New patient or established patients with new insurance

Welcome to our practice. Please read below and call your insurance ahead of your visit if you have any questions.

Insurance coverage
If you're a new patient to our practice or if you're an established patient with a new insurance, please become familiar with your insurance coverage for a specialty visit. Dermatology is a medical and surgical specialty and your insurance coverage may differ from that of your visits to primary care physician, gyn or pediatrician.
If your medical insurance has and unmet deductible or procedure co-pay, you may have to make payments even when procedures are medically necessary. While everything that is covered by medical insurances is medically necessary, not everything that is medically necessary is covered by all insurances.
Your insurance costumer service line should answer all your questions about your insurance coverage.

Full body skin examination
Full body skin examination is a comprehensive skin examination of your skin, hair and nails. The exam is directed to the early detection of skin cancer and pre-cancerous lesions. Education on skin cancer prevention is discussed with each patient. The visit lasts at least 30 minutes. Because of the nature of this visit, no other underlying skin condition will be evaluated or treated during this visit. For billing purposes, this visit does not qualify as a preventative visit. Only GYN, pediatricians and primary care physicians can bill preventative visits. If a patient has unmet deductible or co-insurance, patients may be billed for a 99204 or 99214 code accordingly.

Acne visit, comprehensive
Acne visit, comprehensive, is an extensive evaluation and analysis of acne patients, and the aggravating factors contributing to their condition. A personalized treatment plan and acne regimen is developed for each patient. This visit lasts 30 minutes. Because of the nature of this visit, no other underlying skin condition may be evaluated or treated during the visit. Patients are encouraged to download and fill out the ACNE FORM from our website prior to their visit. Patients should come with no make-up.

Notice of Privacy Practice Acknowledgement consent and acknowledgment form

Villa Dermatology Center, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

Villa Dermatology Center, LLC
3661 South Miami Avenue, Suite 306 FL 33133
Tel: 305-857-3517 / Fax: 305-857-3518

CONSENT AND ACKNOWLEDGEMENT FORM

_____ Initial	**ASSIGNMENT OF INSURANCE BENEFITS** I authorize payment of Medicare or other insurance benefits otherwise payable to me for medical service rendered to me or my child directly to ADRIANA VILLA, M.D. / VILLA DERMATOLOGY CENTER, LLC. These benefits are not limited to Individual Policies, Group Policies, Workers Compensation, Liability, PIP or any other policy that may cover healthcare benefits. Where MEDICARE BENEFITS are applicable, I certify that the information given by me in applying for payment under Title XVII or XIV of the Social Security Act is correct, and request that these payments of authorized benefits be made directly to ADRIANA VILLA, M.D. / VILLA DERMATOLOGY CENTER, LLC on my behalf.

_____ Initial	**THIRD PARTY BENEFIT COLLECTIONS** I authorize ADRIANA VILLA, M.D. / VILLA DERMATOLOGY CENTER, LLC, to act in my behalf as attorney in fact in The collection of benefits from any responsible third party payer through whatever means may be deemed necessary, and the endorsement of benefit checks made payable to me and/or ADRIANA VILLA, M.D. / VILLA DERMATOLOGY CENTER, LLC or any of its providers.

_____ Initial	**GUARRANTEE OF PAYMENT** I hereby understand that I am financially responsible for payment to for any charges not covered or allowable by my Insurance Company, and all deductibles, co-insurance, co-payments, and for any balances remaining, after payment has been made by my Insurance Company. This includes any denials of payment due to lack of medical necessity or pre-certification/authorization, lack of affiliation with an HMO or any other constraint imposed as a condition of my insurance coverage. I further understand and agree that if this account is placed for collection, I will be responsible for applying the balance owed to the physician plus the cost of the collection fees, and/or including reasonable attorney's fees if/when applicable. For patients with no insurance coverage, payment is due at the time of service. We accept cash, checks, and major credit cards. Returned checks are subject to a $50 fee. For patients who have insurance coverage with a plan in which we are not participating providers, you are required to play 100% of the balance at the time of service. You may submit proof of payment to insurance. It is the responsibility of the patient to notify our office if there is any change in your mailing address, contact information or health insurance.

_____ Initial	**CONSENT TO TREATMENT** I consent to all medical and surgical procedures and treatment, including but not limited to surgery, medical treatment, anesthesia, laboratory procedures and medications that may be performed, administered or rendered by or under specific or general instructions of my physician. I hereby voluntarily consent to rendering of medical treatment by ADRIANA VILLA, MD. / VILLA DERMATOLOGY CENTER, LLC and or medical staff, which may include routine diagnostic and or/surgical procedures, administration of injections, and/or other such medical treatment deemed necessary for the treatment and improvement of the patient's condition.

_____ Initial	**APPOINTMENT REMINDERS** I acknowledge that this practice/facility may call for appointment reminders and/or cancellations. This contact may be by phone, in writing, email, or otherwise and may involve leaving a message on an answering machine or any other device available. No disclosure of medical information will occur while leaving messages. If you have any questions, objections and/or preferences, please inform us. This practice/facility will charge the patient $25.00 dollar for every missed appointment NOT cancelled with a 24-hour advance notice.

_____ Initial	**CONSENT TO PHOTOGRAPH** I authorize ADRIANA VILLA, M.D. / VILLA DERMATOLOGY CENTER, LLC, and its affiliates to take pictures of me or my child medical condition or surgical procedure and to use these pictures for medical record and treatment purposes only.

CONSENT AND ACKNOWLEDGEMENT FORM

USE AND DISCLURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS
I understand that as part of my health care, ADRIANA VILLA, MD. / VILLA DERMATOLOGY CENTER, LLC, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as: • A basis for planning my care and treatment. • A means of communication among the many health professionals who contribute to my care, • A source of information for applying my diagnosis and surgical information to my bill, • A means by which a third-party payer can verify that services billed were actually provided & • A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals. I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges: • The right to review the notice prior to signing this consent. • The right to object to the use of my health information for directory purposes. • The right to request restrictions as how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

	RELEASE OF INFORMATION
_____ Initial	I authorize the ADRIANA VILLA, M.D. / VILLA DERMATOLOGY CENTER, LLC to release copies of information in their possession, as acquired in the course of my or my child's examination and/or treatments, to my insurance carriers in connection with my treatment for the purpose of any insurance or Medicare payments, or health care operations. - This facility and its affiliates - Utilization review agencies or auditors - Physician (Attending and consulting) - Other allied health professionals

I understand that I may revoke this consent in writing, I also understand that by refusing to sign the consent or revoking this consent, the ADRIANA VILLA, MD. / VILLA DERMATOLOGY CENTER, LLC may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that ADRIANA VILLA, MD. / VILLA DERMATOLOGY CENTER, LLC reserves the right to change their notice and practices and prior to implementation, in accordance to Section 164.520 of the Code of Federal Regulations. Should ADRIANA VILLA, MD. / VILLA DERMATOLOGY CENTER, LLC change their notice, I have the right to obtain a copy of any revised notice.

I acknowledge that this form has been fully explained to me and that I have read and understand each of the provisions appearing on this form, and that by signing this form, I consent to these provisions individually and collectively.

Patient Signature	**Date**
Print Name	

For Office Use Only

☐**Consent Received by:**	**Consent Received Date:**
☐**Consent refused by patient and treatment refused as permitted**	

VILLA DERMATOLOGY CENTER, LLC
(305) 857-3517
WWW.VILLADERMATOLOGY.COM

DEMOGRAPHICS AND INSURANCE FORM

Last Name / Apellido	First Name / Nombre	M Initial / Inicial	Title / Titulo

Address/Dirección	Apt. / Apto.

City / Ciudad	State / Estado	Zip / Código Postal	Mobile Phone / Tel Portable

D.O.B. / Fecha de Nacimiento	Gender / Genero	Marital Status / Estado Civil (use and X / Marca con una X)			
		Married / Casado		Widowed / Viudo	
		Single / Soltero		Divorced / Divorciado	

E-mail / Correo Electrónico	Telephone / Teléfono

Employer / Empleador	Social Security Number / Numero de Seguro Social								

Parent Guardian / Pariente o Persona Responsable	Telephone / Teléfono

Emergency Contact / Nombre en Caso de Emergencia	Telephone / Teléfono	Relationship / Relación

Family Physician / Médico de Familia	Telephone / Teléfono

Policy Holder Name / Nombre del Asegurado	Relationship / Relación	D.O.B. / Fecha de Nacimiento

Same Address / La Misma Dirección	Policy Holder Address / Dirección
☐Same as Patient ☐Other	

Primary Ins. / Seguro Primario	Second Ins. / Seguro Secundario

ID Number / Numero de ID	Group # / # Grupo	ID Number / Numero de ID	Group # / # Grupo

Pharmacy / Farmacia	Address / Dirección	Telephone / Teléfono

I understand that I am financially responsible for all charges not covered by my insurance company and all collections, attorneys and courts fees incurred while collecting my balance. Yo entiendo que soy financieramente responsable por todos los cargos no cubiertos por mi seguro medico y cargos de corte en caso de colección.

Patient Signature / Firma del Paciente	Date / Fecha

VILLA DERMATOLOGY CENTER, LLC
(305) 857-3517
WWW.VILLADERMATOLOGY.COM

VILLA DERMATOLOGY CENTER, LLC - MEDICAL HISTORY REVIEW Form rev. 10-30-2018

Patient Name / Nombre de paciente	Date / Fecha
What is the reason for today's visit? / Razón de su visita?	
Do you FAINT? / Sufre de desmayos? ☐ YES ☐ NO	Do you have a PACEMAKER or a DEFIBRILLATOR? Usa usted marcapasos? ☐YES ☐NO
Are you ALLERGIC to any medications? If yes, (please list) / Es usted alérgico a algún medicamento? ☐YES ☐NO	
MEDICATION LIST, including vitamins and herbal supplements that you are currently taking: / LISTA DE MEDICAMENTOS, incluya vitaminas o algún otro suplemento que esté tomando en este momento.	
Are you pregnant? / Está embarazada? ☐YES ☐NO	Months of pregnant / Tiempo de embarazo
Are you planning to become pregnant soon? / Está planeando quedar embarazada pronto? ☐YES ☐NO	
Are you taking birth control pills? / Está tomando píldoras anticonceptivas? ☐YES ☐NO	
Are you breastfeeding? / Esta lactando a su niño(a)? ☐YES ☐NO	

PLEASE CHECK ALL MEDICAL CONDITIONS THAT YOU HAVE OR HAVE HAD IN THE PAST:
Seleccione si ha tenido o padece de alguna de estas condiciones

Hepatitis B	_____	Abnormal Moles	_____	Acne	_____
Hepatitis C	_____	Cold Sores	_____	Excessive or keloid scarring	_____
Diabetes	_____	Easy Bruising Bleeding	_____	Transplant	_____
Arthritis	_____	Allergies	_____	Problems with your Kidneys	_____
Glaucoma	_____	Stomach Ulcers	_____	Liver	_____
Cataracts	_____	Tuberculosis	_____	Heart	_____
HIV	_____	Mononucleosis	_____	Urinary System	_____
Hay Fever	_____	High Cholesterol	_____	Hormones, including Thyroid	_____
Asthma	_____	High Blood Pressure	_____	Genital System	_____
		Seizure, Epilepsy	_____	Gastrointestinal System	_____

Skin Cancer? If yes, please list type (melanoma and non-melanoma) and location:
Cáncer de Piel? Si a sufrido de cáncer de piel explique que tipo

☐ YES ☐ NO

Cancer other than skin? If yes, please list type and location / **otro tIpo de Cáncer**? Si a sufrido de otro tipo de cáncer explíquenos.

☐ YES ☐ NO

Do you take antibiotics before a dental appointment? Please explain / Esta usted usando antibióticos antes de una consulta dental? Por favor explique ☐ YES ☐ NO

Other medical conditions you may have that are not listed above / Tiene usted alguna otra condición la cual no está en nuestra lista?

SOCIAL HISTORY / Historia de su vida social

Do you drink alcoholic beverages? / Consume bebidas alcohólicas? ☐ YES ☐ NO
How much and how often? / Cuan frecuente?

Do you smoke cigarettes/cigars/pipe / Usted fuma? ☐ YES ☐ NO
How much and how often? Cuan frecuente?

MEDICAL FAMILY HISTORY INFORMATION:
Please circle if there is anyone in your family with history of / Circule si alguien de su familia tiene historia de las siguientes enfermedades

Non-melanoma-Skin Cancer	Dermatitis	Relation to Patient:
Melanoma	Actinic Keratosis	
Abnormal Moles	Psoriasis/ Eczema	
Severe Acne	Allergy to SULFA drugs	

SURGICAL HISTORY: Please list any surgery you had during the last 5 years and the date they occurred.
Historia reciente de cirugías: Cuales cirugías usted ha tenido en los últimos 5 años y sus fechas?

Referring Physician (if applicable) / Doctor que lo refirió

Referring Physician's Phone Number / Número de teléfono del Doctor que lo refirió

DERMATOLOGY OFTEN REQUIRES PHOTOS TO BE TAKEN. I AUTHORIZE VILLA DERMATOLOGY TO OBTAIN CONFIDENTIAL PHOTOGRAPHS FOR MEDICAL RECORDS PURPOSES ONLY.

DERMATOLOGOS FRECUENTEMENTE REQUERIMOS TOMAR FOTOS SOBRE CASOS A NUESTROS PACIENTES. YO EL PACIENTE AUTORIZO A VILLA DERMATOLOGY A OBTENER O TOMAR FOTOS PARA NUESTRO USO CONFIDENCIAL SOLAMENTE.

Initial: _____

How did you hear about our office? / Como escucho de nuestra oficina?

Patient's Signature / Firma del Paciente	Date / Fecha