DELRAY DERMATOLOGY
+ COSMETIC CENTER

Patient Personal Information

Full Name: ____

Date of birth: ______________ Age:__________

Phone Number: (_____)_______-_____________ ☐Cell ☐Home ☐Other

Email address: ____

Local Address: ____

City: ___________________________ State: ____________ Zip code: __________________

Secondary out of state address: ____

City: ___________________________ State: ____________ Zip code: __________________

Primary Care Doctor: ____________________________Phone Number:___________________

Pharmacy: ___________________________________ Phone Number: _____________________

Referring Doctor: ______________________________Phone Number:____________________

Emergency Contact: ______________________________ Relationship: ___________________

Phone Number: (______)________-_______________

If patient is a minor, custodial parent:____

Mother: ___________________________ Phone number: (_____)_______-__________

Father: ___________________________ Phone number: (_____)_______-__________

I would like to receive appointment reminders by: ☐ Text ☐ Email

Return/Refund Policy:

- No refunds on Prepaid services.
- If you wish to discontinue a service or package that was prepaid, you may one use the credit on your account towards any other service or products in the office.

Returns/Exchanges:

• If there is a problem with your product, please be sure to contact us immediately. • Once your items are purchased, you have 7 days from the date of purchase to bring them back in or ship them back to us for a return or exchange.

- All returned merchandise must be in its original unopened packaging.
- Used products are not eligible for refunds or exchanges.
- We do not reimburse shipping or return fees.

Signature_________________________________

DELRAY DERMATOLOGY
+ COSMETIC CENTER

Authorization to discuss/release medical information

(If you do NOT wish to release your information to anyone please put 'N/A' and Print/ Sign your name at the bottom)

I, ____, allow the release of my health information to

the following people or and/or organization(s):

Name(s) & Relationship(s):

____ ______________________________________

____ ______________________________________

____ ______________________________________

________________________________ _______________________________ ____________ Patient
Name (PRINT) Signature Date

____
Relationship to patient (if other than patient)

DELRAY DERMATOLOGY
+ COSMETIC CENTER

Patient Name:_______________________________________

Review of Systems

Problems with bleeding	YES NO
Problems with healing	YES NO
Problems with scarring (hypertrophic or keloid)	YES NO
Rash	YES NO
Growing skin lesions	YES NO
MRSA	YES NO
Artificial heart valve	YES NO
Artificial joints within the past 2 years	YES NO
Blood thinners	YES NO
Defibrillator	YES NO
Pacemaker	YES NO
Require premedication prior to procedures	YES NO
Rapid heart beat with epinephrine	YES NO
Pregnancy or planning pregnancy	YES NO
Immunosuppression	YES NO
Hay fever	YES NO
Fever or chills	YES NO
Night sweats	YES NO
Unintentional weight loss	YES NO
Thyroid problems	YES NO
Blurry vision	YES NO
Joint aches	YES NO
Headaches	YES NO
Anxiety	YES NO
Depression	YES NO
Tobacco User	YES NO

Allergies:

____

____

DELRAY DERMATOLOGY
+ COSMETIC CENTER

****Please bring a complete list of medications including dosages to your appointment. Thank you!**

Financial Policy

I hereby authorize the payments of medical and/or cosmetics to Delray Dermatology, LLC for services rendered.

I understand that it is my responsibility to verify my individual insurance coverage and benefits and verify providers in my network. I understand that I am financially responsible for any services not covered by my insurance carrier. I understand that I am financially responsible for any and all cosmetic procedures that I do in office.

I understand that I am fully responsible at the time of service for any deductibles, co-pay or coinsurance balance. Given the many high deductible insurance plans, we require payment in full on the day of service for any procedures performed that fall under the deductible or co-insurance OR a credit card to be left on file in a secure network to charge the remaining balance after it has been submitted to insurance. A care credit account may be used towards deductible payments over $200. I understand that the fee I am quoted on the day of service is an estimate and that if there is a balance remaining I am responsible for paying any additional patient responsibility amounts as deemed by my insurance. I understand a $50 fee will be charged if I present an insufficient funds check. We do not accept checks for any services over $100.

I further agree to pay all collection costs, attorney fees, and any other expenses that may be incurred to enforce the collection of any amount outstanding.

I hereby authorize Delray Dermatology, LLC to release any medical information necessary to complete and process my insurance claims.

I understand that if blood work or biopsies are done that I may receive a separate invoice from the laboratory or pathology doctor who reviews and interprets my results. I will be responsible for paying all such invoices directly to the laboratory or physician.

Self-pay Financial Policy: (Only initial if you do NOT have insurance)

____ I currently do not have insurance coverage. Therefore, I understand that all charges must be paid at the date of service.

Prepaid Services: I understand that prepaid services are valid for one year from the date of purchase. After one year prepaid services are no longer valid. If prepayment expires, the credit from prepaid service can be used toward any treatment at full price or refunded to the original form of payment, if available.

Appointment cancellation

If it is necessary to cancel your scheduled appointment, we require that you give us at least 24 hours notice so your appointment time may be given to another patient in need. If you fail to cancel before 24 hours there will be a $50 charge for medical appointments and $100 for surgical or cosmetic appointments. (Unexpected circumstances may warrant special consideration.)

______________________ ______________________ __________ Patient Name (PRINT) Patient or legal guardian signature Date

______________________________ Relationship to patient (if other than patient)

DELRAY DERMATOLOGY
+ COSMETIC CENTER

HIPAA Policy

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 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 the right 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.

______________________________ ______________________________ ____________

Patient Name (PRINT) Patient or legal guardian signature Date

____

Relationship to patient (if other than patient)