We are pleased to welcome you to our practice.

DATE: «TODAYSDATE»

PATIENT INFORMATION	
Patient's **LEGAL** Name:	SSN
ADDRESS	
HOME PHONE:	SEX :
WORK PHONE:	MARITAL STATUS:
OTHER PHONE:	D.O.B.
(FOR CHILDREN)FATHER'S NAME	(FOR CHILDREN)MOTHER'S NAME
Email Address:	EMERGENCY CONTACT:
PLEASE LIST YOUR PRIMARY DR NAME:	PH #:
IF YOU WERE REFERRED BY ANOTHER DR. PLEASE GIVE NAME:	RELATIONSHIP:

PLEASE FILL OUT THIS SECTION IF THE PATIENT IS A MINOR. IF THE PATIENT IS NOT A MINOR, PLEASE JUST SIGN AT THE **X.**		
GUARANTOR'S INFORMATION		
GUARANTOR'S NAME**:**	Phone # :	
GUARANTOR'S ADDRESS:	SSN:	
	DOB:	
Relationship to patient:		
Signature of patient or patient's guarantor: **X**		

- **Is there someone in your household that also needs an appointment? Yes_____ No _____**

INITIAL VISIT AUTHORIZATION

We look forward to working with you in maintaining your skin health.

1. I, the undersigned, consent to undergo all necessary tests, treatment and other procedures required in the course of the diagnosis and treatment of my illness by the physicians and staff of Florida Skin Center. I agree to follow up as indicated by the doctors' recommendations. I understand that Florida Skin Center will not be able to serve as my dermatologist unless I adhere to its policies.

2. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantee has been made to me as to the result of examinations, treatments or operations.

3. I hereby authorize the staff of Florida Skin Center to take and use still photographs as they may be required, including documentation of the progress of my conditions and teaching purposes. I understand that I may refuse any photos at any time and that I will be asked in advance of taking or using photos.

4. I consent to the release of medical information to other institutions or agencies accepting the patient for medical or institutional care, including, but not limited to, pathologists and laboratories.

5. I consent to the release of my initial visit medical note to my primary care physician and/or my referring physician.

6. I understand that my medical information is protected and completely confidential, consistent with the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**). I have been informed that my medical records will not be released to anyone without a specific, signed authorization, and they will be copied and released to anyone whom I designate after giving 48 hours notice, and upon payment of the copying charge ($1.00 per page) and fulfillment of any other obligation I entered into with Florida Skin Center. Should I choose to have my records sent, they will only be sent by registered mail or DHL/Airborne at my expense. These charges do not apply to the sending of records that are deemed medically necessary by my doctors in the course of my treatment. My, or my minor children's, test results will be disclosed only to myself, **in person**, during a scheduled office visit. Should I have questions or complaints about the disclosure or confidentiality of my medical information, I have been informed that the Privacy Officer at Florida Skin Center is our Office Manager. I consent to the release of medical information to my referring physician and to any person or corporation, which is, or may be, under contract to Florida Skin Center or to the patient, including, but not limited to, insurance companies, workers compensation carriers, or third-party payers. I also consent to the release of medical information to my next of kin or my designee in the event of my death.

7. **WEB TPA Patients only:** As of 2010 Web-TPA is no longer covering lab work for biopsies performed in our practice. If a biopsy is required, it will have to be done in a hospital in order for lab fees to be covered. If you choose to have the biopsy done at our practice, out of network lab fees will apply.

8. By providing my e-mail address, I consent to receive promotional e-mails from Florida Skin Center. Florida Skin Center will not share my e-mail address with any other party.

9. Please be advised our physicians and/or physician assistants will not see a minor without the presence of a legal guardian. Our office may require documentation to verify legal guardianship of the minor.

I hereby read and clearly understand the above:

______________________________	______________________________
Patient's signature or one who is legally Authorized to sign.	Parent or Guardian: Patient's under 18 years of age must have the signature of guardian(s).

INITIAL VISIT BILLING POLICIES

1. For patients with no insurance coverage or patients receiving cosmetic treatments, payment is due at the time services are rendered. For any unpaid cosmetic services at check-out, a $30.00 penalty will be added to the bill. At times, a deposit for certain cosmetics treatments will be collected. For appointments not during normal business hours (Monday-Friday 8:00-5:00), a $25.00 fee will be applied for canceling or rescheduling with less than 24 hour notice. I commit myself to pay the account of the physician(s) in accordance with the regular rates and terms of the physician(s). We accept cash, check, money order, and major credit cards.

2. We will bill your primary insurance carrier for all covered services as long as we are participating providers of your plan. Our office does not bill secondary insurances; therefore, we'll bill you for any amount your primary insurance makes you responsible for. You are required to pay for all co-payments at the time services are rendered. For any unpaid co-payments, a $10.00 penalty will be added to the bill.

3. For patients with no insurance coverage, or if our office is not a participating provider of your plan, we offer a 35% cash discount (for medically necessary services only) when payment is received in full at time of services. If your check is returned unpaid, the discount given will be reversed. If **you** bill your insurance company (after receiving the discount) and we receive payment from your insurance carrier, the discount given will be reversed and out of network benefits will be applied instead.

4. Returned checks will be assessed a $25.00 fee to the amounts owed. You will have 45 days to take care of your balance with cash, money order, or major credit card. In addition, checks will no longer be accepted as a method of payment on your account. If you do not have an account with our office, we do not accept checks as a method of payment.

5. Our office is opted out of Medicare. This means we will not bill Medicare on your behalf, nor should you for the services provided. For more information, please see our "Private Contract with Medicare Subscribers" document.

6. For amounts due after insurance has processed your claim (such as unmet deductibles or non-covered services); we will send you three consecutive statements at 30-day intervals. You have 30 days after the third statement is sent to pay the balance. If no payment is received, your account will be forwarded to our national collection agency (Professional Adjustment Corporation of S.W. FL, INC.) and credit bureau for further action. **No additional contact will be made by our office.** The patient agrees to pay reasonable attorney's fees and collection expenses. Once your account is sent to collections, you will also be discharged as a patient from our practice.

7. If your insurance carrier requires additional information from you or your employer in order to process your claim, it is your responsibility to make sure that the needed information is furnished and to follow up with them (to make sure the information was received to avoid getting billed by our office). Our office will let you know when additional information is needed to process your claim.

8. In order for our office to bill your insurance carrier, you must present your current insurance card and a picture ID that we will copy and keep on file. Otherwise, we will not bill your insurance and payment will be expected at time of services.

9. It is your responsibility to notify our office of any changes in your mailing address or contact information. Each time you visit our office, you will be asked to verify that all of your personal and insurance information is correct. Please review this information carefully each time and make corrections as needed. We are only able to discuss the account with the account holder, if you wish to allow another party access to your account, please ask a staff member.

10. If we are required to go to court or give a deposition or speak to your legal representation as part of your visit or follow-up, the patient is responsible for all expenses including reimbursement for the doctor's time. For legal appearances or depositions or speaking to your legal representative, we charge a minimum of four hours at a rate of $1500 per hour, in advance, payable in cash, major credit cards, certified check or money order. Travel time will also be compensated at this rate. If any forms other than the standard office notes are required, they will be filled out at an additional expense. We charge a minimum of one hour at a rate of $750 per hour, payable in advance.

I hereby read and clearly understand the above:

______________________________	______________________________
Patient's signature or one who is legally Authorized to sign.	Parent or Guardian: Patient's under 18 years of age must have the signature of guardian(s).

Are You Interested in Any of the Following?

If so, please check them and we will be happy to discuss them with you!

- Botox: Injections that relax the muscles to prevent fine lines/wrinkles, most commonly used for the forehead, around the eyes, and frown lines.
  - **Hyperhidrosis**: Botox may also be used for under the arms to prevent and lessen sweating.
- Aesthetic Services:
  - **Chemical Peels**: Used to fight sun damage, improve acne, and smooth the skin texture.
  - **Extractions**: Recommended for patients who have blackheads and severe acne, to minimize scarring.
  - **Facials**: Used to maintain smooth, clear, well-hydrated skin.
  - **Products**: We offer a wide variety of skin care products that help restore the skin for a healthy future. (MD Forte', SkinCeuticals, and Theraderm)
  - **Latisse:** Prescription treatment used to grow eyelashes, making them longer, thicker, and darker.
- Cosmetic Fillers: Safe, non-surgical way to reduce the appearance of fine lines/wrinkles.
  - **Juvederm**: Commonly used for around the mouth, frown lines, and to enhance the lips and lasts around 4-6 months.
  - **Perlane**: Used to minimize the appearance of facial wrinkles, folds, and scarring and can last up to 8 months.
  - **Radiesse**: Commonly injected into the frown line (between eyebrows) and around the mouth and can last up to one year.
  - **Restylane**: Used for facial wrinkles and folds to help eliminate the appearance of aging and lasts, on average, 4-6 months.
- Laser Procedures: We offer a variety of laser treatments for patients.
  - **Fraxel Laser**: Eliminates the signs of aging by reducing brown spots and fine lines/wrinkles and helps improve acne scars.
  - **Laser Hair Removal**: Helps remove unwanted facial and body hair.
  - **Laser Hair Restoration**: Stimulates new hair growth/improves quality of hair for conditions such as male/female pattern baldness.
  - **Laser Tattoo Removal**: Safely fades tattoos so there is little to no evidence.
  - **Vascular Laser Treatments**: Treats broken blood vessels on the face and vascular birth marks.
- Vein Treatments
  - **Sclerotherapy/Laser Treatment:** Procedures that improve the appearance of spider veins on the legs.
- Phototherapy / Photofacial Treatments
  - **Phototherapy**: Breaks down or destroys pre-cancerous lesions.
  - **Photofacials**: Helps rejuvenate sun damaged skin, wrinkles, and enlarged oil glands. Also, helps treat moderate to severe acne, rosacea, and mild acne scarring.

Please ask us about Care Credit Program to assist in payment for any of these procedures.