PREMIER DERMATOLOGY, MD

PREMIER DERMATOLOGY, MD NOTICE OF PRIVACY PRACTICES

Premier Dermatology, MD is required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. This information consists of all records related to your health, including demographic information, either created by or received by Premier Dermatology, MD from other healthcare providers.

Premier Dermatology, MD may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare purposes. These include, but are not limited to: providing, coordinating, or managing healthcare and related services by one or more healthcare providers, referrals to other providers or health agencies for treatment, activities undertaken by Premier Dermatology, MD to obtain reimbursement for services provided to you, contacting healthcare providers and patients with information about treatment alternatives, protocol development, case management, or care coordination, when required by law, for example reporting abuse, neglect, domestic violence, or injuries believed to occur as the result of a crime, or for public health reasons. We are required to report certain infectious diseases to public health authorities. We may disclose your health information to insurance or government agencies.

With my consent, Premier Dermatology, MD may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Premier Dermatology, MD reserves the right to revise its Notice of Privacy Practices at anytime. Premier Dermatology, MD may need to release your protected health information to financial parties, credit card entities, banks, collection agencies, and financing companies, when requested, to facilitate your payment.

With my consent, Premier Dermatology, MD may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. With my consent, Premier Dermatology, MD may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. With my consent, Premier Dermatology, MD may e-mail me any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Premier Dermatology, MD restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am acknowledging receipt of Premier Dermatology, MD's Notice of Privacy Practices. By signing this form, I am consenting to Premier Dermatology, MD's use and disclosure of my PHI to carry out TPO. With my signature, I hereby 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. Note: This notice is prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. If you have any questions or requests please contact our privacy officer. If you believe your privacy rights may have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

This office is a doctor's office regulated pursuant to the rules of the board of medicine as set forth in Rule Chapter 64B8, F.A.C.

Patient Name and Signature Date

Witness Date

Premier Dermatology, MD • **Donna Bilu Martin, MD** • www.premierdermatologymd.com
20803 Biscayne Blvd. Suite 305 Aventura, FL 33180 • Tel: 305-521-8971 • Fax: 786-565-9381

PREMIER DERMATOLOGY, MD

PREMIER DERMATOLOGY, MD FINANCIAL POLICY

Thank you for choosing Premier Dermatology, MD for your dermatology needs.

Payment is due at the time of service. We accept cash and credit cards (no checks). If you have insurance that will pay our physician directly, and which we can verify, it is still required that you pay all co-payments, deductibles, and co-insurance at the time of service. Payments for non-covered and insurance deemed non-medically necessary services are your responsibility. Payment for cosmetic services is your responsibility and will be discussed with you before the physician performs such 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 are an established patient to the practice, this form will replace any previously signed financial policy.

If a skin biopsy or such procedure is performed at today's visit, or labs are ordered, there will be a separate charge from the laboratory. Your health plan may not pay for these services and you will be personally responsible for these services.

CANCELLATION POLICY: If you are unable to keep an appointment, it is your responsibility to cancel the appointment 24 hours in advance of the appointment time and date by calling the office. When you do not show up for a scheduled appointment, you are taking an appointment slot that could have been used for another patient. Please note that our text reminder does not allow for cancellations through text, you must CALL to cancel the appointment. If you do not notify the office at least 24 hours in advance to reschedule the appointment, you will be charged the following NO SHOW SCHEDULING FEE:

New patient missed office visit: $50 fee prior to scheduling another appointment
For a missed office visit: $50 fee
For a missed visit with our aesthetician: the entire cost of the facial will be charged
For a missed cosmetic (Neurotoxin, Filler, Laser, Aquagold, Peel, etc) visit: $100 fee
For a missed surgical appointment with Dr. Bilu Martin: $150 fee
For a missed mohs surgical appointment with Dr. Balestra: $150 fee
Please note these fees ARE NOT COVERED BY YOUR INSURANCE.

My signature below indicates that I hereby request payment of benefits for all medical services provided by my physician be issued directly to her. I accept full financial responsibility for all expenses incurred and agree that any portion not paid by my insurance is due and payable from me upon demand. I agree to the cancellation fees as listed above. I grant authorization to release any information required to obtain payment of medical benefits to Premier Dermatology, MD, billing company, credit card processor, and collection agency (if required). I understand and agree to this financial policy, and my questions have been adequately answered.

This office is a doctor's office regulated pursuant to the rules of the board of medicine as set forth in Rule Chapter 64B8, F.A.C.

_____ _____

Patient Name and signature Date

_____ _____

Witness Date

Premier Dermatology, MD • **Donna Bilu Martin, MD** • www.premierdermatologymd.com
20803 Biscayne Blvd. Suite 305 Aventura, FL 33180 • Tel: 305-521-8971 • Fax: 786-565-9381

PREMIER DERMATOLOGY, MD

PREMIER DERMATOLOGY, MD INSURANCE AGREEMENT

Please sign the release(s) below that pertain to your type of insurance:

COMMERCIAL INSURANCE

I, the undersigned, certify that I (or my dependent) have insurance coverage through _____, and assign directly to Premier Dermatology, MD all insurance benefits, if any, otherwise payable to me, for services rendered. I hereby authorize Premier Dermatology, MD to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand 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 are 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.

_____ _____ _____

Beneficiary/Patient Signature Relationship 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 Premier Dermatology, MD for services furnished to me by the physician(s). 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 Name Date

_____ _____ _____

HIC (Medicare Number) Name of Medigap Insurance Co. Medigap Number

PREMIER DERMATOLOGY, MD

Please sign the release(s) below that pertain to your type of insurance

COMMERCIAL INSURANCE

I, the undersigned, certify that I (or my dependent) have insurance coverage through _____, and assign directly to Premier Dermatology, MD all insurance benefits, if any, otherwise payable to me, for services rendered. I hereby authorize Premier Dermatology, MD to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand 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 are 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.

_____ _____ _____

Beneficiary/Patient Signature Relationship 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 Premier Dermatology, MD for services furnished to me by the physician(s). 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 Name Date

_____ _____ _____

HIC (Medicare Number) Name of Medigap Insurance Co. Medigap Number

PREMIER DERMATOLOGY, MD

Date Email

Name Age M/F DOB

Preferred Language: Race: White/Black/Asian/American Indian/Decline to specify/other:
Ethnic Group: Hispanic or Latino/Not Hispanic or Latino/Decline to specify

last 4 SS# Driver's License# Married/Single/Divorced/Widowed

Address Home Phone#
Cell Phone#

Person to Pay Bill Relationship

Address Phone#

Patient's Employer Occupation

Work Address Phone#

Emergency Contact Relationship Phone#

Referred By Primary Physician Phone#

Primary Insurance _____
Policy#_____ Group#_____
Insured Name_____ DOB_____
Secondary Insurance _____
Policy#_____ Group#_____
Insured Name_____ DOB_____

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 further authorize payment of medical and/or surgical benefits, otherwise payable to me, to the party who accept assignment. I understand that any lab charges (including pathology services) are separate from the charges for my medical care. I understand that I am fully responsible for any non-covered services, denied services, health insurance deductibles, and co-insurance payments. I permit a copy of this authorization to be used in place of the original.

Best phone number to leave a message, including **confidential** information:
Home:_____Mobile:_____Work:_____

I authorize Premier Dermatology, MD to discuss my protected health information (including biopsy results and medical treatment) with the following people:
Name_____ Relationship_____
Name_____ Relationship_____

Patient Name and Signature Date

_____
Witness Date

Premier Dermatology, MD • **Donna Bilu Martin, MD** • www.premierdermatologymd.com
20803 Biscayne Blvd. Suite 305 Aventura, FL 33180 • Tel: 305-521-8971 • Fax: 786-565-9381

PREMIER DERMATOLOGY, MD

PREMIER DERMATOLOGY, MD Medical History Intake Form

Past Medical History: please circle all that apply

Anxiety	Colon Cancer	Renal Disease	HIV/AIDS	Prostate Cancer
Arthritis	COPD	GERD (reflux)	High cholesterol	Radiation Treatment
Asthma	Coronary Artery Disease	Hearing Loss	Leukemia	Seizures
Atrial Fibrillation	Depression	Hepatitis	Lung Cancer	Stroke
Breast Cancer	Diabetes	High blood pressure	Lymphoma	Hypoythyroid/Hyperthyroid

Other _____

Past Surgical History: please circle all that apply

Appendectomy	Colectomy: colon cancer/diverticulitis/IBD	Heart transplant	Prostate TURP/ Cancer ☐	Hysterectomy: fibroids
Bladder Removed	Gallbladder removed	Joint Replacement: knee or hip (L/R)? In last 2 years?	Prostate Biopsy	Hysterectomy: uterine cancer/cervical cancer
Mastectomy/Lumpectomy/ Breast Biopsy	Coronary artery bypass	Kidney biopsy/stone/ removed/transplant: L/R	Spleen Removed	Skin: BCC/SCC/ Melanoma
Breast Implants	Heart valve Mechanical/ biological	Ovary Removed: Endometriosis/Cyst/ Cancer	Testicles Removed L/R/Both	None

Other_____

Skin Disease History: please circle all that apply

Acne	Basal Cell Carcinoma	Eczema	Melanoma	Psoriasis
Actinic keratoses	Blistering sunburns	Flaking/itchy scalp	Poison ivy	Squamous cell carcinoma
Asthma	Dry skin	Hay fever/allergies	Precancerous moles	None

Other _____

Do you wear sunscreen? Y/N Tan in tanning salon? Y/N Family History of melanoma? Y/N Who? _____

Medications:_____

_____

_____

Allergies:_____

Social History: please circle all that apply

Cigarette Smoking: Currently daily Smoker/Some day smoker (tobacco/cigarette)Never smoked/Former smoker

Not sexually active/Sexually active: 1 partner/more than 1 partner/same sex partner

Drug Use/IV Drug Use Alcohol Use: None/less than 1 drink daily/1-2 drinks daily/3 or more drinks daily

Family History (1st degree relatives): _____

_____

Pharmacy:_____ Phone #:_____ City/Zip_____

Please circle all that apply:

Allergy to: adhesive/lidocaine/topical antibiotics; artificial heart valve/joint; blood thinners; defibrillator; MRSA; pacemaker; require abx prior to surgery; rapid heartbeat with epinephrine; **Are you pregnant, trying to get pregnant, or currently nursing?**

Patient Name and Signature _____ Date_____

Witness _____ Date_____

Premier Dermatology, MD • **Donna Bilu Martin, MD** • www.premierdermatologymd.com
20803 Biscayne Blvd. Suite 305 Aventura, FL 33180 • Tel: 305-521-8971 • Fax: 786-565-9381