

Beer Dermatology

Cosmetic, General and Surgical Dermatology

Kenneth Beer, M.D., Alejandro Rabionet, M.D., Kerry Fike, M.D., R.Ph., Anne Wade, PA-C

PLEASE COMPLETE BOTH SIDES OF THIS INFORMATION FORM

Name: _____ Date of Birth: ___/___/___ Today's Date: ___/___/___
 First Middle Last

Local Address: _____
 Street Apt# City State Zip Code

Summer Address: _____
 Street Apt# City State Zip Code

Home Phone Number: () _____ Summer Phone Number: () _____

Mobile Phone Number: () _____ e-mail address: _____

Single Married Divorced Widowed *Instagram Handle: _____

Age: _____ Sex: Male Female Social Security Number: _____/_____/_____

Spouses Name: _____

Insured Date Of Birth: _____/_____/_____

Insured Name: _____

Address: _____

Party Responsible For Payment: _____

Policy Number: _____

Primary Insurance/Medicare: _____

Do you have a secondary carrier? Yes No

Name of Company: _____ Policy Number: _____ Group Number: _____

Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Medical History:

Who Referred You to Our Office? _____ Family Physician: _____

Do you have an artificial heart valve, joint or other prosthesis that requires you to take antibiotics when you have dental procedures? Yes No If yes, what antibiotic: _____

Are you allergic to Band-aids, tape or adhesive? Yes No

Do you have a history of skin cancer or skin disease? Yes No If yes, what type? _____

Please list any other information that we need to know about: _____

Female Patients Only: Are you taking oral contraceptives? Yes No

Are you pregnant or trying to become pregnant? Yes No

HIPAA Contact List:

Beer Dermatology and Staff have my permission to speak to the following family members/friends in reference to my medical care:

_____ Relationship _____ Phone _____

_____ Relationship _____ Phone _____

_____ Relationship _____ Phone _____

We offer a full range of cosmetic procedures:

Please indicate whether you are interested in learning more about:

Botox Dysport Restylane Radiesse Sculptra Juvederm Perlane Isolaz for Acne

Fraxel Laser for Rosacea Laser Hair Reduction Intense Pulse Light Treatment Smoothshapes

Treatment of Veins Dr. Beer's Skincare Line Sunscreens Clinical Trials Cool Sculpting

Clear & Brilliant

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GUARANTOR AGREEMENT:

By signing this form as Patient/Guardian/Agent, I hereby agree that any and all charges that arise within the treatment, past or future treatment if related to the incident or condition giving rise to this admission or service, not covered by any insurance, program, sponsorship, or other third party coverage I may have are due and payable by me at the time of discharge or discontinuation of treatment. I hereby acknowledge that Beer Dermatology; Kenneth Beer, M.D.; Alejandro Rabionet, M.D.; Kerry Fike, M.D., R.Ph.; Anne Wade, PA-C has agreed to bill my insurance or other third party carrier and has agreed to do so as a courtesy and Beer Dermatology; Kenneth Beer, M.D.; Alejandro Rabionet, M.D.; Kerry Fike, M.D., R.Ph.; Anne Wade, PA-C has the right to demand payment in full from me at any time prior to full payment from any insurance carrier or third party unless it is contractually stated that I will not be billed. I hereby acknowledge that I have been told, prior to receiving treatment, that I will be billed by Beer Dermatology; Kenneth Beer, M.D.; Alejandro Rabionet, M.D.; Kerry Fike, M.D., R.Ph.; Anne Wade, PA-C. I further agree that if I am more than thirty (30) days late in the payment of any bill connected with this treatment, and past treatment, a finance charge of 1.5% per month will accrue on the unpaid balance; and if the delinquent account is referred to a collection agency and/or attorney, I agree to pay the attorney's fees, court costs and collection agency fees associated with the collection process.

I understand that any lab charges (including pathology services performed by my physician or another physician) are separate from the charges for my medical care. I understand that I am personally and fully responsible for any non-covered services, denied services, health insurance deductibles and co-insurance payments.

Note: If your secondary is an automatic crossover, Medicare will send the claim automatically to them. If not, you are responsible for your deductible and 20% copay at the time service is rendered. You will need to send your Medicare explanation of benefits in to your secondary carrier. If your secondary is a crossover but fails to pay in a timely fashion, you are ultimately responsible for the 20% copay that Medicare does not pay. but fails to pay in a timely fashion, you are ultimately responsible for the 20% copay that Medicare does not pay.

MISSED APPOINTMENTS & NSF FEE:

In order to provide the best possible service and availability to all our patients it is our policy to charge a \$300 fee for any appointments not canceled at least 24 hours prior. Please call us as early as possible if you know you will need to reschedule your appointment. There will be a \$30 Non Sufficient Funds fee for any returned checks.

CONSULT FEES:

There will be a charge payable at time of service for any cosmetic consultation or service performed. In the instance the bill is unpaid, there is a service and collection fee as well as legal fees. I have read and understand the financial policy stated above and authorize the release of any information necessary to process my claims. As a member of a managed care group, I assume all responsibility for any services rendered that are or are not part of my referral, whether or not covered or paid by my insurance and I will pay for those services at the time they are needed.

I hereby acknowledge that I have read this form and I understand its contents and agree to all of the provisions contained herein.

SIGNATURE: _____

DATE: _____

Beer Dermatology

Kenneth Beer, M.D., Alejandro Rabionet, M.D., Kerry Fike, M.D., R.Ph., Anne Wade, PA-C

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Telephone (561) 932-1707

Beer Dermatology
Kenneth Beer, M.D.
Alejandro Rabionet, M.D.
Anne Wade, PA-C
Kerry Fike, M.D., R.Ph.

Patient Consent For Use and Disclosure of Protected Health Information (PHI)

With my consent, Beer Dermatology; Kenneth R. Beer, M.D.; Alejandro Rabionet, M.D.; Kerry Fike, M.D., R.Ph.; Anne Wade, PA-C, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Beer Dermatology; Kenneth R. Beer M.D.; Alejandro Rabionet, M.D.; Kerry Fike, M.D.; R.Ph., Anne Wade, PA-C; Notice of Privacy Practices for a more complete description of such uses and disclosures.

Beer Dermatology; Kenneth R. Beer MD.; Alejandro Rabionet, M.D.; Kerry Fike, M.D., R.Ph.; Anne Wade, PA-C; reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Beer Dermatology; Kenneth R. Beer M.D.; Kerry Fike, M.D., R.Ph; Anne Wade, PA-C; at 1500 N. Dixie Highway Suite 305 West Palm Beach, FL 33401.

With my consent, Beer Dermatology; Kenneth R. Beer, M.D.; Alejandro Rabionet, M.D., Kerry Fike, M.D., R.Ph., Anne Wade, PA-C; may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Beer Dermatology; Kenneth R. Beer, M.D.; Alejandro Rabionet, M.D.; Kerry Fike, M.D., R.Ph.; Anne Wade, PA-C; may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Beer Dermatology; Kenneth R. Beer, M.D.; Alejandro Rabionet, M.D.; Kerry Fike, M.D., R.Ph., Anne Wade, PA-C; may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Beer Dermatology; Kenneth R. Beer, M.D.; Alejandro Rabionet, M.D.; Kerry Fike, M.D., R.Ph.; Anne Wade, PA-C; restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am acknowledging receipt of Beer Dermatology; Kenneth R. Beer, M.D.; Alejandro Rabionet, M.D.; Kerry Fike, M.D., R.Ph., Anne Wade, PA-C; Notice of Privacy Practices.

By signing this form, I am consenting to Beer Dermatology; Kenneth R. Beer, M.D.; Alejandro Rabionet, M.D., Kerry Fike, M.D., R.Ph., Anne Wade, PA-C; use and disclosure of my PHI to carry out TPO.

Signature of Patient or Legal Guardian

Name of Individual(s) Authorized to Speak on Your Behalf

Patient's Name

Date

Print Name of Patient or Legal Guardian

DOB

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and consent to use and disclose PHI to carry out TPO, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____



NAME: _____ D.O.B : _____ DATE: _____

List all current medications, vitamins, and OTC: _____

Pharmacy name and phone number: _____

Primary Care Physician: _____

Medical History (Circle the following medical conditions that apply to you):

Anxiety	End Stage Renal Disease	Pacemaker/Defibrillator	Eczema
Arthritis	GERD (Reflux Disease)	Prostate Cancer	Psoriasis
Asthma	Hearing Loss	Radiation Treatments	Lupus
Atrial Fibrillation	Hepatitis	Seizures	Basal Cell Skin Cancer
Bone Marrow/Organ Transplant	High Blood Pressure	Stroke/TIA	Squamous Cell Skin Cancer
Benign Prostatic Hyperplasia	High Cholesterol	Blistering Sun Burns	Melanoma
Breast Cancer	HIV/AIDS	Bleeding Tendency	Actinic Keratosis
Colon Cancer	Hyperthyroidism	Heart Attack	Acne
Pulmonary Disease / COPD	Hypothyroidism	Stomach Ulcers	Keloids
Coronary Artery Disease / Heart Disease	Leukemia/Lymphoma	Joint Replacement	Herpes Virus/ Cold Sores
Depression	Lung Cancer	Cataracts	Mohs Surgery
Diabetes	Heart Valve Replacement	Glaucoma	Auto Immune Disease

Do you have a family history of skin cancer? Yes No If yes please list: _____

Please list all surgeries you have had in the past 5 years: _____

Please list any allergies you have: _____

Do you have a living will? Yes No

Have you had the flu shot? Yes No Have you had the pneumonia shot? Yes No