Patient Registration Form

Hollywood Dermatology & Cosmetic Specialists

Eduardo Weiss, M.D. • Anna Falabella, M.D. • Ronald D. Smith, M.D. • Julian O'Neil Moore, D.O.
Stanley A. Spatz, M.D. • Sadegh Amini Koves, M.D. • Sholomo Lanes, M.D. • Richard Feinstein, M.D.
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Lucia Kraus, PA • Nancy A. Muskat, PA-C • Susana Mandel, ARNP

601 N. Flamingo Road, Suite 313, Pembroke Pines, FL 33028
Tel. 954-433-0455 • FAX 954-433-8771
www.hollywooddermatology.com

Name: _____ ❑ Jr. ❑ Sr.
First Middle Last

Prefer to be called: _____ Gender(Sex): M ❑ F ❑ Married ❑ Divorced ❑ Single ❑ Widowed ❑

Race : White ❑ Black ❑ Asian ❑ Indian ❑ Other ❑ Declined to Provide ❑

Ethnicity: Hispanic or Latino ❑ Not Hispanic or Latino ❑ Language Spoken (Idioma): _____

Address: _____
Street# Street Name Apt.#

_____
City State Zip Code

Employer: _____
Name Address

Home ☎: _____ Date of Birth: _____/ _____/ _____ Age _____
Month Day Year

Work ☎: _____ Cell.☎: _____

Social Security #: _____ Policy Owner S.S. #_____

Where should statement of your account be sent if different from above?

_____
Name Address Apt.# State Zip

Primary Doctor: _____ ☎: _____

Who referred you? _____

In case of Emergency contact: _____ ☎ _____

Relationship _____ Your E-mail: _____

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial polices of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF THE SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA AND MASTERCARD FOR YOUR CONVENIENCE. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the Doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the Doctor when an assigned claim is filed.

It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service.

_____ _____
Signature of patient or legal guardian Date

_____
Name of Policy owner if other than patient

Patient relationship to Policy owner: ❑ Self ❑ Child ❑ Other:_____

PATIENT CONSENT FORM

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

DO WE HAVE YOUR PERMISSION TO:

- LEAVE A MESSAGE ON YOUR ANSWERING MACHINE AT HOME (INCLUDING REMINDERS FOR APPOINTMENTS)? YES___ NO___
- LEAVE A MESSAGE ON YOUR PLACE OF EMPLOYMENT? YES___ NO___
- LEAVE A MESSAGE ON YOUR CELLULAR PHONE? YES___ NO___
- DISCUSS YOUR MEDICAL CONDITION WITH ANY OTHER MEMBER OF YOUR HOUSEHOLD? YES___ NO___

IF YES, WHOM: _____

RELATIONSHIP _____

Please give any additional comments in reference to the release of your medical condition(s) or appointments.

_____

_____

This Consent was signed by: _____
Printed Name - Patient or Representative

Relationship to Patient (if other than patient): _____

_____ _____/_____/_____
Signature Date

SKY F-4W

DERMATOLOGY MEDICAL HISTORY

Hollywood Dermatology & Cosmetic Specialists

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Patient:_____ Date: _____/ _____/ _____

Reason for today's visit: _____

Are you allergic to any medications? ❑ YES ❑ NO if yes, list below:

1. _____ 2. _____

Have you ever had dental anesthesia (Novocaine or other)? ❑ YES ❑ NO Any bad reaction? ❑ YES ❑ NO

List all medications you are currently taking (including prescriptions, over -the-counter meds..., vitamins and herbal):

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	YES	NO
Bronchitis	❑	❑
Emphysema	❑	❑
Asthma	❑	❑
Chronic Cough	❑	❑
Morning Cough	❑	❑
Shortness of Breath	❑	❑
Wheezing	❑	❑

Cardiovascular	YES	NO
High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Irregular Heartbeat	❑	❑
Phlebitis	❑	❑
Inflammation of vein	❑	❑
Blood clots	❑	❑
Pacemaker	❑	❑

Other Systemic:	YES	NO
Diabetes	❑	❑
Thyroid	❑	❑
Kidney	❑	❑
Bladder	❑	❑
Frequency/burning	❑	❑
Gastrointestinal	❑	❑
Stomach absorptive disorder	❑	❑
Nausea, vomiting, diarrhea when taking antibiotics	❑	❑
Yeast infection when taking antibiotics	❑	❑
Arthritis/Joint Deformity	❑	❑
Arthralgia	❑	❑
Limited motion	❑	❑
Artificial joint	❑	❑
Convulsions, Epilepsy or Seizures	❑	❑
Fainting	❑	❑
Artificial Valves or a Prosthesis	❑	❑

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin:

Have you ever had skin cancer? ❑ YES ❑ NO
Has anyone in your family had skin cancer? ❑ YES ❑ NO
Do you have a history of any specific skin diseases? ❑ YES ❑ NO if yes, _____
Do you have problems with healing? ❑ YES ❑ NO
Do you develop keloids (scars) after surgery? ❑ YES ❑ NO
Do you bleed easily? ❑ YES ❑ NO
Do you develop skin rashes in reaction to ❑ Medications ❑ Food ❑ Environment? _____

Social History:

Do you drink alcohol? ❑ YES ❑ NO if YES _____ drinks per day
Do you use IV drugs? ❑ YES ❑ NO if YES, what? _____ How often? _____
Do you smoke? ❑ YES ❑ NO if YES, how much: _____

Have you had or have you been exposed to HIV (AIDS)? ❑ YES ❑ NO

Please answer the following questions:

(Women) Are you pregnant? ❑ YES ❑ NO Due Date: ____/ ____/ _____

Are you planning to get pregnant in the near future? ❑ YES ❑ NO

What is your occupation? _____ Hobbies? _____

Completed by: ❑ Patient
❑ Medical Assistant _____

_____ Date ____/____/ ____
Signed By Patient

_____ Date ____/____/ ____
Reviewed By

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Name: _____ Chart Number:_____

Hollywood Dermatology Policy Consent Form

The following is to advise you of our office policies. Some policies listed below may not pertain to your specific treatment but may for future procedures and/or treatments. Please review and sign below.

Minors under the age of 18 must be seen, at the time of their appointment, with their parent, legal guardian or an authorized adult. A note must be accompanied with the authorized adult, signed by the patient's parent, giving full authorization to that adult. Minors under the age of 18 will not be seen if not accompanied by an adult.

Treatment Fees: Treatment fees are estimates and could change depending on your treatment plan needs.

The patient is responsible for all insurance deductibles, co-pays and services subject to their insurance plan limitation and exclusions.

The patient is responsible for all balances due with all out-of-network insurance companies.

Providers with your Insurance: It is your responsibility to know if your doctor is considered an "in-network" provider by your plan. Please contact your insurance to verify. If you have more questions with regards to your insurance plan, you may contact our billing department as well.

Payment Options: CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, DEBIT CARDS, MONEYORDERS, CASHIERS CHECK AND CARECREDIT (with $300.00 minimum for care credit) are payment options accepted.

Payment Plans: Payment plans may be arranged with CareCredit. All balances due that do not get paid within 3 months may be referred to a Collection Agency. If you are interested, you may apply for CareCredit in our office today.

There is a $25.00 FEE if you fail to cancel or reschedule an appointment at least 24 hours prior.
Some cosmetic procedures may incur a higher cancellation/no show fee.

All Cosmetic and Private Pay visit fees are due at the time of service. If you cannot attend to your Cosmetic appointment, you must cancel or reschedule your appointment at least 48 hours in advance. A $200.00 fee will be assessed to your account if you do not cancel or reschedule your Cosmetic appointment 48 hours prior.

Cosmetic Procedures, such as Blepharoplasty, Laser Lipo, CO2 Laser, require 100% full payment before the appointment. You may pay by major credit cards, check or CareCredit.

Cosmetic removal of benign lesion(s): Skin tags, age spots and normal moles are considered cosmetic procedures. Hollywood Dermatology does not bill insurance companies for cosmetic procedures since Hollywood Dermatology will not receive any payment from the carrier for services rendered.

Prescription Refill Policy: Our physicians prescribe their patients enough refills to last until their next follow-up appointment. We are unable to refill prescriptions by telephone. If you would like refills of any medications prescribed by one our doctors, please ask the doctor you are seeing today during your examination.

All surgical pathology & other lab specimens are submitted to outside laboratories for processing and analysis, which may lead to an additional fee you may be charged outside of our office.
It is your responsibility to let us know if your insurance company requires that we send your labs to a specific pathologist in order for you to receive full benefits.

Please advise your doctor of your allergy history. Some procedures may require the use of anesthesia, latex glove and certain medications so it is important to know your allergies ahead of time.

DATE: _____ SIGNATURE: _____

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Patient Consent for Medical Photography

Check here if minor or unable to provide consent ____

Patient name:_____ Date:_____

I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals as I have designated below. By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact: By signing this form below I confirm that this consent form has been explained to me in terms which I understand.

1) I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

_____ _____
(Signature) (Witness)

2) I agree for my image to be shown for teaching purposes AND to be used for my medical record but NOT FOR medical publication:

_____ _____
(Signature) (Witness)

3) I agree to use of my image for medical records ONLY:

_____ _____
(Signature) (Witness)

For patients between ages 7 and 18 years, a signature below indicates that the information in this consent form has been explained to me, and I assent to use of my images as outlined above:

_____ _____
(Signature) (Witness)