DERMATOLOGY EXPERTS

Angelo Ayar, MD
Carla Jennings, APRN

Name:_______________________________________**Date of Birth:**______________**SSN**________________

Address:____**Apt #**______

City:______________________**State:**_____**Zip:**________**Email Address**______________________________

Cell #___________________**Name of Primary Doctor**: ______________________**Phone** (____)____________

Reason for today's visit ____**Pharmacy # (**______**)**_____________

Height:______ **Weight**:_______ **Gender**: ☐ **Male** ☐ **Female**

MEDICAL HISTORY

Allergies:______________________________
What oral medications are presently taking?
____

Do you have any of the following medical conditions?

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☐Cancer ☐Diabetes ☐High Blood Pressure ☐Herpes ☐Bronchitis ☐Emphysema ☐Asthma ☐COPD ☐Chest Pain ☐Heart Attack ☐Heart Murmur ☐Stroke ☐Irregular Heartbeat ☐Pacemaker ☐Blood Clot/Phlebitis ☐MVP ☐Glaucoma ☐Arthritis ☐Frequent Cold Sores ☐HIV/AIDS ☐Keloids ☐Skin disease/lesions ☐Seizures ☐Hepatitis ☐Hormone Imbalance ☐Thyroid

Any surgical procedures performed in the last 6 months:______________________

Have you received your flu vaccine ☐Yes ☐No

Have you received your pneumonia vaccine within the last 5 years? ☐ Yes ☐ No

Do you smoke ☐Yes ☐No **Former smoker** ☐Yes ☐No

Do you currently drink alcohol ☐Yes ☐No

How much alcohol do you consume per day _______

Do you require antibiotic prior to surgery? ☐Yes ☐No

Are you currently using UV drugs? ☐Yes ☐No

Do you have artificial joints, pins, or screws? ☐Yes ☐No

If so list location/type: ________________

SKIN

Do you have a history of skin cancer? ☐Yes ☐No

Family history of skin cancer? ☐Yes ☐No

Do you regularly use sunscreen? ☐Yes ☐No

When exposed to the sun do you ?
☐Tan ☐Tan and Burn ☐ Burn

COSMETIC HISTORY

What is your current skin care regimen?
____
____

Have you ever had ☐Laser Treatment ☐Neurotoxin ☐Dermal Fillers ☐Chemical peels

Are you interested in cosmetic treatments? ☐Yes ☐No

If yes which one?___________________________

Are you interested in learning about Coolsculpting:
☐Yes ☐No

In the below diagram, please note anywhere you would like to improve your appearance.

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CONSENT TO DISCUSS MEDICAL INFORMATION

PATIENT NAME: ____________________________ DOB: _____________

MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR VOICEMAIL? ☐Yes ☐No
PHONE NUMBER:____________________________

MAY WE MAIL MEDICAL INFORMATION TO YOU? ☐Yes ☐No

ADDRESS:____

____

MAY WE EMAIL MEDICAL INFORMATION TO YOU? ☐Yes ☐No

EMAIL ADDRESS:_____________________________________

MAY WE DISCUSS PERSONAL MEDICAL INFORMATION WITH SOMEONE? ☐Yes ☐No

I ___________________________hereby give my permission to Dermatology Experts to discuss my medical information to the following listed below

NAME:_______________________________

PHONE NUMBER:____

RELATIONSHIP TO PATIENT:____________________________________

___________________________ ____________________
Print Name Date

____
Signature

CONSENT TO TREATMENT

I hereby give my permission Dermatology Experts to give me medical treatment.
I allow the Practice to file for benefits to pay for the care I receive.

I understand that:

- The Practice will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance

I understand:

I have the right to refuse any procedure of treatment.

I have the right to refuse any procedure of treatment.

I have the right to discuss all medical treatments with my provider.

The most commonly encountered procedures in a Dermatology office are skin biopsies/cryotherapy/skin lesion removal/curettage/and administration of local anesthesia. Each procedure has a small risk of scarring the may or may not be noticeable (common), infection (uncommon), bleeding (rare), or allergic reaction (rare). I understand that a photographs image will be taken of any biopsy or surgery site performed to the sole purpose of identification of said site and insurance claims. I expressly consent to having said photograph taken

**If you are allergic to any type of local anesthesia you much inform you provider immediately. **

I understand that I may be billed by an outside laboratory for work that is preformed in this office, if my insurance company does not have a contracted lab or facility, or if services are not covered by my insurance company. I will notify the provider each time I have an appointment.

In the event that my account must be turned over to a collection agency, I understand that a $15.00 collections fee will be added to my account.

I hereby certify that I have read the foregoing CONSENT and fully understand the contents thereof.

____________________________________ ____________________

Print Name Date

____

Signature

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HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare operations

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms,examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as: a basis for planning my care and treatment;

- A means of communication among the health professionals who may contribute to my health 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 health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))
I have the right to review this Practice's Notice of Information practices prior to signing this consent;

- That this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;

- I have the right to object to the use of my health information for directory purposes;

- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;

- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

______________________________________ __________________________

Signature Date

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I authorize my physician and staff representatives; to take photographs of my body **MEDICAL PURPOSES** to be used for my patient care I understand that: photographs are taken to capture treatment outcomes for my medical procedure.

I hereby certify that I have read the foregoing CONSENT ABOVE and fully understand and the contents thereof. Patient or legal guardians please sign.

__________________________________ _________________

Print Name Date

____

Signature

I authorize images taken of me to be used by the physician, for **MARKETING PURPOSES** and/or social media. I will not be identified by name in any of the published materials. I have the right to revoke this authorization in writing at any time through a written revocation to my physician and company. I hereby release my physician from any and all claims and demands arising out of, or in conjunction with, the use of the photographs. The revocation notice will not affect any actions taken before the receipt of this written notification. I certify that I have read this release carefully and fully understand its terms. If under 18, guardian or parent must sign.

I hereby certify that I have read the foregoing CONSENT ABOVE and fully understand and the contents thereof. Patient or legal guardians please sign.

_____________________________ ______________________

Signature Date

I **DO NOT** wish to have my pictures used for marketing purposes and/or social media.

_____________________________ _____________________

Signature

Tamarac Office: 7301 N University Dr Ste 102 Tamarac, FL 33321
Parkland Office: 7535 N State Rd 7 Parkland, FL 33073
Miami Office: 9065 SW 87th Ave Ste 109 Miami, FL 33176

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Name: ______________________

Date: ________________________

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. **Article 2: All Claims Must be Arbitrated**: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. **Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement. **Article 4: General Provision:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. **Article 5: Revocation:** This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties. **Article 6: Retroactive Effect**: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _______. Effective as the date of first professional services. If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient) OFFICE SIGNATURE **X** .