Miami Dermatology & Cosmetics

PATIENT INFORMATION				
Patient Name:	**ID#**	**Sex:**	**SSN#**	**Birthday:**
Local Address (w/ Apt#):	**City,State, Zip:**			**Ethnicity:**
Home Phone:	**Mobile Phone:**			**Race:**
E-mail address:				
Primary Care Physician:				
Marital Status:	**Smoking Status (Y/N):**	**Emergency Contact:**	**Contact Phone:**	

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN ABOVE)				
Name (Last, First Middle)	**SSN#**	**Birthdate:**	**Language:**	**Sex:**
Local Address:	**City, State, Zip Code:**			
Home Phone:	**Mobile Phone:**	**Email Address:**		
Marital Status:	**Smoking Status: (Y/N)**	**Relationship to Patient:**		

PRIMARY INSURANCE		
Name of Primary Insurance Company:	**Policy#**	**Group#**

SECONDARY INSURANCE(if Applicable)		
Name of Secondary Insurance Company:	**Policy#**	**Group#**

Signature of Patient/Guardian **Date**

Miami Dermatology and Cosmetics
8950 SW 74th Court Suite 1413
Miami, FL 33156-3173
(305) 670-0146

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How Would You Like to Improve Your Appearance?

Check off all that apply:

- ☐ Reduce unwanted fatty tissue
- ☐ Treat hair loss
- ☐ Reduce horizontal forehead lines
- ☐ Reduce vertical frown lines ("1, 11, or 111")
- ☐ Reduce lines around eyes from squinting ("crow's feet")
- ☐ Reduce wrinkles on nose ("bunny lines")
- ☐ Reduce small, vertical lines around the mouth ("smoker's lines")
- ☐ Reduce the appearance of facial folds around the nose and mouth ("parentheses")
- ☐ Reduce horizontal lines on neck ("necklace lines")
- ☐ Reduce vertical bands on neck that appear on strain ("neck bands")
- ☐ Improve the skin fold between the lower eyelid and cheek ("tear trough")
- ☐ Improve lines extending down from the corners of the mouth ("marionette lines")
- ☐ Reduce downturned corners of mouth
- ☐ Improve arch of eyebrows
- ☐ Reduce "double chin"
- ☐ Reduce excessive hair growth
- ☐ Lighten tattoos
- ☐ Reduce facial redness
- ☐ Reduce appearance of large facial veins
- ☐ Reduce brown spots on skin
- ☐ Reduce the appearance of bruises on skin
- ☐ Improve the appearance of scars
- ☐ Improve the appearance of "crepe paper" or "cigarette paper" skin
- ☐ Grow thicker, fuller eyelashes
- ☐ Improve fullness of the cheek
- ☐ Improve the appearance of thin lips
- ☐ Reduce the appearance of acne
- ☐ Improve the texture of the skin
- ☐ Remove unwanted "skin tags" around the neck, armpits, eyelids, or groin
- ☐ Improve sagging, lax skin (face, neck, elbows, knees)
- ☐ Facial contouring – improving the shape of the face and neck
- ☐ Body contouring – improving the shape of the arms/legs, trunk, waistline, buttocks
- ☐ Other: _____

_____
PRINT NAME

_____ _____
SIGNATURE DATE

OUR FINANCIAL POLICY

Thank you for choosing this office for your health care needs. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign.

Payment is due at the time of service. We accept cash and credit cards. If needed a payment plan can be established with prior credit approval.

If you have insurance which will pay our doctor directly, and which we can verify, we still require that you pay all co-payments, co-insurances, deductibles, and charges for non-covered services at the time of service.

If you are a member of an insurance plan that requires a referral from your primary care physician, this referral must be first obtained before a visit can be scheduled with the doctor.

If you have questions or concerns about a bill, our billing department can be reached at 305-631-7685.

Important Information about Biopsies

Dermatologists traditionally take a sample (surgical biopsy) of suspicious skin growths or rashes in order that microscopic examination of the sample can be performed, and a diagnosis made.

This is to inform you that the work associated with processing each biopsy, preparing slides, microscopically examining the slide, and issuing a report of the resulting diagnosis (together known as surgical pathology) is a distinct and separate service from the biopsy itself, and there will be a separate charge billed by the laboratory that you may be responsible for in whole, in part, or not at all, depending upon the terms of your insurance coverage.

Thank you for understanding our financial policy. Please let us know if you have questions or concerns.

I have read and understand the office's Financial Policy. All of my questions have been answered.

_____ _____

Signature Date

IMPORTANT INFORMATION FOR OUR PATIENTS

FILLING YOUR PRESCRIPTION

Just Got Quicker and Easier

Our office has switched to electronic prescribing, also called "e-prescribing." That means we will send your prescription to your pharmacy via a computer or handheld device.

E-PRESCRIPTIONS ARE:

√ **Fast** : Your prescription is sent to your pharmacy before you leave our office.

√**Convenient:** There is no need for an extra trip to the pharmacy to drop off your paper prescription.

√ **Legible:** There is no handwriting for the pharmacist to interpret. Instead, you get a printed receipt with your prescription and pharmacy details.

√ **Secure:** E-prescriptions are sent through a private, secure network – not over the internet or by e-mail.

Tell us where you'd like your e-prescription sent: Use the form below to tell us which pharmacy you'd like your prescription sent to. Not sure where its located ? Provide the nearest cross streets, or we can suggest a pharmacy close to this practice. We will always confirm which pharmacy you'd like to use before your prescription is sent electronically. This information will help speed the process.

Keep in mind, your prescription may not always be ready as soon as you arrive at the pharmacy. Occasionally, you may receive a paper prescription as electronic transmission of prescriptions for certain drugs is prohibited by law.

Primary Pharmacy: _____

Address or cross streets: _____

City, State, Zip: _____

Phone: _____

Secondary Pharmacy: _____

Address or cross streets: _____

City, State, Zip: _____

Phone: _____

E-prescriptions will soon be the standard for how medicine is prescribed nationwide. If you have any other questions, just ask us. Or visit www.learnabouteprescriptions.com

CONSENT FOR ELECTRONIC FILLING OF PRESCRIPTIONS

By signing below, I am authorizing Dr. Bridges and his assigned personnel to fill prescriptions electronically to the pharmacy of my choice.

_____	_____	_____
Print Name	**Patient Signature**	**Date**

Miami Dermatology & Cosmetics

USE OF CONTACT INFORMATION

TEST RESULTS

Pathology reports and blood test results will be reviewed with the doctor at either an office visit or telehealth follow-up appointment. Patients will be notified by both text message and e-mail when test results are available for review on the patient portal. Test results can also be reviewed separately through patient portals managed directly by the testing laboratory.

_____ _____

SIGNATURE DATE

RELEASE OF MEDICAL INFORMATION

Please indicate names of other individual(s) with whom you authorize the office to discuss your care.

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

E-MAIL MARKETING

Ok to e-mail updates and promotional offers? [ ] Yes [ ] No

_____ _____

SIGNATURE DATE

Miami Dermatology & Cosmetics

AUTHORIZATION FOR CLAIMS AND BENEFITS

CLAIMS

I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of benefits to the medical office and its providers when the medical office or its providers accept assignment on claims.

_____
PRINT NAME

_____ _____
SIGNATURE DATE

BENEFITS

I authorize payment of medical benefits to the medical office for services rendered.

_____
PRINT NAME

_____ _____
SIGNATURE DATE

EXHIBIT 1
Revised May 1, 2017
WRITTEN ACKNOWLEDGEMENT FORM
RECEIPT OF NOTICE OF PRIVACY PRACTICES
Miami Dermatology & Cosmetics

I, _____, have (1) received a copy of the Notice of the Privacy
Patient Name

Practices or (2) has been offered a copy of the Notice of the Privacy Practices but declined to accept a copy.

_____ _____
Signature Date

WRITTEN ACKNOWLEDGEMENT OF PATIENT REFUSAL TO SIGN A RECEIPT OF NOTICE OF PRIVACY PRACTICES

On the ___ day of _____, 2013, the Notice of Privacy Practices was

_____offered and/or given to_____.
Patient Name

____ The Patient accepted a copy of the Notice of Privacy Practices but refused to sign an acknowledgement that it was given to the patient.

____ The Patient refused to accept a copy of the Notice of Privacy Practices and refused to sign an acknowledgement that it was offered to the patient.

_____ _____
Signature of Employee Date

Miami Dermatology & Cosmetics

NO-SHOW / RESCHEDULING / CANCELLATION POLICY

The office uses an automated appointment reminder system that sends multiple reminders to scheduled patients via text messaging and telephone starting one week prior to the appointment date.

Appointments can be rescheduled or cancelled for any reason with two business days' advance notice (i.e. weekends and federal holidays are excluded), so that the office has the opportunity to offer the appointment time to another patient. The office can be notified by 1) responding to the automated reminder system, or 2) contacting the office.

There is a $40 no-show fee for any appointment not kept with less than two business days' notice, for any reason. This includes, but is not limited to: changes in insurance coverage, changes in personal circumstances, personal or family emergencies, employment obligations, illness, transportation/travel delays, or any circumstances related to COVID-19. This fee can not be billed to insurance. Any outstanding no-show fees must be paid in full before any new appointments can be confirmed.

While we understand that there are reasons to miss an appointment with short notice, this fee represents the time reserved for you with the physician when an appointment is made.

Thank you for understanding.

Signature:_____ Date:_____

Miami Dermatology & Cosmetics

PATIENT INFORMATION

First and last name: _____ Date of birth: _____

Billing address: _____ Apt./Unit No.: _____

City/State/Zip Code: _____ Mobile phone number: _____

E-mail address: _____

CARD ON FILE AUTHORIZATION FORM

A valid credit card is required to be on file to receive care and/or services from Miami Dermatology and Cosmetics.

Our office is PCI-DSS compliant, and all staff are thoroughly background-checked as a condition of employment. Your card data will be securely stored in a PCI-DSS compliant database in which your full card details will not be accessible.

Initial

1) CO-PAY, DEDUCTIBLE, AND CO-INSURANCE ESTIMATES: During the course of the patient visit, when it is estimated that a co-pay, deductible, or co-insurance is due from the patient, the patient will be notified and the credit card on file will be charged for the amount.

Initial

2) BALANCES: After claims have been submitted to insurance, if there is any remaining balance which is the patient's responsibility, the balance will be charged to the credit card on file. The patient will be notified by both text and e-mail regarding this charge.

Initial

3) NO-SHOW FEES: For insured patients, the no-show policy requires, for any reason, two business days' advance notice (i.e. weekends and federal holidays are excluded) of rescheduling and cancellation, so that the office has the opportunity to offer the appointment to another patient. If an appointment is rescheduled or cancelled with less than two business days' advance notice for any reason, a $40 no-show fee will be charged to the card on file. The patient will be notified by both text and e-mail regarding this charge.

Last 4 digits of credit card number: _____ Signature: _____ Date: _____

CONTINUED ON BACK

Initial

4) COSMETIC PROCEDURE AND SELF-PAY VISIT DEPOSITS: In the event of requesting a cosmetic procedure or other self-pay visit appointment, a 50% deposit no greater than $100 will be charged to the credit card on file. This deposit will be used to cover the visit and is 100% refundable, for any reason, with two business days' advance notice (i.e. weekends and federal holidays are excluded) of rescheduling or cancellation. If the appointment is rescheduled or cancelled with less than two business days' advance notice for any reason, the deposit fee will be used to cover the appointment time, and the patient will have to make another deposit payment to schedule the appointment again. The patient will be notified by both text and e-mail regarding this charge.

I understand that Miami Dermatology and Cosmetics must be notified immediately of any changes/updates to my credit card information and that failure to notify of such change will result in the company's right to charge any active credit card on file in the event my primary authorized card becomes compromised, expired, or canceled.

I authorize Miami Dermatology and Cosmetics to charge the credit card indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Last 4 digits of credit card number: _____ Signature: _____ Date: _____