Patient Information Form

Name: ____
(First name) (Last name) (Occupation)

Address: ____________ City ____________ Apt _____ State _____ Zip _____

Home Phone: ____________ **Cell Phone #** ____________

Work Phone: ____________ **Marital Status:** ____________

Social Security # ____________ **Age:** _____ **Sex:** _____ **Birthdate:** ___/___/______

Employer's Name: ______________________________

Pharmacy Name: ____________ Pharmacy # ____________

E mail address: ______________________________

Emergency Contact Name/Address: ______________________________

Emergency Contact Phone: ______________________________

Insurance Information/ Medicare Information:

Medicare #: ____________ **Insurance:** ____________

Insured's Name Policy/Group ______________________________

Insurance Address: ______________________________

Insurance Phone# ____________ **Policy #** ____________

Group Name/Number: ______________________________

Medical Information: Are you allergic to any medications? ____________

Referred by? ______________________________

Reason for this visit? ______________________________

I consent to the performance of certain necessary tests and medical procedures during the course of study, diagnosis, and treatment of my condition as recommended and explained to me by my physician. I consent to the release of medical records to my insurer and other networks. If we accept your health insurance, we will send claims for services rendered. **Patients are responsible for payment (some in advance) for deductibles, co-pays, co-insurance, denied claims, terminated policy, non-covered service etc....** Certain financial arrangements can be pre-arranged for payment of bills. Please inform us of your health insurance i.e.: PPO, HMO, Medicare plan before your office visit. Medical emergencies or any other unforeseen circumstances may prevent Dr. Bellman from keeping scheduled appointments. **I understand that I am responsible for payment when services are rendered unless prior arrangements have been made.** I agree that should my account be referred to an agency or attorney for collection that I will be responsible for all collection costs, attorney's fees and court costs. (10/27/16)

Signature: ______________________ Date: ______________________

Betty Bellman M.D., P.A.
Patient Medical History Form (Updated 11/09/04)

1) Do you have any allergic reactions to medicine or local anesthetics such as Penicillin, or Novocaine? () yes ( ) no

2) Are you presently in good health?
( ) yes ( ) no

3) Do you have any respiratory problems?
( ) yes ( ) no

4) Do you have any heart disease such as a history
of irregular heart beats (arrhythmia's), heart attack, heart murmur, chest pain, high blood pressure?
( ) yes ( ) no

5) Have you ever had cosmetic surgery ?
( ) yes ( ) no

6) Do you have any kidney, urinary, or prostate problems? ( ) yes ( ) no

7) Are you currently taking any medications and if yes, please list them ( ) yes ( ) no

____

8) Do you have a history of diabetes and/or thyroid gland disease? ( ) yes ( ) no

9) Have you ever had a stroke, seizures, headaches, or fainting spells? ( ) yes ( ) no

10) Have you ever had cancer? If so, what type.
() yes ( ) no

11) Do you have a pacemaker?
( ) yes ( ) no

12) Have you ever had a blood transfusion?
( ) yes ( ) no

13) Do you have any history of skin problems?
( ) yes ( ) no

14) Do you develop keloids or thickened scars?
( ) yes ( ) no

15) Have you ever had a skin cancer?
( ) yes ( ) no

16) Have you or anyone in your family ever had a melanoma? ( ) yes ( ) no

17) Have you noticed any moles enlarging, bleeding, becoming darker, becoming irritated or changing colors?
( ) yes ( ) no

FOR WOMEN:

1) Do you have a history of breast cancer ?
( ) yes ( ) no

2) Do you have a family history of cancer ?
( ) yes, who? What kind?____________
________________ ( ) no

3) Are you pregnant or nursing? ( ) yes ( ) no
____

Note: The dermatological examination, which you are about to receive, is not a complete physical examination. It is suggested that you have a complete physical examination periodically by your family physician or internist.
Signature of Patient (Parent or guardian if patient is a minor)

X______________________________

Betty Bellman M.D, .P.A.
4302 Alton Road Suite 705
Miami Beach, FL 33140

I hereby certify that (the patient) ________________________________ am not pregnant or anticipate becoming pregnant at this time. If you are trying to get pregnant or are pregnant you need to notify Dr. Bellman.

I also acknowledge that if I should become pregnant while under the care of Dr. Bellman, that it is my responsibility to discontinue all prescribed medication, both oral and topical, and to notify my doctor immediately.

Date: ______________________________

Signature: ___________________________

Witness: ____________________________

BETTY BELLMAN, M.D, P.A.

Insurance Assignment Agreement/ Privacy Notice Acknowledgment

****PLEASE SIGN THE RELEASE(S) BELOW THAT PERTAINS TO YOUR TYPE(S) OF INSURANCE****

COMMERCIAL INSURANCE

I, the undersigned, certify that I (or my dependent) have insurance coverage through____________________________________, and assign directly to Betty Bellman, M.D., P.A. all insurance benefits, if an, otherwise payable to me, for services rendered. I hereby authorize Betty Bellman, M.D, P.A. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am responsible for my health insurance deductibles and coinsurance and co-pays.

__________________________ __________________________ ____________________

Beneficiary/Patient Signature | Relationship | Date

MEDICARE and/or MEDICAID *Lifetime authorization. Medicare and Medicaid patient certification. Patient certification authorization to release information and payment request.*

I certify that the information given by me in applying for payment under Title XVIII and or Title XIX of Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance and co-pays.

__________________________ __________________________ ____________________

Patient Signature | Print Patient Name | Date

MEDIGAP NOTE: IF YOU SIGN HERE YOU SHOULD ALSO SIGN FOR MEDICARE ABOVE

Beneficiary Signature Authorization.

I request that payment of authorized Medigap benefits be made on my behalf to Betty Bellman, M.D, P.A. for services furnished to me by the physician group of Betty Bellman, M.D, P.A. I authorize any holder of medical information about me to release to my Medigap carrier any information needed to determine these benefits of the benefits payable services.

__________________________ __________________________

Beneficiary/ Patient Signature | Print Beneficiary/ Patient Name

__________________________ __________________________

HIC (Medicare) Number | Medigap Number

__________________________ __________________________

Name of Medigap Insurance Company | Date

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I have read and I may receive a copy of the Notice of Privacy Practices (or had the opportunity to read if I so choose) and understood the notice.

__________________________ __________________________ ____________________

Patient Signature | Print Patient Name | Date

____

Parent or Authorized representative (if applicable)

Patient Responsibility
Betty Bellman M.D., P.A.
4302 Alton Road #705
Miami Beach, FL 33140

Name of Patient: ______________________________ Date: __________
Name of Insurance Carrier: ______________________________________
Date of Service: __________

I understand that my health insurance plan may require me to pay certain fees the day of my visit and possibly afterwards. These are my responsibilities and are different for every person's individual plan. These fees include **co-pays, co-insurance and deductibles.**

I understand that I will need to pay for these fees on the date of service.

Should my carrier not pay the bill in its entirety, or should my physician determine that I was terminated from my health plan and did not have coverage at the time of service, my signature acknowledges that I will be responsible for the entire unpaid balance regardless of the reason for the denial.

I clearly understand that my carrier may consider the charges in excess of their fee schedule, consider a service(s) medically unnecessary, bundle certain services, or apply benefits to the annual deductible.

I understand that I am responsible for the entire, outstanding balance, regardless of the reason for any reductions in payment made by my carrier. I agree that should my account be referred to a collection agency, I will be responsible for all collection costs.

______________________________ __________
Signature of Patient Date

______________________________ __________
Signature of Witness Date

(Optional: The credit card information below may be added as a payment option.) My signature below allows this office to charge any outstanding balance to my credit card.

____
Name on Card

______________________________ __________
Card# Expiration Date

____
Authorized Signature

OUR FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment.

All patients must complete our registration form in full before seeing the doctor.

Payment is a due at the time of service. We accept cash, checks, and credit cards. If needed, a payment plan can be established with prior credit approval.

If you have insurance:
Your insurance, if active, and which we can verify, will pay the doctor directly. We still require that you pay all co-payments, deductibles, co-insurance and charges for non-covered services at the time of service.

If you are a member of an HMO or PPO that requires a referral form from your primary care physician, you are responsible to bring this form with you for your visit.

If you have questions or concerns about your bill, you may speak with the office billing department (305)534-8480.

Missed Appointments:
If you are unable to keep an appointment kindly give 24 hour notice. Please, help us serve you better by keeping scheduled appointments. If you need to cancel or do not show up to your appointment for which ever reason there will be a $35 fee.

Important Information about Biopsies:
Dermatologist traditionally take a sample (surgical biopsy) of suspicious skin growth or rashes in order that microscopic examination of the sample can be performed, and a diagnosis can be made.

This is to inform you that the work associated with processing each biopsy, preparing slides, microscopically examining the slide, and issuing a report of the resulting diagnosis (together known as surgical pathology) is a distinct and separate service from the biopsy itself, and there will be a separate charge.

Thank you for understanding our financial policy. Please let us know if you have questions or concerns. ANY CHANGES MADE BY THE PATIENT TO THIS FORM WILL NOT BE LEGALLY BINDING.

I have read the Financial Policy. I understand and agree to this Financial Policy.

______________________________ ____________________
Signature of responsible party Date

______________________________ ____________________
Witness Date