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 Name: _____ Middle Initial: ____

SSN: ____-____-____ 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 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: ____/____/____

SSN: ____-____-____ 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: ____/____/____

SSN: ____-____-____ Relationship to Patient: _____

MEDICAL INFORMATION

Reason for visit: _____

Were you referred by another doctor? *No* *Yes, Dr.* _____

Have you received recent treatment for your current condition? *No* *Yes, when?* _____

Any known allergies to drugs? *No* *Yes* _____

Other medical problems: _____

_____

Personal history of skin cancer? *No* *Yes,* _____

Family history of skin cancer? *No* *Yes,* _____

Your preferred pharmacy: _____ Phone:(____) ____-____

Name and Location

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PRIMARY CARE INFORMATION

Name of Primary Care Physician: _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____

AUTHORIZATIONS

Insured patients: 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 and laboratory results, bills, etc. Please complete the following statement:

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

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____

NOTICE OF PRICACY PRACTICES

As per HIPPA Privacy Rules, I have had the opportunity to read the Privacy Practices provided along with this form.

Patient/Guardian Signature: _____

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 it 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.

Patient Signature: _____

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FINANCIAL POLICY

We are 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 and Pathology charges are not included in the cost of procedures done in the office or in association with your office visit. All billing for laboratory and pathology services is handled by the lab.

Copayments 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 contracted with your insurance company. Once your insurance has processed the claim, the allowable of your insurance will be applied to the deductible. In the case of overpayment, 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 ID at their first visit for photocopying. Uninsured patients must present a photo ID. 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, Xeomin, Juvéderm, sclerotherapy, laser resurfacing, and any other injectable procedure. Payment for cosmetic services must be paid before the treatment is performed. Returned checks are subject to a **$35.00 returned check fee.** Unpaid accounts that are more than 60 days old will be sent to a **Collections Agency with a $13.50 fee** after due notice is served to the patient.

I understand agree that the cosmetic services provided by Orlando Dermatology, Inc. and Beau Terre, LLC are elective in nature and are not covered by medical insurances. Therefore, payments are due in full at the time the services are rendered. Because of the elective nature of these treatments, I understand that there is a no refund policy for any services or treatments rendered. I have read the Financial Policy of Orlando Dermatology and agree to comply with its terms.

Patient/Guardian Signature: _____

Patient/Guardian Name (please print): _____

Date: _____/_____/_____

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CANCELLATION AND NO-SHOW POLICY

It is your responsibility to remember when your appointments are scheduled. Orlando Dermatology uses a 3rd party reminder service as a courtesy to our patients.

Patients scheduled for new patient or regular/follow-up appointments with Dr. Lateef may reschedule our cancel the appointment no later than **24 hours** before the scheduled date and time. You must speak with a member of the office staff to cancel or reschedule the appointment. **All regular appointments that are not kept are subject to a $75.00 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 **$75.00 fee.** *No exceptions will be made for missed surgery appointments.*

If you are scheduled for treatment with Beau Terre Advanced Skin Clinic 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 $75.00 fee.**

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

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

Patient/Guardian Signature: _____

Patient/Guardian Name (please print): _____

Date: _____/_____/_____

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MEDICATION LIST

Date: ____/____/_____

Patient Name: _____ DOB: ____/____/_____

Medication/Supplement	Dosage	Frequency

Beau Terre LLC
Advanced Skin Clinic
At Orlando Dermatology

Do you know about our Med Spa? We offer products and treatments for your cosmetic concerns, including ZO Skin Health by Dr. Obagi, Juvéderm fillers, Botox, Xeomin, Kybella, RF treatments, facials, chemical peels, HydraFacial MD, laser hair removal, PRP, feminine rejuvenation, and body contouring with fat loss.
Please circle your concerns and we'll arrange a consultation for you.

Patient Name: _____

PRP Scalp & Sunetics:
Hair Loss
Thinning Hair
Hair Restoration

GentleYAG & Diode Laser:
Unwanted Hair

Viva & Fractora:
Rough Texture
Laxity
Lines/Wrinkles
Stretch Marks
Acne Scars
Large Pores

Xeomin & Botox:
Frown Lines
Crow's feet
Forehead Lines

Contoura BodyFX/MiniFX:
Cellulite
Stubborn Fat
Sagging Skin
Contouring
Double Chin

Kybella:
Double Chin

Juvéderm Fillers:
Thin lips
Facial volume loss
Nasolabial folds

Sclerotherapy:
Spider Veins

Pur-Sil & Biocorneum+:
Scars

ZO Medical Products:
Dark Spots
Melasma
Lines/Wrinkles
Eye area
Acne
Dull/Dry/Rough Skin
Sun Damage
Aging Skin
Large Pores
Oily Skin

Votiva Vaginal Rejuvenation:
Laxity
Wrinkling
Low sensitivity
Pain
Weakening of muscles
Dryness
Stress incontinence

Recommendations for you: _____

_____

_____

_____

_____

Staff Member: _____ **Date:** ____/____/____

Quotes given are good for 1 month. Exclusions may apply.