MIAMI
DERMATOLOGY
& MOHS SURGERY

PATIENT REGISTRATION

Last Name: _____ First Name: _____ M.I.: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Sex: _____ Marital Status: _____ Race/Ethnicity: _____

Address: _____

City: _____ State: _____ Zip: _____

PHONE/EMAIL

Home: _____ Preferred number: ☐ Home ☐ Mobile ☐ Work

Mobile: _____ May we leave a message on your answering machine or cell phone with medical information? ☐ Y ☐ N

Work: _____

Email: _____ May we email personal medical information to you? ☐ Y ☐ N

Would you like to be notified of promotions/events via email? ☐ Y ☐ N

CONSENT TO DISCUSS CARE

Do you give us your consent to discuss your medical information with family members or caregivers? ☐ Y ☐ N

If yes, Name: _____ Phone number: _____ Relationship: _____

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PRIMARY CARE PHYSICIAN

Name: _____ Phone number: _____

Do you give us your consent to discuss your medical information with your primary care physician? ☐ Y ☐ N

EMERGENCY CONTACT

Name: _____ Phone number: _____ Relationship: _____

REFERRAL

How did you hear about us? ☐ Social Media ☐ Google ☐ Yelp ☐ TV ☐ Insurance Company

☐ Family/Friend Referral _____

☐ Doctor Referral _____

☐ Employee from Our Clinic _____

☐ Other _____

PHARMACY

Pharmacy: _____ Phone number: _____

Pharmacy Address: _____

CONSENT FOR EVALUATION AND TREATMENT

I give my informed consent for dermatologic treatment by Miami Dermatology & Mohs Surgery.

I understand that the recommended treatment may include procedures or medications and I understand that there are risks associated with each procedure or medication. Risks of dermatologic procedures include but are not limited to:

- Skin discoloration
- Scarring
- Infection
- Bleeding
- Nerve damage
- Pain

I have discussed the benefits and risks of each procedure or medication with my healthcare provider and have had the opportunity to ask any questions that I may have. I understand that I may refuse any procedure or medication recommended by my healthcare provider. I understand that there may be alternative treatments available and I have discussed the advantages and disadvantages of each alternative with my healthcare provider.

I authorize my healthcare provider to perform the recommended procedures or prescribe the recommended medications. I understand that the results of treatment cannot be guaranteed and that there may be complications or side effects associated with the treatment or procedure.

I understand that I may need additional treatments or follow-up visits with my healthcare provider, and I will comply with any recommended follow-up care. I have read and understand the information provided in this consent form.

This authorization shall remain in effect for this visit and all future visits to the office.

By signing below, I authorize evaluation and treatment by the providers and staff at Miami Dermatology & Mohs Surgery.

Patient or Legal Guardian Signature:_____ Date: _____

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

I understand and agree that by signing this Patient Financial Responsibility Agreement, I am accepting responsibility for all charges related to the medical services I receive, including but not limited to: office visits, diagnostic tests, procedures, surgeries, medical equipment, prescription medications, non-prescription topicals or medications.

I acknowledge that I am responsible for paying all deductibles, co-payments, and co-insurance amounts that are due under my health insurance plan. I understand that my health insurance plan may not cover all of the services that I receive, and that I will be responsible for paying any amounts that are not covered by my insurance.

I understand that if I do not have health insurance or if my health insurance does not cover the services I receive, I will be responsible for paying the full amount of the charges. I understand that if I am unable to pay for the services I receive, I may be eligible for financial assistance programs.

I understand that if I fail to pay for the services I receive, the healthcare provider may take appropriate action to collect the amount owed, which may include sending the amount owed to a collections agency, or reporting the amount owed to credit reporting agencies.

By signing below, I acknowledge that I have received a copy of this Patient Financial Responsibility Agreement, and that I have read and understand its terms and conditions. I agree to pay for all medical services I receive and to fulfill my financial obligations under this agreement.

Patient or Legal Guardian Signature:_____ Date: _____

NOTICE OF PRIVACY PRACTICES

We are committed to protecting the privacy and confidentiality of your medical information. This Notice of Privacy Practices (NPP) explains how we may use and disclose your medical information and the rights you have with respect to your medical information.

Uses and Disclosures of Medical Information:
We may use and disclose your medical information for treatment, payment, and healthcare operations. We may also use and disclose your medical information for other purposes that are permitted or required by law. We will obtain your written authorization before using or disclosing your medical information for any other purpose.

Your Rights:
You have the right to request a copy of your medical information. You have the right to request that we restrict the use and disclosure of your medical information. You have the right to receive a notice if we experience a breach of your unsecured medical information.

We reserve the right to change our privacy practices and to make the new practices effective for all medical information we maintain. If we change our privacy practices, we will update this NPP and post a copy of the revised NPP at our facilities.

By signing below, you acknowledge that you have received a copy of this NPP and that you have read and understand its contents.

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PLEASE KEEP A COPY OF THIS PAGE FOR YOUR RECORDS.