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 REGISTRATION FORM

TODAY'S DATE: ________________

NAME (LAST, FIRST, MI): ____

SSN: ____________________ DATE OF BIRTH: ____________________ SEX: MALE FEMALE

MARITAL STATUS: __________________ E-MAIL: ______________________________

MAILING ADDRESS: ____

CITY: ______________________ STATE: __________ ZIP CODE: ______________

CELL PHONE NUMBER: ______________________ HOME NUMBER: ______________________

EMPLOYER: ______________________ OCCUPATION: ______________________

PARENT OR RESPONSIBLE PARTY (if different from patient)

NAME (LAST, FIRST, MI): ____

CELL PHONE NUMBER: ______________________ HOME NUMBER: ______________________

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

PRIMARY INSURANCE: ______________________ INSURANCE PHONE NUMBER: ______________

PRIMARY INSURED'S NAME: ______________________ DATE OF BIRTH: ______________

SSN OF POLICY HOLDER: ______________________ RELATIONSHIP TO PATIENT: ______________

INSURED'S ID #: ______________________ GROUP #: ______________

RELATIONSHIP TO POLICY HOLDER: ______________________

SECONDARY INSURANCE: ______________________ INSURANCE PHONE NUMBER: ______________

PRIMARY INSURED'S NAME: ______________________ DATE OF BIRTH: ______________

SSN OF POLICY HOLDER: ______________________ RELATIONSHIP TO PATIENT: ______________

INSURED'S ID #: ______________________ GROUP #: ______________

RELATIONSHIP TO POLICY HOLDER: ______________________

IN CASE OF AN EMERGENCY, PERSON TO CONTACT OTHER THAN SPOUSE: ______________________

THEIR RELATIONSHIP TO YOU: ______________________ PHONE NUMBER: ______________

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: ____

FINANCIAL 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 OFFICE OR IN ASSOCIATION WITH YOUR OFFICE VISIT. ALL BILLING FOR LABORATORY AND PATHOLOGY 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 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 TAKE 45 TO 60 DAYS ONCE THE EXPLANATION OF BENEFITS (EOB) HAS BEEN RECEIVED. IN CASE OF UNDERPAYMENT, OUR PRACTICE WILL SEND YOU A BILL SHORTLY AFTER THE EOB HAS BEEN RECEIVED.

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, JUVEDERM, LASER RESURFACING, AND ANY OTHER INJECTABLE PROCEDURE. PAYMENT FOR COSMECTIC 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 $25.00 FEE AFTER DUE NOTICE IS SERVED TO THE PATIENT.

** I UNDERSTAND AND 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, INC AND AGREE TO COMPLY WITH ITS TERMS.

PATIENT/GUARDIAN SIGNATURE: ____

PATIENT/GUARDIAN (please print): ____

DATE: ____________________

CANCELLATION AND NO-SHOW POLICY

IT IS YOUR RESPONSIBILITY TO REMEMBER WHEN YOUR APPOINTMENTS ARE SCHEDULED. ORLANDO DERMATOLOGY, INC. USES A 3RD PARTY REMINDER SERVICE AS A COURTESY TO OUR PATIENTS.

PATIENTS SCHEDULED FOR NEW PATIENT OR REGULAR/FOLLOW-UP AND BEAU TERRE APPOINTMENTS MAY RESCHEDULE OR 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 APPOINTMENTS THAT ARE NOT KEPT ARE SUBJECT TO A $75.00 FEE.

FAILURE TO KEEP OR CANCEL UP TO 3 APPOINTMENTS WILL RESULT IN YOUR BEING DISCHARGED FROM ORLANDO DERMATOLOGY, INC. AND BEAU TERRE, LLC.

I HAVE READ THE CANCELLATION AND NO-SHOW POLICY OF ORLANDO DERMATOLOGY, INC. AND AGREE TO COMPLY WITH ITS TERMS.

PATIENT/GUARDIAN SIGNATURE: ____

PATIENT/GUARDIAN NAME (please print): ____

DATE: ________________________

MEDICATIONS (INCLUDE OVER THE COUNTER AND ASPIRIN):

______________________________ ______________________________

______________________________ ______________________________

PERSONAL HISTORY OF SKIN CANCER? NO YES, ______________________________

FAMILY HISTORY OF SKIN CANCER? NO YES, ______________________________

YOUR PREFERRED PHARMACY (NAME AND LOCATION): ______________________________

PHARMACY PHONE NUMBER: ______________________________

PRIMARY CARE INFORMATION

NAME OF PRIMARY CARE PHYSICIAN: ______________________________

PHONE NUMBER: ______________________________

AUTHORIZATIONS

INSURED PATIENTS: I HEREBY AUTHORIZE DIRECT PAYMENT OF SURGICAL/MEDICAL BENEFITS TO ORLANDO DERMATOLOGY, INC. FOR SERVICES RENDERED BY DR. FAROOQ 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 REGARD 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 PRIVACY PRACTICES

AS PER HIPAA 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 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: ______________________________

DO YOU KNOW ABOUT OUR ADVANCED SKIN CLINIC HERE AT ORLANDO DERMATOLOGY?

PLEASE ***CIRCLE*** YOUR CONCERNS AND WE WILL ARRANGE A **FREE** CONSULTATION FOR YOU WITH OUR MEDICAL AESTHETICIAN

PATIENT NAME: ____

HAIR RESTORATION

*PRP SCALP INJECTIONS

*SUNETICS RED LIGHT LASER

HAIR REMOVAL FOR ALL SKIN TYPES

*CANDELA GENTLE YAG LASER

*LUMENIS DIODE LASER

ACNE TREATMENTS

*SKINCEUTICALS – CHEMICAL PEELS

*SKIN PEN – MICRONEEDLING

*ZO SKIN CARE PRODUCTS

***NEW** – MORPHEUS8 FRACIONAL RESURFACING

ANTI-AGING & RESURFACING TREATMENTS

*ZO SKIN CARE PRODUCTS

*SKINCEUTICALS – CHEMICAL PEELS

*SKIN PEN - MICRONEEDLING

***NEW** – MORPHEUS8 FRACTIONAL RESURFACING

*VENUS LEGACY – RF SKIN TIGHTENING

*PLASMA PEN - FIBROBLAST

***NEW** – LUMMECA IPL

*COOLIFTING

PIGMENTATION/DARK SPOTS

*ZO SKIN CARE PRODUCTS

*SKINCEUTICALS - CHEMICAL PEELS

***NEW** – LUMMECA IPL

SCARRING/TEXTURE IRREGULARITIES

*ZO SKIN CARE PRODUCTS

*SKIN PEN - MICRONEEDLING

*SKINCEUTICALS - CHEMICAL PEELS

FILLERS/INJECTABLES

JUVEDERM

LIPS, TEMPLES, JAWLINE, LOWER FACE, CHEEKS

BOTOX/XEOMIN

UPPER FACE, CROW'S FEET, FOREHEAD, GLABELLA

RECOMMENDATIONS FOR YOU: ____

____

TEAM MEMBER: ______________________________ **DATE:** ______________

**** QUOTES GIVEN ARE GOOD FOR 1 MONTH. EXCULISONS MAY APPLY. ****

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Virus Acknowledgment

We have taken enhanced health and safety measures – for you, our other patients, and employees. You must follow all posted instructions while visiting our office.

An inherent risk of exposure to COVID-19 exists in any public place where people are present. COVID-19 is an extremely contagious disease that can lead to severe illness and death. According to the Centers for Disease Control and Prevention, senior citizens and patients with underlying medical conditions are especially vulnerable.

By visiting our office, you voluntarily assume all risks related to exposure to COVID-19 as well as other known viruses.

Help keep each other healthy.

Patient/Guardian Signature: ____

Patient/Guardian Name (please print): ______________________________________

Date: ________________________