LEGENDS DERMATOLOGY
IULIA FUNIERU MD

LG/DERM

Minor Patient Registration

Child's Name_____ Sex: M / F
First Middle Last

Preferred to be called:_____

Date of Birth: ___/___/____ Social Security Number_____
Month Day Year

Address:_____
Street # Street Name Apartment #

_____
City State Zip Code

Cell Phone: ( ) _____-_____ Home Phone: ( ) _____-_____

In the case of an emergency, who should be notified?

_____
Name Phone Number Relationship to Patient

Primary Care Physician:_____ Who Referred You?_____

Legal Guardian's Name_____ Date of Birth: ___/___/___
First Middle Last Month Day Year

Employer:_____ Work Phone: ( ) _____-_____
Address

Where should statements of your account be sent if different address than above?

_____
Name Address City State Zip Code

In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE FOR "YOUR PART" OF THE CHARGES. WE ACCEPT MAJOR CREDIT CARDS FOR YOUR CONVENIENCE. Your Signature below indicates that you understand and accept this policy. Further, your signature authorizes the release of medical information to your primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. You herein authorize payment of medical benefits to the physician.

_____ _____
Signature of Patient or Legal Guardian Date

Name of policy holder if other than patient:_____ ___/___/___
Date of Birth

Patient relationship to policy owner: Self / Child / Spouse Other:_____

Please Present Insurance Cards and Photo ID to the Receptionist so Copies can be made

May we leave a message on your voicemail at home or on your cell? Yes / No
May we leave a message at your place of employment? Yes / No
Discuss your medical condition and or financial information with any member of your household? Yes / No If yes, whom?_____
Name Relationship to patient

_____ _____
Signature of Patient or Legal Guardian Date

Patient: _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? ____Yes No_____ If yes, list:
1. _____ 2. _____

List all Medications you are currently taking:
1. _____ 2. _____
3. _____ 4. _____

Do you have now or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	Yes	No
Bronchitis	____	____
Emphysema	____	____
Asthma	____	____
Chronic Cough	____	____
Morning Cough	____	____

Other Systemic:	Yes	No
Diabetes	____	____
Thyroid	____	____
Kidney	____	____
Bladder	____	____
Stomach	____	____
Bowel	____	____
Hepatitis	____	____
Glaucoma	____	____

Vascular

High Blood Pressure	____	____
Chest Pain	____	____
Heart Attack	____	____
Heart Murmur	____	____
Irregular Heartbeat	____	____
Pacemaker	____	____
Phlebitis	____	____

Do you drink alcohol? Yes ___ No ___ If YES _____ drinks per day/week
Do you use IV Drugs? Yes ___ No ___ If YES, what? _____ How much? _____
Have you had or have you been exposed to HIV (AIDS)? Yes _____ No _____
Have you ever had dental anesthesia (Novacaine)? Yes _____ No _____ Any bad reaction? Yes _____ No _____

Skin:
When you are exposed to sun do you: _____ Tan only ____ Tan and burn ____ Burn
Have you ever had skin cancer: _____ Yes _____ No
Has anyone in your family had skin cancer? _____ Yes _____ No
Do you have a history of any specific skin diseases: _____ Yes _____ No
If yes, please list: _____
List any other disease or condition we should know about: _____
List surgical procedures you have had in the last 6 months: _____

Please answer the following questions:

A. Do you smoke? _____ Yes _____ No
B. Do you bleed easily? _____ Yes _____ No
C. (Women) Are you pregnant? _____ Yes _____ No If YES, Date due_____
D. Do you have artificial joints? _____ Yes _____ No
E. What is your occupation? _____
F. What are your hobbies? _____

Completed by: ____Patient and/or _____ Medical Assistant ___(Initials)
Signed by Physician_____ Date_____
Reviewed by _____ Date _____

LG/DERM
LEGENDS DERMATOLOGY, LLC
IULIA FUNIERU, MD
Diplomate of the AAPS

1497 LEGENDS BLVD,
CHAMPIONS GATE, FL 33896
PHONE (407) 479-2924
FAX (407) 479-2999

PARENTAL CONSENT FORM

Date:_____

I, _____ PARENT/GUARDIAN, of minor child
(Printed Name of Parent/Guardian)

_____ give Legends Dermatology, Physician and staff
(Printed Name of Minor Child)

permission to treat my minor child. This consent is limited to office visits or cryosurgery procedures but does not include any surgical procedure as it is understood that I must be present during any such surgical procedure including but not limited to a biopsy or excision performed upon my minor child. I further agree that Legends Dermatology will not telephone me before or after any office visit by my minor child to discuss treatments provided or medications prescribed. I understand that all payments are due at time of service and that Legends Dermatology does not bill for copays or deductibles.

_____ _____
(Parent/Guardian Signature) Witness Signature

_____ _____
Printed Name of Parent/Guardian Printed Name of Witness

Patient Receipt of Privacy Notice

LEGENDS DERMATOLOGY
1497 LEGENDS BLVD,
CHAMPIONS GATE, FL 33896
PHONE (407) 479-2924
FAX (407) 479-2999

EXHIBIT 1
Review Date September 3, 2013

WRITTEN ACKNOWLEDGEMENT FORM
RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have (1) received a copy of the Notice of the Privacy

Practices or
(2) have been offered a copy of the Notice of the Privacy Practices but declined to accepl a copy.

_____
Signature of PatientDate

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WRITTEN ACKNOWLEDGEMENT OF PATIENT REFUSAL TO SIGN A
RECEIPT OF NOTICE OF PRIVACY PRACTICES

On the ___ day of _____, 2014, the Notice of Privacy Practices was

_____offered and/or given to_____.
Patient Name

____The Patient accepted a copy of the Notice of Privacy Practices but refused to sign an acknowledgement that it was given to the patient.

____The Patient refused to accept a copy of the Notice of Privacy Practices and refused to sign an acknowledgement tha

it was offered to the patient.

_____ _____
Signature of Employee Date
that offered the Patient the Notice

EXHIBIT 1
Review Date January 2, 2014
WRITTEN ACKNOWLEDGEMENT FORM
RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ _____ _____ 09/25/201
Witness Signature 09/25/2014 Patient / Agent / Guardian Signature

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DIPLOMATE OF THE AAPS

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FINANCIAL POLICY

We are committed to providing you with the best possible medical care. If you have medical insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance, and your understanding of our payment policy.

Please be aware that it is your responsibility to know your insurance policy and coverage in relation to Dermatology. We do not acknowledge responsibility for each individual plan. Laboratory charges are not included in the cost of the procedure and all billing for laboratory services is handled by the lab.

Co-payments (the amount a patient is responsible to pay every time they see a primary doctor or a specialist) and **Deductibles** (the fixed amount of money patients are required to pay before the insurance starts to pay, based on contracted rates with your insurance and the type of service is provided), as well as **Co-insurances** (the portion of your medical bill patients pay, for certain services, after the deductible is met) **must be paid at the time services are rendered**. Once the insurance has processed the claims the payments made at the office will be applied towards the deductible or the out of pocket maximum established by each individual insurance plan.

In case of an overpayment the office will refund the overpaid amount AFTER the EOB (explanation of benefits) from the insurance is received. This may take 30 to 45 days. You can opt to leave the overpaid amount in the account here as a credit for future visits.

In case of an underpayment we will bill you after the EOB from insurance is received.

New patients need to provide us with **Photo ID and Insurance** card, or just photo ID if no insurance available. Established patients please notify the front desk of any change of address, telephone number or insurance.

All cosmetic services will require $50.00 deposit at the time the appointment is made, except cosmetic laser procedures and dermal fillers which require $100.00 deposit. The deposit will be credited towards the cosmetic procedure.

Returned checks are subject to **$35.00 charge**. Unpaid accounts that are more than 90 days old will be sent to a Collection Agency after due notice is served to the patient with a fee **of $12.00**

I have read and understood the Financial Policy of Legends Dermatology and agree to comply with its terms

Signature_____ Date____/____/_____

Print name_____