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

Miami Dermatology & Cosmetics

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

_____

PATIENT 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 of responsible party 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.learnaboutеprescriptions.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

Patients will be notified of all test results by both e-mail and text message, and all test results are available to patients through the patient portal. Text message notifications will inform whether results are negative/normal or positive/abnormal. Positive/abnormal test results will require a follow-up appointment with the doctor for further management.

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

_____
PRINT NAME

_____ _____
PATIENT SIGNATURE 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, phone calls, and e-mail starting one week prior to the appointment date.

If you need to reschedule or cancel your appointment, please give the office at least two business days' notice in advance of the appointment date so that the office can offer the appointment to another patient. The office can be notified by 1) responding to the automated reminder system, or 2) calling the office.

There is a $25 no-show/reschedule/cancellation fee for any appointment not kept with less than two business days' notice. This fee can not be billed to insurance.

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

Thank you for understanding.

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

PATIENT SIGNATURE DATE

BENEFITS

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

PRINT NAME

PATIENT 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 of Patient 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
Who offered the Patient the Notice?

5. ADVANCED SKIN TYPING CHART

Customer Name: _____

Date: _____

Ethnicity: _____

Grandparents & Parents Ethnicity: _____

Pigment/Hair Density of treatment area: Mild, Moderate, Severe: _____

What is your SAFE TYPE: _____

Score	Fitzpatrick Scale
0-7	1
8-16	2
17-25	3
26-31	4
Over 31	5-6

Value	0	1	2	3	4	Total
Eye Colour	Light Blue Grey/Green	Blue Grey/Green	Blue	Brown / Dark Brown	Brownish Black	
Natural Hair Colour	Sandy Red	Blonde	Chestnut / Dark Blonde	Brown / Dark Brown	Black	
Natural Skin Colour	Reddish	Very Pale	Pale With Beige Tint	Light Brown	Dark Brown	
Freckles	Many	Several	Few	Incidental	None	
Too Long in Sun	Painful Redness / Blister /Peels	Blistering Then Peel	Burns Some Then Peel	Rarely Burns	Never Burns	
Degree of Tanning Brown	Hardly or Not At all	Light Colour Tan	Reasonable Tan	Tans Easily	Turn Dark Brown Very Quickly	
Turn Brown Hours After Exposure	Never	Seldom	Sometimes	Often	Always	
Face Response to Sun	Very Sensitive	Sensitive	Normal	Very Resistant	Never a Problem	
Last Exposure to Tanning / Tan Creams	3 Months Ago	2-3 Months Ago	1-2 Months Ago	Less Than 1 Month Ago	Less Than 2 Weeks Ago	
Sun Exposure to Treatment Area	Never	Hardly Ever	Sometimes	Sometimes	Always	

Miami Dermatology & Cosmetics

BILLING AND COLLECTIONS

To Our Patients:

As you know, if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. You will be given the option to provide a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of healthcare down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays, co-insurances, deductibles, and cosmetic procedure payments due at the time of the visit will, of course, still be due at the time of the visit, and any overpayments to your account will be refunded to you.

If you have any questions about this payment method, do not hesitate to ask.

[ ] I authorize Miami Dermatology and Cosmetics Prime, LLC to charge outstanding balances on my account to my credit card (credit card information to be entered on following page):

Name on card:_____

Signature:_____ Date:_____

BILLING AND COLLECTIONS – CREDIT CARD INFORMATION

Visa MasterCard American Express Discover Other:_____

Credit card #:_____

Exp. Date: _____ CVV:_____ Zip Code: _____

Patient Name: _____

Cardholder Name: _____

Signature:_____

*** For internal use only ***