ORLANDO DERMATOLOGY, INC.
F. Lateef M.D., F.A.C.P., F.A.A.D.

Diplomate - American Board of Dermatology
Fellow - American Academy of Dermatology
Diplomate - American Board of Internal Medicine

Treatment of Skin Diseases
Dermatologic Surgery & Laser

6000 Turkey Lake Rd. • Suite 110 • Orlando, FL 32819
Phone: (407) 351-1888 Fax: (407) 226-9804

PATIENT INFORMATION

TODAY'S DATE: ____/____/_____
Please print clearly
Last Name: _____ First: _____ Middle Initial: _____
S.S.N.: _____-_____-_____ Date of Birth: ____/____/_____ Sex *Male Female*
Marital Status: *Single Married Divorced Widowed Other*
Address: _____ Apt#: _____
City: _____ State: _____ Zip code: _____
Telephone Numbers: Home: (_____) _____-_____ Work: (_____) _____-_____
Cell: (_____) _____-_____ Other: (_____) _____-_____
Email: _____
Are you a student? *Full- Time Part-Time Not a student*
Employment Status: *Full-Time Part-Time Retired Not employed*
Employer: _____
Spouse/Parent Name: _____
Emergency Contact's Name: _____ Phone (_____) _____-_____
Their Relationship to You: _____ Phone (_____) _____-_____
How did you hear about our office? _____

INSURANCE INFORMATION

Primary Insurance Company: _____
Are you the primary Insured: *Yes No* If not, please complete the following:
Primary Insured's Name: _____ Date of Birth: ____/____/_____
S.S.N.: _____-_____-_____ Relationship To Patient: _____
Secondary Insurance Company: _____
Are you the primary insured: *Yes No* If not, please complete the following:
Primary Insured's Name: _____ Date of Birth: ____/____/_____
S.S.N.: _____-_____-_____ Relationship to Patient: _____

MEDICAL INFORMATION

Reason for visit: _____
Were you referred by another doctor? *No Yes,* Dr. _____
Have you received recent treatments for your current condition? *Yes No*
Have you seen a dermatologist before? *No Yes, when?* _____
List of current medications and supplements you are taking: _____
_____
Any known allergies to drugs: _____
Other medical problems: _____
_____
Have you ever had skin cancer? *Yes No*
Has anyone in your family had skin cancer? *Yes No Who?* _____

Your preferred pharmacy: _____ Phone: (_____) _____-_____
NAME AND LOCATION

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PRIMARY CARE INFORMATION

Name of Primary Care Physician: _____
Phone Number: (____) ____-____ Fax Number: (____) ____-____

AUTHORIZATIONS

I hereby authorize direct payment of surgical/medical benefits to Orlando Dermatology, Inc. for services rendered by Dr. Lateef and/or employees under his supervision. I understand that I am financially responsible for all balances not covered including cosmetic services.

Patient/Guardian Signature: _____
Patient/Guardian Name (Please Print): _____

We require your signed consent in order for us to provide any medical information about you to anyone other than one of your healthcare providers or your medical insurance company in regards to appointments, medical information such as biopsy results, bills, etc. Please complete the following statement:

I, _____, hereby grant permission to the physicians or staff of Orlando Dermatology Inc., to release information related to my condition to any of the following individuals.

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____

NOTICE OF PRIVACY PRACTICES:

As per HIPPA Privacy Rules, I have had the opportunity to read the Notice of Privacy Practices provided along with the registration form

Signature: _____ Date: ____/____/_____

MEDICARE PATIENTS ONLY

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require if for the proper consideration of a claim. Please read and sign the following:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries to release any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and requested payment of medical insurance benefits either to myself or the party who accepts assignment. Regulation pertaining to Medicare assignment of benefits applies.

Signature: _____ Date: ____/____/_____

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FINANCIAL POLICY

We committed to providing you with the best possible care. If you have medical insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Please be aware that it is your responsibility to know your insurance policy, benefits and coverage in relation to Dermatology. We do not acknowledge responsibility for each individual plan. Laboratory charges are not included in the cost of procedure and all billing for laboratory services is handled by the lab.

Co-payments and deductibles must be paid at the time services are rendered. *No exceptions will be made.* Patients with deductibles will be charged the allowable amount. Once your insurance has processed the claim, the allowable of your insurance will be applied to the deductible. In the case of an over payment, you may request a refund. Refunds will take 30 to 45 business days once the Explanation of Benefits (EOB) has been received. In the case of an underpayment, our practice will send you a bill shortly after the EOB has been received. New patients with medical insurance must present their insurance card(s) and a photo I.D. at their first visit for photocopying. Uninsured patients must present a photo I.D. The patient will not be seen without these. Uninsured patients must pay the cost of the office visit before they are seen by the Doctor.

Please notify the Front Desk of any change of address or insurance. They will provide you with a change of address/insurance form.

All cosmetic services performed by the doctor will require a **$50.00 deposit** to be paid at the time the appointment is scheduled. This deposit will be credited toward your service. Cosmetic appointments subject to deposit include Botox, Juvederm, Radiesse, sclerotherapy, and Equinox laser. Payment for cosmetic services must be made before the treatment is performed.

Returned checks are subject to **$35.00** charge. Unpaid accounts that are more than 60 days old will be sent to a Collection Agency after due notice is served to the patient with a fee of **$12.00**.

I have read the Financial Policy of Orlando Dermatology and agree to comply with its terms.

Signature: _____ Date: ____/____/_____
Print Name: _____

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Cancellations and No Show Policy

It is your responsibility to remember when your appointments are scheduled. Orlando Dermatology gives reminder calls as a courtesy as often as we are able.

Patients scheduled for appointments with Dr. Lateef or Rosy Singleton, P.A. may reschedule or cancel the appointment no later than **24 hours** before the scheduled date and time. You must speak to a member of the office staff to cancel or reschedule the appointment. **All regular appointments that are not kept are subject to a $25.00 fee.** If you have an emergency and will not be able to make your appointment, please notify the office as soon as possible.

If you have a surgery scheduled and you miss your appointment or cancel with less than **48 hours** notice, there will be a **$50.00** charge. No exceptions will be made.

If you are scheduled for a treatment in the Med Spa, you may cancel or reschedule your appointment no later than **24 hours** before the scheduled date and time. **Failure to keep your appointment for a Med Spa treatment will result in a $50.00 fee.**

Patient Signature: _____

Failure to keep or cancel up to 3 appointments will result in your being discharged from Orlando Dermatology and Beau Terre Advance Skin Clinic.

I have read the Cancellation and No Show Policy of Orlando Dermatology and agree to comply with its terms.

Signature: _____ Date: ____/____/_____
Print Name: _____