Skin Associates of South Florida

4425 Ponce de Leon Blvd., Suite 200
Coral Gables, Florida 33146
T: 305.443.6606 F: 305.443.4890

GENERAL INFORMATION

_____ /_____ /_____
Today's Date

Last Name ______________________ **First Name** ______________________ **M.I.** ________

Date of Birth _____ /_____ /_____ **Age** ____________ **Sex** ____________

Street Address ____

City ____________ **State** ________ **Zip Code** ____________ **Occupation** ________________

Cell Phone (_____)________________ **Home Phone** (_____)________________ **Work Phone** (_____)________________

Do you give us permission to leave voice messages at (please select where acceptable): ☐ **Home** ☐ **Office** ☐ **Cell**

Email Address ______________________

May we send to you, by mail or email, occasional communications about products or services? ☐ **Yes** ☐ **No**

EMERGENCY CONTACT INFORMATION

Name of a person we can contact in case of an emergency ______________________

Your emergency contact's relationship to you ______________________

Emergency contact's phone number (_____)________________

PERMISSION TO DISCUSS PERSONAL HEALTH INFORMATION

I authorize my doctor and Skin Associates of South Florida, P.A. to discuss my health information with the following person(s):

1. Full Name: ______________________ **2. Full Name:** ______________________

INSURANCE INFORMATION

(Please present insurance card(s) at time of check-in)

Primary Insurance Name ______________________ **ID #** ______________________

Secondary Insurance Name ______________________ **ID #** ______________________

Name of Subscriber of Insurance ______________________ **Subscriber's Date of Birth** ______/______ /______

Your relationship to the subscriber ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other:** ____________

City ______________ **State** ____________ **Zip Code** ____________

Primary Care Physician ______________________ **Pharmacy of choice and location** ______________________ **Phone Number** (_____)________________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Skin Associates of South Florida, P.A. is committed to safeguarding the privacy of patients. The Notice of Privacy Practices provided to you with this form, and posted on a wall in our waiting room, states your rights under the Privacy Rule. It provides examples of permitted uses and disclosures of information and ways you can reach our HIPAA Compliance Officer if you have questions or concerns.

My signature below acknowledges my receipt of the Notice of Privacy Practices of Skin Associate of South Florida, P.A. on this day.

Signature ______________________ Date _____ /_____ /_____

SASF Staff: ☐ RFD or ☐ Other: ____________
Staffer's Initials: ___________ Date: ________

Joely Kaufman, MD
Jeremy B. Green, MD
Christopher O'Connell, MD
Cynthia Golomb, MD
Jacquelyn Dosal, MD

skin ASSOCIATES OF SOUTH FLORIDA

Please place a mark next to any service or product that you are interested in learning more about during your visit.

	Soft tissue augmentation fillers to volumize and smooth out wrinkles (Restylane®, Restylane Silk, Restylane Lyft, Juvederm® XC Ultra, Belotero Balance®, Radiesse®, Sculptra®)
	Botox®, Dysport® and Xeomin® to soften fine lines
	Kybella®, to improve the appearance and profile of fat below the chin

	Fraxel® DUAL 1927/1550
	Lutronic® Infini for skin texture/tightening
	Intense Pulsed light (IPL) photorejuvenation
	Hand rejuvenation
	Fractional lasers for scars, wrinkles, stretch marks
	Ultherapy® for skin tightening/lifting
	TruSculpt®/Exilis® for skin tightening and body contour
	LED phototherapy for inflammation and acne
	Photodynamic therapy for actinic keratosis (precancers)
	Sclerotherapy for leg veins
	Acleara™ or Isolaz® light treatment for acne
	Clear + Brilliant® Permea to treat sun damage
	Body Sculpting or fat removal consult (including Cellfina™, SculpSure®, TruSculpt & CoolSculpting®)
	Cellulite Treatment (Cellfina™)

	Laser removal of pigmented lesions
	Laser tattoo removal
	Laser hair removal
	Laser for broken facial capillaries
	Laser for rejuvenation

	Patch testing for skin allergens
	Skin cancer screenings
	Professional facials
	Oxygen rejuvenation therapy
	Peels

FINANCIAL RESPONSIBILITY POLICIES

FINANCIAL RESPONSIBILITY POLICY (MEDICAL CONSULTATIONS):

I authorize Skin Associates of South Florida, P.A. to submit claims to my insurance carrier on my behalf for services rendered and considered to be covered. I authorize Skin Associates to release financial and medical information, including photographs to my insurance company. I understand that I am financially responsible for and agree to pay for any service if I fail to obtain required referrals or other authorizations from my PCP or referring physician. Please be aware that patients are ultimately responsible for the costs of their medical care and tests provided, if not covered by their insurance (for example, copays, deductibles and coinsurance), including fees charged by laboratories and pathologists. Payment is required for all services at the time they are rendered unless you are covered by an insurance plan in which we participate. Co-payments and deductibles will be collected pursuant to the terms of your insurance plan. **I understand that biopsy specimens, blood samples, and cultures are sent to and analyzed by independent pathologists or laboratories and that I may receive a separate bill for their services. Even though most insurance plans cover pathology and laboratory fees, some plans have limitations. Let us know if we can help you determine whether your insurance will cover those costs, or any other charges related to your visit.** Your signature below acknowledges your review and acceptance of this policy.

FINANCIAL RESPONSIBITLY POLICY (COSMETIC CONSULTATIONS):

In order to establish optimal relations with our patients and avoid misunderstanding or confusion regarding our payment policies, our staff is trained to regularly inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered. The patient is financially responsible for all cosmetic procedures. This office is not able to bill insurance companies for cosmetic procedures (not medically necessary). This office does not accept checks. Your signature below acknowledges your review and acceptance of this policy.

____ ______ /______ /______

Patient Signature for acknowledgment of Medical and Cosmetic Consultation Financial Responsibility Date

THE PRIMARY REASON FOR YOUR VISIT WITH US TODAY:

MEDICATIONS

Do you have any known Drug Allergies? (Please List):

____

Do you take any Medications? (Please List):

____

Do you take any of the following, below, on a daily basis?

☐ Aspirin	☐ Vitamin E	☐ Motrin	☐ Aleve	☐ Coumadin	☐ Fish oil	☐ Excedrin	☐ Other blood thinners

PAST MEDICAL HISTORY

Have you ever had any of the following?

	Y	N	Comments		Y	N	Comments
Migraine Headache				Bleeding Tendency			
Heart Disease				Asthma			
Cancer				Stroke			
High Blood Pressure				Gold Therapy			
Diabetes				Pacemaker			
Skin Cancer				Unusual Moles			
Melanoma				Blistering Sunburns			

Do you have any family history of Melanoma / Non Melanoma skin cancer? _____ YES _____ NO

Do you have any other medical conditions that we should be made aware of? ____

PREVIOUS HOSPITALIZATIONS / SURGERIES / SERIOUS ILLNESS	Date(s)	Hospital, City, State
1.		
2.		
3.		

____ _____ /_____ /_____

Patient Signature **Date**

____, **MD** _____ /_____ /_____

Physician Signature **Date**

REFERRAL

Who may we thank for referring you to our office? ____

Thank you for taking the time to complete this form.

Notice of Privacy Practices

SKIN ASSOCIATES OF SOUTH FLORIDA, P.A.

This Notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices-We are required to follow the terms of this Notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on its web site.

You have the right to request an alternative means of confidential communication–This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI-This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines. We will provide a copy of your record, usually within 30 days of your request.

You have the right to request a restriction of your PHI-This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your PHI-This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request but will provide an explanation within 60 days.

You have the right to request an accounting of disclosures -This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office for six years prior to the date of your request. We will include all the disclosures except for those about treatment, payment and health care operations and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable fee if you request another one within 12 months.

You have the right to receive a privacy breach notice-You have the right to receive written notification if the practice discovers a breach that may have compromised the privacy and security of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our HIPAA Compliance Officer. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment-We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Reminders/Health-Related Communications-We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office or for fund-raising activities. You will have the right to opt out of receiving fundraising notices, and each such notice will include instructions for opting out.

Payment- Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations-We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization-The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare -Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures-We are also permitted to use or disclose your PHI subject to conditions specified in the law for the following purposes:

- **Required by law** - We will disclose your PHI if state or federal laws require it including to the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.
- **Public health activities** - We may use or disclose your PHI for certain activities such as preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect or domestic violence and preventing or reducing a serious threat to anyone's health or safety.
- **Research** - We may use or disclose your PHI for health research.
- **Legal** Proceedings - We may use and disclose your PHI in response to a court or administrative order, or in response to a subpoena, discovery request or other lawful process.
- Workers Compensation/Law Enforcement/Other Government Requests - We may use or disclose your PHI for workers compensation claims; for law enforcement purposes or to a law enforcement official; to health oversight agencies for activities authorized by law; and for special government functions such as military, national security, and presidential protective services.
- **Coroners/Funeral Directors** - We may disclose PHI to a coroner, medical examiner or funeral director when an individual dies.
- **Organ Donation** - We can disclose PHI to organ procurement organizations.

Special Protections for Sensitive Condition Information

In addition to the federal rules regarding PHI, we follow Florida State rules that impose additional protections for certain sensitive information. For example, with limited exceptions, we will obtain written permission from you before we share information concerning HIV status, genetic tests, and substance abuse treatment.

We will not use or disclose your PHI other than as described in this Notice unless you provide written authorization. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the HIPAA Compliance Officer at: **305-443-6606**

We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy and security of protected health information. We must provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the Notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

This Notice of Privacy Practices applies to the following:

- Skin Associates of South Florida, P.A., 4425 Ponce de Leon Blvd., Suite 200, Coral Gables, FL 33146 (305) 443-6606

Effective Date: 05/2015