KHOURI DERMATOLOGY

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LAST NAME: _____ FIRST NAME: _____ _____ MI: _____
ADDRESS: _____ APT #: _____
CITY: _____ STATE: _____ ZIP CODE: _____ **TEL #: (_____)_____- _____ CELL PH# (_____)_____-_____**
EMERGENCY CONTACT:_____RELATIONSHIP: _____ TEL #: (_____) _____-_____
PHARMACY: _____
DATE OF BIRTH: ____/ ____ / _____ SEX: _____ MARITAL STATUS _____ EMAIL: _____
PREFERRED LANGUAGE: _____
HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

ALLERGIES

☐Medication:_____ ☐Other: _____

MEDICATIONS:

_____
_____

MEDICAL HISTORY: Mark the ones that apply to your history

☐ Anxiety ☐ Diabetes ☐ Hearing Loss
☐ Hepatitis ☐ Hypertension ☐ HIV / AIDS
☐ Skin Disease: _____
☐ Skin Cancer: _____ ☐Pancreatic Cancer_____ ☐Renal Cancer_____
☐ Others: _____
Family History of ☐Melanoma: ☐BCC ☐SCC Relationship_____

VACCINES:

☐ Flu ☐ Pneumonia ☐ Shingles

SURGICAL HISTORY

☐ Heart Surgery :_____ ☐ Pacemaker:_____
☐ Joint Replacement in the last 2 years:_____ ☐ Other:_____

SOCIAL HISTORY

☐ Do you wear Sunscreen:___. SPF:_____ ☐ Use of Tanning Bed _____
☐ Sexually Active_____
☐ Drug Use: Type_____ ☐ Alcohol: amount_____ ☐ Smoking: amount_____

COSMETIC QUESTIONNAIRE

Are you interested in any of the following treatments?

☐ Botox & Dysport
☐ Fillers
☐ Microneedling
☐ Chemical peels
☐ Facials & Hydrofacials
☐ Laser Hair Removal
☐ Microdermabrasion
☐ Daily Skin Regimen
☐ Scar Treatments
☐ Dark Spots Correction
☐ Spider Veins

NEW PATIENT CONSENT AND ACKNOWLEDGEMENT FORM

ASSIGMENT OF INSURANCE BENEFITS

I authorize-payment of Medicare, Medicaid or other Insurance benefits otherwise payable to me for medical services rendered to me or my child directly to KHOURI DERMATOLOGY. These benefits are not limited to individual Policies, Group Policies, Workers Compensation, Liability, PIP or any other policy that may cover healthcare benefits.
Where MEDICARE/MEDICAID BENEFITS are applicable, I certify that the information given by me in applying for payment under the Title XVII or XIV of the Social Security Act is correct and request that these payments of authorized benefits be made directly to KHOURI DERMATOLOGY on my behalf.

THIRD PARTY BENEFIT COLLECTIONS

I authorize KHOURI DERMATOLOGY to act in my behalf for the Collection of benefits from any responsible third party payor through whatever means may be deemed necessary, and the endorsement of benefit checks made payable to me and /or KHOURI DERMATOLOGY.

RELEASE OF INFORMATION

I authorize KHOURI DERMATOLOGY to release copies of information in their possession, as acquired in the course of me or my child's examination and/or treatment, to my insurance carriers in connection with my treatment for the purpose of any insurance, Medicare and Medicaid payments:

-This facility and its affiliates
-Physician (Attending and consulting)
-Utilization review agencies or auditors
-Other Allied Health Professionals

GUARANTEE OF PAYMENT

I hereby understand that I am financially responsible for payment to KHOURI DERMATOLOGY for any charges not covered or allowable by my Insurance Company, and all deductibles, co-insurance, co-payments and for any balances remaining after payment has been made by my Insurance Company. This includes any denials of payment due to lack of medical necessity or pre-certification/authorization, lack of affiliation with an HMO or any other constraint imposed as a condition of my insurance coverage. I further understand and agree that if this account is placed for collection, I will be responsible for paying the balance owed to the physician plus the cost of collection fees, and/or including reasonable attorney's fees if/when applicable. I further acknowledge that I have read and reviewed the FINANCIAL POLICIES of KHOURI DERMATOLOGY.

CONSENT TO TREATMENT

I consent to all medical and surgical procedures and treatment, including but not limited to surgery, medical treatment, anesthesia, laboratory procedures and medications that may be performed, administered or rendered by or under specific or general instructions of my physician. I hereby voluntarily consent to rendering of medical treatment by KHOURI DERMATOLOGY and /or the medical staff, which may include routine diagnostic and /or surgical procedures, administration of injections, and/or any other such medical treatment deemed necessary for the treatment and improvement of the patient's condition.
I consent to the examination, use, storage and disposal by KHOURI DERMATOLOGY of any tissue, bones, organs, fluids or body parts that may be removed during the procedure if any individual(s) in my care is exposed to any of these, I consent to having any bodily fluids and/or tissue obtained and submitted for any testing
deemed reasonable by my health care providers.

OPEN DOOR POLICY

Due to the nature of the practice, KHOURI DERMATOLOGY has an open door policy. Reception and waiting areas are open and examining room doors may be kept open. If you have any questions or objections to this policy, please inform the privacy officer or the designated staff member.

APPOINTMENT REMINDERS

I acknowledge that this practice/facility may call for appointment reminders and / or cancellations. I authorize the use or disclosure medical information to contact you as a reminder. This contact may be by phone, in writing, e-mail or otherwise and may involve leaving a message on an answering machine or any other device available. If you have any questions and /or objections to this policy, please inform us.

CONSENT TO PHOTOGRAPH

I authorize the KHOURI DERMATOLOGY and its affiliates to take pictures of me and/or my child. For medical or surgical procedure(s) and condition(s) and to the use of such pictures for treatment, scientific, educational or research purposes.

RELATIONSHIP BETWEEN FACILITY AND PHYSICIAN

KHOURI DERMATOLOGY wishes to disclose to her patients pursuant to Florida Statue 445.25 Disclosure of financial interest by producing the following:
That she has a financial interest in:
Khouri Dermatology located at 580 Crandon Blvd Suite 101 Key Biscayne, Fl 33149,
Key Biscayne Surgery Center located at 580 Crandon Blvd Suite 301 Key Biscayne, FL 33149,
That Susana Leal-Khouri, MD is a licensed physician and licensed Dermatopathologist employed by KHOURI DERMATOLOGY and performs Pathological examinations on behalf of said corporation.
You, as a patient, have the right to obtain alternative sources of services for both lab and clinical work as stated below.

The names and addresses of alternative sources for Lab Services available to the patient are as follows:
(1) Dermpath Diagnostics, 895 SW 38th Ave #101., Pompano Beach Fl 33069 (954)633-3387
(2) LabCorp of America, 4200 N. 29th Ave., Hollywood Fl 33020 (800) 877-7831
(3) Quest Diagnostics Clinical Laboratories, Inc, 1611 NW 12th Ave Miami FL 33136-1005 (866) 697-8378

The names and addresses of alternative sources for Surgery/ Repairs available to the patient are as follows:
(1) Dr. Thomas John Zaydon Jr MD, 3661 South Miami Ave Suite 509 Miami, Florida 33133 (305) 856-3030
(2) Dr. William Scott McDonald MD, 848 Brickell Ave Suite 1020 Miami, (305) 377-8004
(3) Dr. Johnny Salomon, 6705 S Red RD # 708, Miami, FL 33143, (305) 270-1361

A fee schedule of typical fees for items / services usually provided by the providers are Pathology Examination of specimen code 88305 and for repair codes 14000 through 14302 or 15220 through 15260.
I have read the above and signed acknowledgement in the patient signature provision above and under the release of information provision this same day.

USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS
I understand that as part of my health care, KHOURI DERMATOLOGY originates and maintains paper and / or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care of treatment. I understand that this information serves as:
A basis for planning my care and treatment
A means of communication among the many health professionals who contribute to my care,
A source of information for applying my diagnosis and surgical information to my bill,
A means by which a third-party payer can verify that services billed were actually provided &
A tool for routine healthcare operations such as assessing qualify and reviewing the competence of healthcare professionals. I understand and have been provided with a notice of privacy practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:
The right to review the notice prior to signing this consent,
The right to object to the use of my health information for directory purposes, and
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment , payment or health care operations. I understand that KHOURI DERMATOLOGY is not required to agree to the restrictions requested.
I understand that I may revoke this consent in writing. I also understand that by refusing to sign this consent or revoking this consent KHOURI DERMATOLOGY may refuse to treat me as permitted by section 164.506 of the Code of Federal Regulations. I further understand that KHOURI DERMATOLOGY, reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations., should KHOURI DERMATOLOGY, change their notice, I have the right to obtain a copy of any revised notice. I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I acknowledge that I have read and reviewed the NOTICE OF PRIVACY PRACTICES and I am in agreement of such. I acknowledge that this form has been fully explained to me and that I have read and understand each of the provisions appearing on this form, and that by signing this form, I consent to these provisions individually and collectively.

_____ _____ _____

Patient's Signature **Print Name** **Date**