OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. 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 prior to any treatment.

All patients must complete our registration form in full before seeing the doctor.

Payment is due at the time of service. We accept cash, checks, 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, deductibles, co-insurance and charges for non-covered services at the time of service.

If you are a member of an HMO or PPO that requires a referral form from your primary care physician, you are responsible to bring this form with you for your visit.

If you have questions or concerns about your bill, you may speak with the:

Patient Accounts Office (305) 623-8025
OR
Outside of Dade (888) 479-6415

Missed appointments- If you are unable to keep an appointment kindly give 24 hours notice. Please, help us serve you better by keeping scheduled appointments.

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.

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

I have read the Financial Policy. I understand and agree to this Financial Policy.

_____ _____
Signature of responsible party Date

_____ _____
Witness Date

SKIN AND CANCER ASSOCIATES

Insurance Assignment Agreement/Privacy Notice Acknowledgment

****PLEASE SIGN THE RELEASE(S) BELOW THAT PERTAINS TO YOUR TYPE(S) OF INSURANCE****

COMMERCIAL INSURANCE

I, the undersigned, certify that I (or my dependent) have insurance coverage through _____

_____, and assign directly to Skin and Cancer Associates (SCA) all
Name of Insurance Company(ies)

insurance benefits, if any, otherwise payable to me, for services rendered. I hereby authorize SCA to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. **I understand that I am responsible for my health insurance deductibles and coinsurance.**

_____ _____ _____
Beneficiary/Patient Signature Relationship Date

MEDICARE and/or MEDICAID

Lifetime Authorization. Medicare and Medicaid patient certification. Patient certification authorization to release information and payment request.

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 or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits me 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.**

_____ _____ _____
Patient Signature Print Patient Name Date

MEDIGAP

NOTE: IF YOU SIGN HERE YOU SHOULD ALSO SIGN FOR MEDICARE ABOVE.

Beneficiary Signature Authorization.

I request that payment of authorized Medigap benefits be made on my behalf to SCA for services furnished to me by the physician(s) of SCA. I authorize any holder of medical information about me to release to my Medigap carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Beneficiary/Patient Signature Print Beneficiary/Patient Name

_____ _____
HIC (Medicare) Number Medigap Number

_____ _____
Name of Medigap Insurance Company Date

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____ _____
Patient Signature Print Patient Name Date

_____
Parent or Authorized representative (if applicable)

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Skin and Cancer Associates, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective 04-15-03 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Skin and Cancer Associates, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating heath professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Skin and Cancer Associates the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Request we amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of certain disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.
- If you have paid for services "out of pocket" in full and in advance, and you request we do not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

Our Responsibilities

Skin and Cancer Associates is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post a revised notice.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We may also provide other physicians or subsequent health care providers with copies of various reports that should assist him or her in treating you.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Your information may be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do to protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location, and general condition. We may call to confirm appointments and communicate lab results.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the practice's Privacy Officer, Darlene Tomlinson at 1-888-479-6415 Ext 636.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

NOTICE OF PRIVACY POLICIES

FOR

Skin and Cancer Associates

September 2013

Appointment Policy

No shows and cancellations with less than 2 weekdays' notice are a significant problem for our small practice. Many practices overbook on purpose so that no-shows and cancellations won't limit access for other patients as well as cause a financial hardship for the practice.

In the Office

Schedule an appointment by calling 954-974-3664 for Margate office or 561-798-3494 Wellington office.

No Walk Ins. Glick Skin Institute is open by appointment only and cannot accommodate walk-in patients.

Schedule same-day appointments for **ill visits.** An ill visit is a new rash, a bleeding mole, an infection or an acute problem. When our office manager speaks with patients it is determined through triage how soon a patient needs to be seen. Our policy is to see patients with urgent-care needs the same day they call provided they call at least 2 hours before we close. When it is an emergency which ever provider is open for appointments will be assigned emergency visits.

Patients who arrive on time are seen at their appointment time. Patients who have arrived on time will be seen ahead of those who arrive late. If you arrive late, we may need to abbreviate or reschedule your visit.

Call ahead if you are late or unable to make your appointment time. We will do all that we can to accommodate your appointment and to minimize the need to reschedule your appointment.

Turn off cell phones in the office and examination rooms.

Glick Skin Institute will charge a $50.00 no show fee for violating this policy. Violations include:

1. Not showing for scheduled appointments
2. Cancelling appointments with less than 2 weekdays' notice (excluding holidays)

Patient Signature: _____

Date:_____

*AUTHORIZATION FOR MEDICAL TREATMENT

AUTHORIZATION FOR MEDICAL TREATMENT, ADMINISTRATION OF ANESTHESIA AND THE PERFORMANCE OF OPERATIONS AND/OR PROCEDURES

1. I do hereby authorize the use of administration of such drugs, anesthetics, and other treatments and the performance of such operation and other procedures as may be deemed advisable, desirable, or necessary for diagnostic, therapeutic, or investigation purposes by any physician or physician assistant on the medical staff of Skin and Cancer Associates for or upon me or my minor.

2. I further consent to the examination for diagnostic investigational purposes, and disposal by authorities of the above named medical facility of any tissue or parts which may be removed.

3. I recognize the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures.

This office is Regulated to 64B8-9.009 Standard of Care for Office Surgery, and Such Notice is Prominently Posted.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT, AND THE EXPLANATIONS CONCERNING THE ABOVE ITEMS WERE MADE TO ME.

When patient is under age 18 or unable to affix signature, signature of a person authorized to consent for the patient.

Witness Signature	07/13/2017	Patient / Agent / Guardian Signature	07/13/2017

SKIN AND CANCER ASSOCIATES/CENTER FOR COSMETIC ENHANCEMENT®

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms ☐ Dr.	Marital status (circle one) Single ☐/ Mar ☐/ Div ☐/ Sep ☐/ Wid ☐

Date of Birth: / /	Age:	Sex: ☐ M ☐ F	Social Security No.: - -	Driver's License No. & State

Home Phone No: ( )	Work Phone No: ( )	Cell Phone No: ( )	Email Address:

Local Street Address:	City:	State:	ZIP Code:
Permanent Street Address:	City:	State:	ZIP Code:

Occupation:	Employer:

Name of Parent (for Minor Patient):	Name of Parent Employer:	Parent Work Phone No: ( )

Parent Address (if different)	City:	State:	ZIP Code:

Referred to practice by:	☐ Dr.	☐ Insurance Plan	☐ Yellow Pages/Advertising:
☐ Family/Friend:	☐ Web Site:	☐ Other:	

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home Phone No.: ( )

Occupation:	Employer:	Employer address:	Employer Phone No.: ( )

Primary Insurance:	Address:	Phone No: ( )

Insured's name:	Insured's S.S. No.:	Birth Date: / /	Sex: ☐ M ☐ F	Group No.:	Policy No.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Secondary Insurance (If Any):	Address:	Phone No: ( )

Insured's name:	Insured's S.S. No.:	Birth Date: / /	Sex: ☐ M ☐ F	Group No.:	Policy No.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

AUTHORIZATION TO PAY/ FOR MEDICARE, LIFETIME AUTHORIZATION

The above information is true to the best of my knowledge. I authorize any holder of medical or other information about me to release to my insurance company, and, for Medicare/Blue Cross/Blue Shield to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers or to the billing agent of Blue Cross/Blue Shield of Florida, any information needed for this or a related insurance or claim. I permit a copy of this authorization to be used in place of the original. I further authorize payment of medical and/or surgical insurance benefits, otherwise payable to me, to the party who accepts assignment. I understand that I am financially responsible for those charges not paid by my insurance.

Patient Signature Date

Other Signature if Patient Unable to Sign Date

Intake and History Form

Name: _____

Street Address: _____ City / State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Phone Number (day): _____ Phone Number (night): _____

Email Address: _____

Emergency Contact: _____

Preferred Language: _____ Race: _____ Ethnic Group:_____

Primary Care Provider: _____ Referred by: _____

Preferred Pharmacy

Name: _____

Phone Number: _____

City or Zip Code: _____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign prostatic hyperplasia
- ☐ Cerebrovascular accident
- ☐ Chronic obstructive lung disease
- ☐ Coronary arteriosclerosis
- ☐ Depressive disorder
- ☐ Diabetes mellitus
- ☐ Disease caused by 2019-nCoV
- ☐ Elevated blood pressure
- ☐ End-stage renal disease
- ☐ Epilepsy
- ☐ Gastroesophageal reflux disease
- ☐ Hearing Loss
- ☐ H/O Hypertension
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory Disease of Liver
- ☐ Leukemia
- ☐ Malignant Lymphoma
- ☐ Malignant tumor of lung/breast/colon (which one)
- ☐ Malignant tumor of Prostate
- ☐ Radiation Therapy
- ☐ Transplantation of bone marrow
- ☐ NONE
- ☐ Other

_____

_____

_____

Past Surgical History

Have you had any surgeries on the following organs?

- ☐ Abdominoperineal resection (APR)
- ☐ Bilateral replacement of knee joints
- ☐ Biopsy of breast
- ☐ Biopsy of prostate
- ☐ Coronary artery bypass graft
- ☐ Entire transplanted kidney
- ☐ Excision of basal cell carcinoma
- ☐ Excision of melanoma
- ☐ Excision of squamous cell carcinoma
- ☐ H/O: Colostomy
- ☐ H/O: Tubal ligation
- ☐ History of appendectomy
- ☐ History of bilateral mastectomy
- ☐ History of cholecystectomy
- ☐ History of colectomy
- ☐ History of liver excision
- ☐ History of percutaneous transluminal coronary angioplasty
- ☐ History of tissue graft heart valve replacement
- ☐ History of total cystectomy
- ☐ History of transurethral prostatectomy
- ☐ Hysterectomy
- ☐ Kidney biopsy
- ☐ Low anterior resection of rectum
- ☐ Lumpectomy of breast
- ☐ Lumpectomy of left breast
- ☐ Lumpectomy of right breast
- ☐ Mastectomy of left breast
- ☐ Mastectomy of right breast
- ☐ Mechanical heart valve replacement
- ☐ Oophorectomy
- ☐ Pancreatectomy
- ☐ Percutaneous extraction of kidney stone
- ☐ Portosystemic shunt operation
- ☐ Prostatectomy
- ☐ Prosthetic arthroplasty of bilateral hips
- ☐ Splenectomy
- ☐ surgical biopsy of skin
- ☐ Total nephrectomy
- ☐ Total orchidectomy
- ☐ Total replacement of left hip joint
- ☐ Total replacement of right hip joint
- ☐ Total replacement of left knee joint
- ☐ Total replacement of right knee joint
- ☐ Transplantation of heart
- ☐ Transplantation of liver
- ☐ None
- ☐ Other:

_____
_____
_____

Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asteatosis cutis
- ☐ Basal Cell Skin Cancer
- ☐ Contact dermatitis due to poison ivy
- ☐ Dysplastic nevus
- ☐ Eczema
- ☐ History of asthma
- ☐ History of Hay Fever
- ☐ Malignant Melanoma
- ☐ Pruritus of scalp
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Sunburn of second degree
- ☐ NONE
- ☐ Other

_____

_____

Do you wear Sunscreen?

◯ Yes ◯ No

If yes, what SPF? _____

Do you tan in a tanning salon?

◯ Yes ◯ No

Do you have a family history of Melanoma?

◯ Yes ◯ No

If yes, which relative?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter
- ☐ Other

_____

_____

Intake and History Form

Medications

List all current medications include dosage and frequency:

_____
_____
_____

Allergies

List all allergies and reactions if known:

_____
_____
_____

Social History

Smoking Status (please choose one):

- ☐ Current everyday smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy _____

Quit Smoking:

- mm/dd/yyyy _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Driving Status:

- ☐ Drives in the Daytime
- ☐ Drives at Night

How often do you exercise?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

What is your caffeine use?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

Intake and History Form

Pneumonia vaccination ☐ **YES** ☐ **NO**

Do you have a health care proxy? ☐ **YES** ☐ **NO**
Designee's name_____ Designee's phone number_____

Do you have a Living will? ☐ **YES** ☐ **NO**

Review of Systems

Please check yes or no for the following:

Symptom	Yes	No
Allergy to adhesive – rash	☐	☐
New hair growth on face, chest or abdomen	☐	☐
New moles	☐	☐
Problems with bleeding/easy bruising	☐	☐
Problems with healing	☐	☐
Problems with scarring (Hypertrophic or keloid)	☐	☐
Rash	☐	☐
Sensitivity to sunlight	☐	☐
Significant change in existing moles	☐	☐
Significant hair loss	☐	☐
Significant, persistent or intermittent burning of the skin	☐	☐
Significant, persistent or intermittent itching of the skin	☐	☐
Currently having menstrual periods	☐	☐
Irregular menstrual cycle	☐	☐
Hay fever	☐	☐
Immunosuppression	☐	☐
Palpitations, irregular heart beat	☐	☐
Unintentional weight loss	☐	☐
Thyroid problems	☐	☐
Joint aches	☐	☐
Anxiety	☐	☐
Depression	☐	☐

Alerts

Please check yes or no for the following:

Symptom	Yes	No
Allergy to lidocaine – itching	☐	☐
Allergy to lidocaine – palpitations	☐	☐
Allergy to lidocaine – sweating	☐	☐
Allergy to topical antibiotic ointments	☐	☐
Allergy to – latex	☐	☐
Artificial heart valve	☐	☐
Artificial joints within past two years	☐	☐
Blood thinners	☐	☐
Defibrillator	☐	☐
MRSA	☐	☐
Pacemaker	☐	☐
Patient vasovagal	☐	☐
Personal history of malignant melanoma	☐	☐
Premedication prior to procedures	☐	☐
Rapid heartbeat with epinephrine	☐	☐
Pregnancy or planning pregnancy	☐	☐