RSB Dermatology, Inc.

Adult Dermatology • Skin Cancer Screenings • Growth Removal
Mohs' Micrographic Surgery • Cosmetic Surgery • Skin Cancer Surgery

1500 EAST HILLSBORO BLVD., SUITE 204 • DEERFIELD BEACH, FL 33441 • TELEPHONE: 954-421-3200
8130 ROYAL PALM BLVD, SUITE 201 • CORAL SPRINGS, FL 33065 • FACSIMILE: 954-421-3201

WELCOME TO OUR PRACTICE

Please take a few minutes to answer the following questions so we can better assist you with your health care needs.

CONFIDENTIAL PERSONAL INFORMATION

NAME OF PATIENT:………………………………………………………………….. SEX (circle one): Male Female
(last) (first) (middle)

HOME STREET ADDRESS:…………………………………………………….. APT:………………

CITY:……………………………………………….. STATE:…………………. ZIP CODE:………………………….

DATE OF BIRTH:………./………../……….. Home Phone: (………)………………….. Work Phone: (………)…………………..
(month) (day) (year)

Email Address: …………………………… Other Phone: (………)…………………..

SOCIAL SECURITY NUMBER:…………-…………..-………………….

MARITAL STATUS (circle one): SINGLE MARRIED OTHER

SPOUSE'S NAME:…………………………………… Spouse's Work Phone: (………)…………………..

PATIENT'S EMPLOYER:…………………………………… OCCUPATION:……………………

WORK ADDRESS:……

REFERRING PHYSICIAN:……………………………………………………………… Phone: (………)…………………..

ADDRESS:……..

PRIMARY PHYSICIAN (if different than referring physician):…………………………………… Phone: (………)…………………..

ADDRESS:……..

PARENT'S NAME (if patient is a minor):………………………………………………. Work Phone: (………)…………………..

WHOM SHALL WE CONTACT IN CASE OF AN EMERGENCY (who does not live with you):……………………………………

RELATIONSHIP TO PATIENT:……………………………… Phone: (………)…………………..

I WILL PAY FOR SERVICES BY (circle one): CASH CHECK MASTERCARD VISA

WHO WILL BE RESPONSIBLE FOR PAYMENT (check one): patient spouse patient's parent

other—name:______________________ address:____________________________ phone:_____________________

WHO REFERRED YOU? ______________________________

Do we have permission to: **please answer all**

Leave a message on your answering machine at home?	YES	NO	N/A
Leave a message at your place of employment?	YES	NO	N/A
Discuss your medical condition with any member of your household?	YES	NO	N/A

PAYMENT POLICY

Medicare: We are participating providers of the Medicare program. We will accept Medicare assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% co-payment. Our office will file secondary insurance claims with insurance carriers that automatically cross over from Florida Medicare (Medigap). For all others, patients are responsible for paying their 20% copayment, although our office may submit a claim on your behalf as a courtesy.

Insurance plans with which we have contracts: You will be responsible for paying your annual deductible, co-payment, and charges for any non-covered, cosmetic services.

Insurance plans that we do not accept: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay for services at the time that they are rendered unless payment arrangements are made prior to the visit.

ALL PATIENTS:

(1) If you have joined (or changed to) any managed care plan (HMO, PPO, Medicare HMO, etc.) you must inform the staff by providing a copy of your insurance care before your visit. Please note that if you fail to do so, you will be *personally* responsible for any and all amounts due that we are unable to collect from your insurance plan.

(2) There will be a $25 service charge for any returned checks.

(3) Payments are due within 10 days of your receipt of any mailed billing statement. Accounts that are past due will be subject to a monthly 1.5% interest charge.

(4) Overdue accounts may be sent to collections. You will be responsible for any and all collection fees required for us to collect the full amount due.

Patient or Responsible Party Signature: ____________________________ Date: ____ / ____ / ______

ASSIGNMENT AND RELEASE

LIFETIME AUTHORIZATION: I hereby authorize payment directly to RSB Dermatology, Inc. or Robert S. Bader, M.D. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by my insurance, and for all services rendered on my behalf or my dependents.

A photocopy of this assignment shall be considered as effective and valid as the original.

I authorize the doctor/practice to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I authorize the above and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance companies.

X ……………………………………………………………………………… ………………………………………………

(Responsible party's signature) (date)

FOR MEDICARE PATIENTS ONLY: ***LIFETIME AUTHORIZATION:*** I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration of its intermediary carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

X ……………………………………………………………………………… ………………………………………………

(Patient's signature) (date)

FOR MEDICARE/MEDIGAP (Medicare Secondary Insurance) PATIENTS ONLY: ***LIFETIME AUTHORIZATION:*** I request that payment of authorized Medigap benefits be made on my behalf to RSB Dermatology, Inc. for services rendered by RSB Dermatology, Inc. I authorize any holder of medical information about me to release to my insurance carrier (listed above) any information needed to determine these benefits of the benefits payable for related services.

X ……………………………………………………………………………… ………………………………………………

(Patient's signature) (date)

RSB Dermatology, Inc
& Cosmetic Surgery Center

Mohs' Micrographic Surgery
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Robert S. Bader, M.D.

Please complete and give back to the receptionist.

Name: ______________________________ Telephone Number: _________________

(please check one)

My friend, _____________________________, recommended the doctor.
(please print name)

My doctor, _____________________________, recommended the doctor.
(please print name)

I was a patient of Dr. Kloep's

I was a patient of Dr. Wilson's

I noticed you in the (circle one): Yellow Pages Deerfield Observer Happy Herald CVE Reporter Florida Panthers Scott Linett Newsletter B'nai B'rith Shofar The Pelican Other ________

The doctor was in my health plan book. Name of health plan: ____________________

I saw your website, *www.drbader.com*

Please circle the services that interest you:

GENERAL DERMATOLOGY

YES	NO	Acne/Rosacea Treatments
YES	NO	Hair & Scalp Disorders
YES	NO	Nail Disorders
YES	NO	Wart Treatment
YES	NO	Skin Cancer Detection/ Treatment
YES	NO	Psoriasis Treatment

COSMETIC SURGERY

YES	NO	Acne Scar Removal/ Scar Revision
YES	NO	Age Spot Removal
YES	NO	Botox™ or Dysport™ for the treatment of frown lines, crow's feet, and forehead wrinkles.
YES	NO	Chemical Peels
YES	NO	Collagen Implantation
YES	NO	Dermabrasion/ Microdermabrasion
YES	NO	Hair Removal
YES	NO	Juvederm™
YES	NO	Laser Surgery
YES	NO	Radiesse™
YES	NO	Restylane™ or Perlane™
YES	NO	Sculptra™
YES	NO	Spider Vein Treatments for the legs

R.S.B. DERMATOLOGY, INC.

1500 E. Hillsboro Blvd., Suite 204
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Coral Springs, FL 33065

954-421-3200

Receipt of Notice of Privacy Practices Written Acknowledgement Form

We keep a record of health care services we provide you. You may ask to review your record and ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so, such as the case with referring doctors. You may get more information about how you can access your record by contacting Sarah

Our **Notice of Privacy Practices** describes in detail how your health information may be used and disclosed, and how you can access your information.

I, ________________________________, have reviewed/received a copy
patient name

of **RSB Dermatology, Inc**.'s Notice of Privacy Practices.

_____________________________ _________________
Signature of Patient/Guardian Date

HIPAA

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

OFFICE POLICY REGARDING CANCELLING AN APPOINTMENT

RSB Dermatology, Inc.

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We do our best to ensure that all of our patients receive the best possible care. In order to do so, we try to ensure that all of our patients be seen in a timely fashion. When one does not cancel his/her appointment, the ability of others to be seen in a timely fashion is affected as that appointment time is wasted. Therefore, in an effort to reduce the number of patients that do not show for their appointments, our office has instituted a no show policy.

Every no show fee paid to our office is donated to *charity*.

In order to cancel an appointment, our office requires that:

- Everyone **provide 1 full business day's notice** to cancel an appointment __________ (initial)
- One **speak with a staff member directly** to cancel an appointment (e-mails or messages are unacceptable) and they must receive a confirmation #.

  ___________(initial)

Our current no show fees are as follows:

$50 - regular visit
$125 - surgical visit or procedure

My signature below affirms that I have been informed of this policy and that I agree to be personally responsible for these charges. I understand that these charges may change at any time.

____________________	____________________	____________________
Signature	Patient Name	Date