmacy** 8780 SE 165th Mulberry Lane, The Villages, FL 32162 (352) 751-0304	**Publix Pharmacy** 327 Colony Boulevard, The Villages, FL 32162 (352) 391-1808	**Publix Pharmacy** 3475 Wedgewood Lane, The Villages, FL 32162 (352) 751-6280
Publix Pharmacy 1120 Bichara Boulevard, Lady Lake, FL 32159 La Plaza Grande West (352) 750-2424	**Publix Pharmacy** 717 North 14th Street, Leesburg, FL 34748 Palm Plaza (352) 787-0664	**Publix Pharmacy** 27615 US Highway 27, Leesburg, FL 34748 (352) 787-2122	**Wal-Mart Pharmacy** 17861 U.S. HWY 441, Summerfield, FL 34491 (352) 307-4410
Walmart Pharmacy 4085 Wedgewood Ln, The Villages, FL 32162 (352) 259-2844	**Walmart Pharmacy** 2501 Citrus Blvd, Leesburg, FL 34748 (352) 326-4044	**Target Pharmacy** 716 N US HWY 441, The Villages, FL 32162 (352) 205-8943	**Premier Pharmacy** 1580 Santa Barbara Blvd The Villages, FL 3216 (352) 561-3234
Sam's Club Pharmacy 755 N Highway 27/441, Lady Lake, FL 32162 (352) 751-5989	**Winn-Dixie (Sumter)** 820 Old Camp Rd, The Villages, FL 32162 (352) 391-1594	**Winn-Dixie Pharmacy** 944 Bichara Blvd, Lady Lake, FL 32159 (352) 753-6115	**The Medicine Chest** 910 Old Camp Rd, The Villages, FL 32162 (352) 847-0905
Leesburg Pharmacy 225 N First Street, Leesburg, FL 34748 (352) 314-7403	**Oxford Pharmacy** 3612 Wedgewood Ln, The Villages, FL 32162 (352) 750-1400	**Vintage Pharmacy & Specialty Compounding** 725 Highway 466, Lady Lake, FL 32159 (352) 751-6895	**RX CARE PHARMACY** 13733 N US Hwy 441, The Villages, FL 32159 (352) 391-5533
Rx Care Pharmacy 725 Highway 466, Lady Lake, FL 32159 (352) 633-1873	**Burry's Pharmacy** 500 Webster Street, Leesburg, FL 34784 (352) 787-3787	**Leesburg Community Pharmacy** 2500 Citrus Blvd, Leesburg, FL 34748 (352) 728-0477	**Publix (Brownwood)** 2925 Traverse Trail, The Villages, FL 32163 352-750-2714
Winn-Dixie (Pinellas) 2500 Burnsed Blvd, The Villages, FL 32163 (352) 753-5575	**Walgreens (Pinellas)** 2615 Burnsed Blvd, Wildwood, FL 34785 (352) 391-9370	**Wal-Mart Pharmacy** 270 Heald Way, The Villages, FL 32163 (352) 461-5017	

Please tell us your pharmacy if you do not see it listed: _____
_____

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Alliant Dermatology, PA New Patient Registration

Patient Name (Last, First, MI): _____

Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different): _____

Male/Female: _____ Social Security Number: _____ Marital Status: _____

Date of Birth: _____ Home Phone: _____ Cell Phone: _____

E-mail: _____Employer: _____

Occupation: _____ Work Phone: _____

Preferred Language: _____ Race: _____ Hispanic or Latino? Yes or No

Preferred Reminder Method (Circle One): Phone Call Text Email

How did you hear about us? _____

Emergency Contact:_____ Relationship: _____

Address:_____ Telephone: _____

Medical Insurance Information:

1. Primary Insurance: _____ Policy Holder: _____
2. Secondary Insurance: _____ Policy Holder: _____

Relation to Policy Holder: _____ Policy Holder's SS#: _____

Policy Holder's Date of Birth: _____ Policy Holder's Phone #: _____

Consent for Treatment and Assignment of Insurance and Medicare Benefits:

The patient and/or authorized representative of the patient, who signed below, do hereby consent to any medical treatment which may be deemed advisable by my physician. I authorize my insurance carrier to pay directly to Alliant Dermatology PA all charges submitted for service incurred by me. I also authorize and assign payment directly to Alliant Dermatology PA for benefits otherwise payable to me for medical services incurred. If payment is not received from my insurance company within 45 days of the date of my treatment, I understand that I am responsible for the balance in full. I understand that I will be responsible for any charges not paid by my insurance company. I authorize Alliant Dermatology PA to release information concerning my medical condition to my insurance company for the purpose of processing a claim. This authorization and assignment shall be valid until I notify Alliant Dermatology PA in writing of the cancellation.

Signature (Patient/Legal Representative): _____ Date: _____

Relationship of Legal Representative: _____

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Alliant Dermatology - Patient Medical History Questionnaire

Name: _____ Date of Birth: ____/___/___ Age: _____

Primary Care Doctor: _____ Telephone: _____

Did a Doctor Request a Consultation? YES NO Doctor's Name: _____

Doctor's Phone #: _____ Doctor's Fax #: _____

Reason for your visit today? (e.g. Skin and/or mole check, Skin lesion(s), Skin rash)

Location: _____ Duration: _____ Severity: Mild/Moderate/Severe

Symptoms (e.g. Itch/Pain/Changing): _____ Treatments: _____

Triggers (What improves/worsens it?): _____

Past Medical History (Please circle all that apply)		
Anxiety	Depression	Hyperthyroid
Arthritis	Diabetes	Hypothyroid
Asthma	End stage renal disease	Leukemia
Bone marrow transplant	GERD	Lung cancer
Breast cancer	Hearing loss	Lymphoma
Colon cancer	Hepatitis A / B / C	Prostate cancer
COPD	High blood pressure	Radiation treatment
Coronary artery disease	HIV/ AIDS	Seizures
Other _____	High cholesterol	Stroke
Past Surgical History (please circle all that apply)		
Appendix removed	Colectomy: colon cancer	Kidney removed (left, right)
Bladder removed	Colectomy: diverticulitis, IBD	Kidney stone removal
Mastectomy (right, left, both)	Gallbladder removed	Ovaries removed (left, right)
Lumpectomy (right, left, both)	Coronary artery bypass	Prostate removed
Breast biopsy (right, left, both)	Heart valve replacement	TURP
Breast reduction	Heart transplant	Spleen removed
Breast implants	Knee replacement (right, left)	Testicles removed (left, right)
OTHER_____	Hip replacement (right, left)	Hysterectomy
Skin Disease History (please circle all that apply)		
Acne	Dry skin	Poison ivy
Actinic keratoses (precancer)	Eczema	Precancerous moles
Asthma	Flaking, itchy scalp	Psoriasis
Basal cell skin cancer	Hay fever/ allergies	Squamous cell skin cancer
Blistering sunburns	Melanoma: Year and Location:	Sunscreen use
Tanning salon	_____	
Social History (please circle all that apply)		
Currently smokes (packs/day):_____		Last flu vaccine (year)_____
Has smoked in the past		Pneumonia vaccine (year)_____
Never smoked		Shingles vaccine (year)_____
Drug use (type):_____		Alcohol (How many drinks/day?):_____

Family History (list 1st degree relatives with dermatological conditions)		
Family history of Melanoma yes or no If yes which relative? _____ Family history of Autoimmune disease? yes or no Please name: _____ Family history of Psoriasis? yes or no If yes which relative? _____ Family history of Non-melanoma skin cancer? yes or no If yes which relative? _____		
Name:		
Medications: (Name, strength, frequency) Please include all prescription, OTC and herbal agents		
1.	7.	
2.	8.	
3.	9.	
4.	10.	
5.	11.	
6.	12.	
Drug Allergies: Please list any medications and specify the type of allergic reaction (e.g. rash)		
Review of Systems (please circle all that apply)		
Problems bleeding Problems with healing Problems with scarring Immunosuppression Changing mole Rash Abdominal pain Anxiety Bloody stool	Bloody urine Blurry vision Chest pain Cough Depression Fever or chills Headaches Hay fever Joint aches	Muscle weakness Neck stiffness Night sweats Seizures Shortness of breath Sore throat Thyroid problems Unintentional weight loss wheezing
Alerts (please circle all that apply)		
Pacemaker Defibrillator Artificial joints within past 2 years Artificial heart valve Premedication prior to procedure Allergy to adhesive Allergy to topical antibiotic ointments Allergy to oral antibiotics	Blood thinners Pregnancy or planning pregnancy Allergy to lidocaine Rapid heartbeat with epinephrine MRSA Yeast infection with antibiotics GI upset with antibiotics Other:_____	

_____ _____

Signature of Patient/Legal Guardian Date

_____ _____

Patient's Name (Please Print) Legal Guardian's Name (Please Print)

Alliant Dermatology PA - Office Financial Policy

Dear Patient: We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

Medicare:

We are participating Medicare providers. You will be responsible at the time of service for payment of:

- Annual deductibles and co-payments
- Charges for non-covered or cosmetic services

If you have Medicare as well as secondary coverage with a commercial plan, we will file a claim to your secondary/supplemental carrier. If no payment is received from your secondary/supplemental carrier within 45 days after we file a claim, you will be sent a bill and will be responsible for the balance.

Non-Medicare/Commercial Plans:

We will bill any commercial carrier (in-network or out-of-network) for charges for all covered, medically necessary services rendered. We will bill both your primary and secondary insurance plans. You will be responsible at the time of service for payment of:

- Annual deductibles and co-payments
- Charges for non-covered or cosmetic services

Self-Pay:

Patients without insurance coverage will be expected to pay at the time of service. If you will not be able to pay in full, you must contact our office manager prior to seeing the doctor to make payment arrangements.

POS/HMO Commercial Insurance Plans:

It is the responsibility of the patient to obtain prior authorization from your primary care physician before each visit to our office. If this is not done, you will be responsible for any unpaid balance due.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

_____ _____

Signature of Patient/Legal Guardian Date

_____

Patient's Name (Please Print)

Alliant Dermatology, PA

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

With my consent, Alliant Dermatology PA may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. I understand and consent that Alliant Dermatology PA may email me, call me, or mail to my home appointment reminders, statements, insurance items, or clinical documents such as laboratory results.

Authorization for Voicemail Usage for PHI

□ I hereby GIVE permission to leave a message on my voicemail concerning my personal health information.

□ I hereby DENY permission to leave a message on my voicemail concerning my personal health information.

I _____, am aware if call blocker is activated, I will miss a call back with my results.

Consent to Share Personal Health Information

It will be the policy of Alliant PA to not release any confidential and/or unauthorized information to anyone not personally authorized by the patient. I hereby authorize Alliant Dermatology PA to share my personal health information with named persons below until further written notice from me:

Name: _____Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

By signing this form, I am consenting Alliant Dermatology PA, to use and disclose my PHI to carry out treatment, payment, and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. I understand that if I do not sign this consent, Alliant Dermatology PA may decline to provide treatment to me.

_____ _____

Signature of Patient/Legal Guardian Date

_____

Patient's Name (Please Print)

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Notice of Privacy Practices Acknowledgement and Consent

You have the right to review the Notice of Privacy Practices prior to signing this consent. The Notice of Privacy Practices tells you how we may use and share your health records. Please read it.

You have the following rights with respect to your health records:

1. You have the right to look at and receive a copy of your health records.
2. You have the right to receive a list of whom we have given your health records to.
3. You have the right to ask for us to correct a mistake in your health records.
4. You have the right to ask that we not use or share your health records.
5. You have the right to ask us to change the way we contact you.

All of these rights are explained in more detail in the Notice of Privacy Practices.

THIRD PARTY MESSAGING

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

ACKNOWLEDGEMENT AND CONSENT TO NOTICE OF PRIVACY PRACTICES:

I have received a copy of Alliant Dermatology PA Notice of Privacy Practices and I consent to the use and sharing of my health records for treatment, payment and operation purposes as described in the Notice. I understand that if I do not consent, Alliant Dermatology PA cannot provide services to me.

_____ _____

Signature of Patient/Legal Guardian Date

_____

Patient's Name (Please Print)

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INFORMED CONSENT FOR CRYOSURGERY AND SKIN BIOPSIES

Patient Name: _____ Date of Birth: _____

I hereby authorize the Providers at Alliant Dermatology, PA to perform cryosurgery and skin biopsies and to administer topical or local anesthesia, as necessary, and to administer any emergency care they deem necessary or advisable.

I have been fully informed of and understand that the risks and complications include: pain, abnormal sensation, bleeding, irregular pigmentation, scarring including hypertrophic, keloid or spread scarring, infection, recurrence, sensory nerve changes, neurologic damage including loss of muscle function, positive margins and possible need for further surgery, asymmetry and a rare, but life-threatening allergic reaction to injected anesthesia. I understand that it is impossible for the doctor to inform me of every possible complication that may occur, and occasionally rare and unexpected side effects happen. The nature and purpose of the cryosurgery and/or skin biopsy, alternative methods of treatment, no treatment, and the risks involved, and the possibilities of complications have been explained to me. No guarantee has been made regarding results that may be obtained. I understand that photographs may be taken, and I consent to this as long as my identity is not revealed. I understand that these photographs may be used for medical documentation, teaching, research or scientific publication. I consent to the disposal by Alliant Dermatology and its physician's staff of any tissues or body parts which may be removed and not used for pathology and any and all related data and documentation for use as research and development for any all purposes so long as my identity is not revealed.

Cryosurgery Alternative Treatment Options: Topical chemotherapy creams (used twice daily for 2-4 weeks), electrodessication and curettage, photodynamic therapy, chemical peels, and laser.
Biopsy Alternative Treatment Options: No reliable alternative.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS CONSENT, WHICH THE EXPLANATIONS WERE MADE, THAT MY QUESTIONS HAVE BEEN ANSWERED, AND NO GUARANTEES WERE MADE. THIS CONSENT IS IN EFFECT UNTIL REVOKED BY PATIENT IN WRITING.

_____ _____
Signature of Patient / Parent / Guardian MRN

_____
Signature of Provider

_____ _____
Signature of Witness Date

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Vein Survey

Patient name: _____ Date of Survey:_____ MRN:_____

Do you experience any of the following? Please check one.

	Yes	No
Aching/Pain		
Heaviness		
Bulging varicose veins		
Fatigue		
Spider veins		
Itching/Burning		
Swelling/Edema		
Cramps/Throbbing		
Restless legs		
Non-healing ounds/Ulcers		
Skin changes/pigmentation		
Neuropathy/Numbing/Tingling		

Are you presently being treated or seeing a specialist for these symptoms? __Yes __No

Would you be interested to cosmetically treat your spider veins? __Yes __No

Would you like to be contacted to schedule a Vein Therapy Consultation? __Yes __No

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Care instructions for your biopsy site(s)

- Clean the biopsy site(s) once daily with soap and warm water. After drying, apply a plain ointment such as Vaseline. It is okay to use an antibiotic ointment such as Bacitracin or Neosporin, so long as you are not allergic.
- Simply cover the area with a Band-Aid. Do this once daily until the area has healed.
- If the biopsy was taken from your leg or foot, healing will take longer and can sometimes take several weeks.
- If you have problems with bleeding from the biopsy site, you may apply WOUND SEAL powder to the biopsy site. This can be purchased at your local pharmacy.
- The biopsy site will initially be red, then gradually return to normal skin color over the next several weeks. Occasionally, the treatment area(s) will heal slightly darker or lighter than your normal skin color. If at any time, you feel the treated site(s) are infected or not healing correctly, please contact the office as soon as possible.

General Information

- You have had an abnormal appearing lesion or growth biopsied. The tissue removed has been sent to the lab for evaluation. It usually takes from seven to ten working days to get the results from the lab. Please call us within 2 weeks for the results of your biopsy.
- If your biopsy results show an abnormality, we will contact you to schedule a follow-up appointment to ensure this area is successfully treated.
- If at any time you feel the biopsy site is infected or not healing correctly, please contact the office at (352)399-7295 as soon as possible. Some types of abnormal scars can be improved with topical or injected medication.

Care instructions for Liquid Nitrogen treatment site(s)

You have just had treatment with Liquid Nitrogen (also called Cryotherapy). Please follow these instructions for care of the treated site(s):

- The treated site(s) might become red or swollen. A fluid-filled blister or blood blister may form. Try not to “pop” the blisters but if the blisters do “pop” try to leave the blister “roof” intact to cover the treated site and not pick at the blister skin.

- When you shower, wash area(s) gently with soap and warm water once a day. After drying, you may apply a plain ointment such as Vaseline. You may apply a Band-Aid if needed.

- The new skin will be pink then gradually return to normal skin color over the next several weeks. Occasionally, the treatment area(s) will heal slightly darker or lighter than your normal skin color. If at any time, you feel the treated site(s) are infected or not healing correctly, please contact the office as soon as possible. Occasionally the treated growth does not disappear and the area(s) may need additional treatment or removal by another method. If you have any questions or concerns, please contact the office at (352)399-7295 as soon as possible.