Do NOT Email These Forms Back

Email is NOT secure

Before your appointment we will need the following:

1. A copy of these completed forms
2. A copy of both sides of your Insurance Card
3. A Valid GOVERNMENT-ISSUED Identification Card (Driver's license, US Passport)

It is very time consuming for our staff to enter all of your demographic information into our system, verify your insurance benefits, and enter your health information into our system. We have found that most patients are extremely upset that they would be in the office for 45 minutes or longer prior to being seen. Therefore, we have adopted the policy of patients getting us this information in advance so that we can perform this labor intensive task PRIOR to you arriving. Alternatively, you may complete this forms online via our online check-in process. We hope that you understand as this is aimed at enhancing your experience with RSB Dermatology.

You may get the above information to us one of several ways:

1. bring this to our office no later than the BEFORE the day of your appointment

2. Fax it to our office (ensure that you get a confirmation page
3. on your fax machine that it was received) no later than the BEFORE the day of your appointment

4. Mail to:

   RSB Dermatology
   1500 E. Hillsboro Blvd., Suite 204
   Deerfield Beach, FL 33441
   Attn: Patient Registration

VERY IMPORTANT - please read!

On the Day of your Appointment:

1. Bring a government-issued photo ID (local card to a club or residence not accepted)
    i. If you do not bring one, you cannot be seen
    ii. If patient is a minor without one, the parent must bring their ID as well.
2. Bring your insurance card(s)
    i. if you have insurance and don't bring it, you cannot be seen
3. Bring ALL of your medications that you are taking or a list
    i. We will need the name of the medications, the dose, the frequency taken, and how long you have been taking the medicine.
4. **Bring ALL of the medications that you are using or have used recently on your skin.** If you have been recently treated, bring a list of all of the medications that were used.
5. **If you are coming in to discuss the treatment options for a skin cancer, mole, or growth, you must have the pathology report and know where the exact location of the cancer is. If you are not sure of the site, the Doctor who took the biopsy may have taken a photograph of the site, which we will need.**
6. If the patient is a minor-> a parent or legal guardian (with documentation of such) must accompany the patient.
7. If the patient is unable to make decisions for themselves (lacks the capacity to do so), the patient's spouse (if they have the capacity to make decisions) must bring the patient to the office OR the person with the legal authority to do so WITH legal documents stating so--if not, the patient will not be able to be seen. If there is no spouse able to make decisions and no legal guardian or health care proxy is present, please contact our office manager PRIOR to the appointment! A child may NOT be able to make decisions--CALL US!
8. Please do not wear perfume or cologne to your appointment

Patient Name: _____

Date of Appointment _____ / _____ / _____

Primary Physician Name _____

Phone # _____

Pharmacy Name & Address: _____

Phone # _____

RSB DERMATOLOGY

Adult Dermatology • Skin Cancer Screenings & Treatment • Growth Removal • Wrinkle Treatment
Mohs' Micrographic Surgery • Cosmetic Surgery • Laser Hair Removal • Laser Resurfacing
Dermabrasion • Fillers • Chemical Peels • Sclerotherapy (Leg Vein Treatments)

1500 East Hillsboro Blvd, Suite 204 • Deerfield Beach, FL 33441

Telephone: 954-421-3200 • 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)

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

HOME STREET ADDRESS:…….. APT:……

CITY:…….. STATE:……. ZIP CODE:…….

SUMMER ADDRESS (if relevant):……
Dates at Summer Address: …….. - ……. Summer Phone: (……)……

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

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

SOCIAL SECURITY NUMBER:…….-……..-……. Email and mobile phone are used to confirm appointments

MARITAL STATUS (circle one): SINGLE MARRIED OTHER

SPOUSE'S/SIGNIFICANT OTHER'S NAME:…….. Work Phone: (……)……..

PATIENT'S EMPLOYER:…… OCCUPATION:……
WORK
ADDRESS:……

REFERRING PHYSICIAN:…… Phone: (……)…….

ADDRESS:……

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

ADDRESS:……

WHOM SHALL WE CONTACT IN CASE OF AN EMERGENCY:…….

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

Alternate Contact (someone who does <u>not</u> live with you):…… Phone: (……)…….

WHO REFFERED YOU? ……

PHARMACY (name, address & phone #): …….

Payments for all services are due in full on the day of service unless arrangements are made in advance.

I WILL PAY FOR SERVICES (including deductibles, copays, co-insurance) BY: CASH CHECK VISA MC DISCOVER

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

☐ Other - name:_____ Address:_____

phone:_____

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 on the day of service unless arrangements are made prior to the visit. Unforeseen charges will be billed when the claim is adjudicated by the insurance company.

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/late fee.

(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 (Legal Power of Attorney) 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)

1500 E. Hillsboro Blvd., Suite 204
Deerfield Beach, FL 33441

954-421-3200

WWW.DRBADER.COM

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

_____ _____

Signature of Patient/Guardian Date

HIPAA

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

I authorize the names listed below to have access to my medical information. These people may call and speak with the nurse/doctor about my case. I have the right to terminate this agreement at any time by informing a staff member of RSB Dermatology.

Name(s):

_____

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:

RSB DERMATOLOGY

Robert S. Bader, M.D.
Board-Certified Dermatologist
Fellowship Trained Mohs' & Cosmetic Surgeon

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OFFICE POLICY REGARDING CANCELLING OR CHANGING AN APPOINTMENT

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 or does not give enough notice, 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 the following policy regarding cancelled appointments.

In order to cancel or change an appointment, our office requires the following:

- **Regular office visits:** Everyone **provide 24 hour notice** to cancel an appointment. Failure to do so will result in a **$50 charge**.
- **Cosmetic Consultations:** Everyone **provide 24 hour notice** to cancel an appointment. Failure to do so will result in a **$99 charge**.
- **Minor Surgical Procedures** (excision, Botox, Dysport, Restylane, sclerotherapy 3cc or less, Radiesse, CO2 laser for post-surgical scars, acne surgery, milia removal, sebaceous hyperplasia treatment, seborrheic keratosis treatment, skin tag removal, acne surgery, milia removal, spot dermabrasion, light chemical peels, laser hair removal, IPL): Everyone **provide 48 hour notice.** Failure to do so will result in a **$125 charge**
- **Mohs' Surgery & Full Sclerotherapy Sessions (over 3-cc planned): provide 5 day notice (120 hours).** Failure to do so will result in a **$250 charge**.
- **OTHER PROCEDURES (Ultherapy, laser resurfacing, acne scar treatment, threadlift, or other procedures requiring a deposit:** The terms will be stated on the deposit agreement that is signed for that procedure. In any case, it will require no less than 5 day notice (120 hours) and be no less than $125.

If one provides less than the above required notice, our office may waive or reduce the charges above (for existing patients only). This should not be expected and will be at our discretion and restrictions will apply. If our office believes that circumstances warrant such, this may only be done once in the patient's lifetime.

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. No patient can be seen unless they agree to this policy.

Signature	Patient Name	Date

RSB DERMATOLOGY

1500 E. Hillsboro Blvd., Suite 204
Deerfield Beach, FL 33441

954-421-3200

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HMO INFORMATION

VISITS: Few HMO's only allow five visits per year without a referral or prior authorization. Due to HIPPA (patient privacy), your insurance carrier will not provide us the total number of visits that you have had to a Dermatologist as this information is considered "confidential". Therefore, it is YOUR responsibility to inform us if you have been to any other Dermatologist within the past year or during the one-year term of your insurance. Additionally, if you go to another Dermatologist after seeing us and come back, we have no way of tracking the total number of visits that you have had. If you believe that you have an insurance which limits the number of visits to a Dermatologist without a referral, it is your responsibility to get a referral to see us if you have had 5 or more visits to any Dermatologist as you will be personally responsible for charges that we are unable to collect due to this rule.

RESTRICTIONS ON PROCEDURES: Most HMO's require that we obtain a referral or authorization prior to performing certain procedures. In most cases, the removal of **skin tags**, **cysts**, and **benign growths** require that we evaluate the patient first, and then submit a request for approval for treatment. Most companies require a referral or authorization for **destruction (cryosurgery/freezing) of benign lesions** (such as seborrheic keratosis, age spots, or warts) and some require a referral for the treatment of actinic keratosis (pre-cancerous lesions), although this is uncommon. Some carriers are now requiring authorization for any procedure, including a biopsy. Unfortunately, patients must first be evaluated and then return at a later date for the biopsy and/or procedure.

Depending upon the insurance carrier and/or our relationship with your Primary Care Provider, we are able to submit for an authorization at the time of your visit. This is not common and **should not be expected**. This is unfortunate for many patients whom wish to have treatment performed immediately. There is nothing that we can do to circumvent this rule and you may have treatment performed immediately if you wish to pay for these services yourself (out of pocket). If you request a procedure that is not covered without a referral or authorization, you will be informed of such and you may make a decision to either: (1) have the procedure performed immediately and be personally responsible for payment at the end of today's visit; or (2) have us submit a request for a referral, and if approved you may come back for treatment.

I have been to a Dermatologist a total of _____ times this calendar year.

Patient Signature: _____ Date: _____

RSB DERMATOLOGY

Robert S. Bader, M.D.
Board-Certified Dermatologist
Fellowship Trained Mohs' & Cosmetic Surgeon

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Credit Card Authorization Form

I agree to RSB Dermatology's **Credit Card on File Policy**, which requires patients to have a valid credit card on file with RSB Dermatology Inc. Credit cards are stored securely in a Payment Card Industry (PCI) compliant payment gateway. Once this information is entered, we no longer have access to that personal information.

By signing this document, I authorize RSB Dermatology to automatically charge my card for any outstanding balance. When an insurance company adjudicates a claim, RSB Dermatology will charge my credit card no less than 10 days after the adjudication. My insurance company is required to mail me a statement (explanation of benefits) that explains the charges and my personal financial responsibility.

If I have any questions regarding these charges, it is my responsibility to contact my insurance company or RSB Dermatology, Inc.

I understand that the credit card on file with RSB Dermatology Inc. can be changed at any time upon my request.

This authorization will remain in effect until cancelled.

_____ _____

Signature Date

RSB Dermatology, Inc. 1500 E. Hillsboro Blvd., Suite 204 Deerfield Beach, FL 33441 954-421-3200

Patient Name: _____ Date: _____

Reason(s) for today's visit (LIST ALL): □ skin cancer screening (remove all clothing)

_____

Do you have any allergies to medications (including creams and anesthetics)? □ no □ yes – please list all below – include when it last happened and the type of reaction that you had (i.e itchy red rash all over):

_____

List ALL medications that you are currently taking (including over-the-counter meds, vitamins, and creams)-Dose and how many times/day

1. _____ 2._____ _____ 3. _____
4._____ 5._____ 6._____

Have you ever been told that you need to take medication before getting your teeth cleaned or before surgery? □ no □ yes

Do you have a heart murmur/leaky heart valve? □ no □ yes Have you had a joint replacement? □ no □ yes-explain_____

Have you ever had a reaction to anesthesia (such as that given by a dentist)? - - - - - - - - - - - □ no □ yes

Females: Are you pregnant? □ no □ yes Are you trying to get pregnant? □ no □ yes Are you breast feeding? □ no □ yes

Have you ever had skin cancer? □ no □ yes If yes, please explain:_____

Has any family member ever had skin cancer? □ no □ yes If yes, please explain (melanoma?)_____

Do you have a history of any specific skin disease? □ no □ yes If yes, please explain_____

Do you have problems with healing (i.e. keloids)? □ no □ yes If yes, please explain_____

Do you bleed easily? □ no □ yes—if yes, why?_____

Do you develop skin rashes in reaction to any of the following: □ Medications □ Food □ Environment □ Bandages

□ Topical antibiotic creams or ointments □ other:_____

PAST MEDICAL HISTORY

Do **you** have any of the following?

Bronchitis - - -	□ no	□ yes	Asthma - - - -	□ no	□ yes	Emphysema -	□ no	□ yes
High Blood Pressure	□ no	□ yes	Heart Attack - - -	□ no	□ yes	Pacemaker -	□ no	□ yes
Irregular Heart Beat	□ no	□ yes	Phlebitis - - - -	□ no	□ yes	Diabetes/Sugar	□ no	□ yes
Thyroid problems -	□ no	□ yes	Arthritis - - - -	□ no	□ yes	High Cholesterol	□ no	□ yes
Are you on dialysis	□ no	□ yes	Have you ever had hepatitis	□ no	□ yes	Ever had a seizure	□ no	□ yes
Had Stomach ulcers	□ no	□ yes	Kidney disease	□ no	□ yes	Lupus or other CVD	□ no	□ yes
						HIV/AIDS	□ no	□ yes

List any other medical problems :_____

Have you ever had cancer? □ no □ yes – explain_____

Please list all surgeries (including cosmetic) that you have had:_____

Do you have breast implants, chin implants, etc? □ no □ yes– explain_____

Did you have any joint replacement surgeries? □ no □ yes– explain (site and when)_____

REVIEW OF SYSTEMS. **Do you have any of the following symptoms:**

Fever	□ no	□ yes	Excessive Urination	□ no	□ yes
Chills	□ no	□ yes	Fatigue	□ no	□ yes
Shortness of Breath	□ no	□ yes	Painful Urination	□ no	□ yes
Chronic Cough	□ no	□ yes	Blood in Urine	□ no	□ yes
Wheezing	□ no	□ yes	Leg Swelling	□ no	□ yes
Chest Pain	□ no	□ yes	Joint Pain	□ no	□ yes
Leg Cramps	□ no	□ yes	Seizures, Convulsions, or Fainting	□ no	□ yes
Nausea or Vomiting	□ no	□ yes	Numbness or Tingling	□ no	□ yes
Diarrhea or Constipation	□ no	□ yes	Depressed Mood	□ no	□ yes
Excessive Thirst or Hunger	□ no	□ yes	Anxiety	□ no	□ yes

SOCIAL HISTORY

Do you drink alcohol? - - - □ no □ yes If yes, how much and how often?	Do you smoke? - - - - □ no □ yes If yes, what & how much?
Have you ever used illegal drugs? □ no □ yes If yes, when and what?	Have you ever been exposed to HIV(AIDS)? □ no □ yes
Do you live alone? - - - - □ no □ yes	What is/was your occupation?
What are your hobbies?	Are you retired? □ no □ yes-how long_____

This form was completed by: □ patient □ parent □ legal guardian □ medical assistant/nurse ____(initials)

X_____ X_____ _____ _____

Signed by the patient or guardian date Reviewed by date