



**FLORIDA SKIN CENTER
INITIAL VISIT RECORD**

DATE _____

****** PLEASE COMPLETE THE FOLLOWING AND GIVE TO THE STAFF; THIS ****
WILL EXPEDITE YOUR VISIT WHILE YOU COMPLETE THE MEDICAL FORMS.**

PATIENT INFORMATION	
PT'S LEGAL LAST NAME:	FIRST: MI: SSN
ADDRESS	CITY STATE ZIP
HOME PHONE	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
WORK PHONE	MARITAL STATUS
OTHER PHONE	D.O.B.
(FOR CHILDREN) FATHER'S NAME	(FOR CHILDREN) MOTHER'S NAME
<i>IF YOU WERE REFERRED BY YOUR PCP. PLEASE GIVE NAME:</i> PH #: ADDRESS:	EMERGENCY CONTACT:
	PH #:
	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:	PH #
GUARANTOR'S ADDRESS	SSN:
	DOB:
Relationship to patient:	
Signature of person responsible for payment: (required for some insurances)	
X	

NAME: _____



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Please indicate the following:	
What is the reason for your visit?	
1)	_____
2)	_____
3)	_____
What has been the duration period?	
1)	_____
2)	_____
3)	_____
What are the symptoms?	
1)	_____
2)	_____
3)	_____
Have you had prior treatment? If yes please indicate:	
1)	_____
2)	_____
3)	_____
What has helped?	
1)	_____
2)	_____
3)	_____
What makes it worse?	
1)	_____
2)	_____
3)	_____
Please list all <u>current</u> medical conditions.	

Please list all hospitalizations.	

Last visit to a doctor?	

What was the reason for the visit?	

Would you be interested in any of the following services?	
<input type="radio"/> Botox <input type="radio"/> Restylane Laser Treatments like: <input type="radio"/> Hair Rem. <input type="radio"/> Tattoo Rem. <input type="radio"/> Brown Spot Rem. <input type="radio"/> Fraxel Aesthetic services like: <input type="radio"/> Peels <input type="radio"/> Facials <input type="radio"/> Products	



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DATE: _____

Please give your: Height _____ Weight _____

YES	NO	Health History
		Have you ever been treated by a Dermatologist ? If YES, by whom?
		Have you ever had eczema as a child or adult?
		Have you ever been told you have psoriasis ?
		Have you ever had skin cancer ?
		Have you ever had any type of cancer ?
		Have you ever had X-Ray or Gamma Ray treatment for your skin?
		After an accident or surgery, have you ever formed an overgrown, thickened scar ?
		Have you ever had asthma, emphysema, or chronic bronchitis ?
		Have you or a close relative had Tuberculosis ?
		Have you ever had difficulty breathing ?
		Do you have any other lung disease ?
		Do you have any heart disease , history of heart attack or other heart problems?
		Do you have high blood pressure (even if controlled on medication)?
		Have you ever had a stroke ?
		Have you been told to take antibiotics before any dental work ?
		Do you have diabetes ?
		Do your wounds heal poorly?
		Do you bleed excessively after tooth extractions or surgery?
		Do you have any thyroid disease?
		Have you ever had auto-immune disorders such as lupus or scleroderma ?
		Do you have immune deficiency disorders?
		Do you have arthritis ?
		Are you ALLERGIC to any DRUGS or FOOD ? If so, please list:
		Are you taking any PRESCRIPTION MEDICINE ? If so, please list:
		Are you taking OVER-THE-COUNTER MEDICINE ? If so, please list:
		Have you ever had ulcers or other stomach or intestinal diseases?
		Have you had liver disease, hepatitis or jaundice ?
		Have you had kidney, urinary or prostate problems?
		Have you had diseases of the eyes, ears, nose, mouth or throat ?
		Have you ever had cataracts or cataract surgery?
		Have you ever had seizure or fainting spells ?
		Do you have any history of psychiatric disorder?



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YES	NO	
Family History:		
Has any family member had the following:		
		Diabetes?
		Lupus or Scleroderma?
		Melanoma or Abnormal Mole?
		Skin cancer?
		Asthma, eczema or hives?
Social History:		
What is your occupation ?		
		Have you ever used street drugs such as cocaine, crack, LSD or PCP?
		Have you ever used intravenous drugs such as heroin?
		Do you drink alcohol ?
		Do you smoke cigarettes ? How many packs per day?
		Have you ever had significant sun exposure or sunburns ?
		Do you use sunscreen ?
System Review:		
		Do you have significant, persistent or intermittent itching on your skin?
		Do you have any new hair growth on your face, chest or abdomen?
		Do you have any new moles or changes in existing moles?
When you go out in the sun, do you...		
		Always burn , never tan?
		Usually burn , tan with difficulty?
		Sometimes burn, usually tan ?
		Rarely burn, tan easily ?
For Females:		
		Are you still having menstrual periods ?
		Is your menstrual cycle regular ?
		Have you ever had problems with your ovaries such as Polycystic Ovary Disease ?
		Are you pregnant now or planning pregnancy in the near future?
		Are you currently using contraceptives ?
Newborn History (For Children Only)		
		Natural birth ?
		C-section ?
		Were there any complications ?
		How many days in the hospital?
		What was the birth weight?
		What was the length?



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INITIAL VISIT
AUTHORIZATION

DATE: _____

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 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.

6. 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 parent(s)
or guardian(s).



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INITIAL VISIT
Billing Policies

DATE: _____

1. For patients with no insurance coverage or patients receiving cosmetic treatments, payment is due at the time services are rendered. For cosmetic services not paid in full at check-out, a \$30.00 penalty will be added to the bill. I obligate 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.
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, we must have a front and back copy of your current insurance card on file. Without this copy, 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.

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 parent(s)
or guardian(s).