Orlando Dermatology, Inc.

Farooq Lateef, MD, F.A.C.P., F.A.A.D.

6001 Vineland Road Suite 116
Orlando, FL 32819

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: _____

Phone: 407-351-1888 Fax: 407-226-9804

www.orlandodermatologyinc.com

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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: _____

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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: _____

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