Patient Registration

Patient Name: _____Sex:_____

S.S.#: _____ Date of Birth: _____/_____/_____ Age: _____ Marital Status: S M D W

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____ Home Phone: _____

Cell Phone: _____Work Phone: _____ Email: _____

Spouse Name: _____ Phone: _____

If Pt's under 18, Name of Parent or Legal Guardian: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance Co._____ Member ID: _____

Insured Name: _____ Date of Birth: _____ Relation to Pt: _____

Secondary Insurance Co. _____ Member ID: _____

Insured Name: _____ Date of Birth: _____ Relation to Pt: _____

INSURANCE RELEASE AND ASSIGMENT (ALL PATIENTS)

I hereby authorize Dr. Michael Margulies to release any information to my insurance co. or its representatives any information including diagnosis, and records of treatment/examination rendered to me during the period of medical/surgical care. I also authorize and request that all payments for services rendered to _____ be made directly to Dr. Michael Margulies.
Patient Name

LIFETIME SIGNATURE AUTHORIZATION (MEDICARE PATIENTS ONLY)

I authorize Dr. Michael Margulies, or its representative to release any information about me to the Social Security Adm. and Health Care Financing Admin. or its intermediaries, carriers, or to the billing agent of Dr. Margulies related to Medicare claim. I permit a copy of this authorization to be used in place of the original, and for payment of medical benefits be made to myself or to the party who accepts assignment.

_____ _____

Signature as it appears on Medicare Card Date of Signature

Michael C. Margulies, M.D., P.A.
8940 N. Kendall Drive Suite # 704E
Miami, FL 33176
Tel: (305)595-0393 Fax: (305)595-0911

Patient Agreements

* I agree to pay all laboratory fees sent from this office, including pathology reports which are not covered by my insurance plan or if I am a self-paying patient. I understand that these fees are in addition to any medical office fees for which may be rendered to me by Dr. Margulies.

_____ _____

Signature of Patient or Parent/Guardian of Patient Date of Signature

* I hereby agree to pay for all services rendered to me, including attorney's fees, collection agency fees, and/or court costs necessary to affect payment of this amount. **I also understand that interest rate of 1.5% per month may be charged should my account become delinquent.**

_____ _____

Signature of Patient or Parent/Guardian of Patient Date of Signature

Patient Obligations

Copayments If you are an enrollee of a managed care (HMO), PPO, or POS plan that Dr. Margulies is contracted with, **you are required to pay your copayment amount each time services are rendered to you by Dr. Margulies.** Your appointment will be rescheduled if you are not prepared to pay at time of service unless prior arrangements have been made with our billing department.

Referrals/Authorizations If you are enrolled in an HMO, PPO, or POS plan, your health plan may deny any/all medical services provided by this office and Dr. Margulies without a referral or authorization from either your health plan or your primary care physician. **It is the responsibility of the patient to obtain his/her own referral/authorization.** Should you arrive for your appointment without your referral or authorization you as the patient have 1 of 2 options:

1. You can reschedule your appointment for another day, or
2. You can pay for the visit at the time of service. Our office will hold your payment for no more than 3 working days. If the referral/authorization is provided within the 3 working days, your payment will be refunded back to you.

Dr. Margulies & staff are dedicated to working with you and your insurance carrier to get the best possible reimbursement and to keep you the patient satisfied to the fullest.

Deductibles/Co-Insurance In addition to the copayments, some plans also have annual deductibles/co-insurance.. You may be required to pay this said amount at the time services are rendered to you. In the event that there is a balance due from you after your insurance carrier had paid its portion, we will bill you. There will only be three (3) statements sent to you. **The third (3rd) and final statement will advise you that no further bills will be sent and at which time your account will be forwarded to national collection agency.** To avoid this situation, please pay your bill promptly after you have received your first statement. Should you not understand the reason of your balance, do not hesitate to contact our billing department.

Note to the Patient

You as the patient have the responsibility to understand all of your patient agreements and obligations. It is not the responsibility of the staff of Dr. Margulies to know how your insurance plan works. Should you not sign any of the agreements and obligations, Dr. Margulies reserves the right not to provide medical services to you.

_____ _____

Signature of Patient or Parent/Guardian of Patient Date of Signature

Michael C. Margulies, M.D., P.A.
8940 N. Kendall Drive ~ Suite 704-E ~ Miami, FL 33176
Tel: (305) 595-0393 ~ Fax: (305) 595-0911

Appointment Cancellation/No Show Policy

The policy of this office is to encourage patients to give us notice of cancellation of any appointment within at least **24 hours** before the end of the day prior to the scheduled appointment time. Likewise, we require patients to arrive punctually for their scheduled appointment to avoid any unnecessary delays or inconveniencing of other patients.

It is further understood that if any patient fails to appear or cancel an appointment without at least **24 hours** advance notification to this office, the following fees will be applied to your account with reasonable consideration of circumstances, including unforeseen emergencies or sickness.

(Please note that your insurance will not reimburse you for these fees)

Office Visit w/ Dr. Margulies **$ 100.00**

The signature of the patient and/or guardian below acknowledges the understanding of the above.

_____ _____

Please print Patient's Name Date

_____ _____

Signature of Patient/Guardian Witness

COMPLETE MEDICAL HISTORY QUESTIONNAIRE

Primary or Referring Physician: _____

Past Medical History-
Medical Problems_____
_____

Surgical Problems _____
_____

Family History-
Skin Cancer _____
Skin Diseases- _____
Other Medical Diseases- _____

Social History-
Occupation- _____
Smoking- _____
Alcohol- _____
Substance Abuse _____

Review of Systems- List present problems involving the following organ systems:
Head, Ears, Eyes, Nose, Throat- _____
Heart & Lungs _____
Stomach & Intestines- _____
Genitals & Urinary System- _____
Muscles & Bones- _____
Nerves & Brain- _____

Allergies: _____

Patient Signature: _____

Record reviewed by: _____
Michael C. Margulies, M.D.

Medical History Questionnaire

Skin Growth / Rash / Acne

Chief Complaint:_____

History of the Present Illness;
What is the location of the acne, growth/rash_____

How you noticed it? _____ How long? _____

Extended (4 of 6) **Acne**
Any history of prior treatment? _____ Any Response to this treatment? _____

Current Medication _____

Menstrual Irregularities or taking of any hormones (Birth control pill)? _____

Are you Pregnant? _____ Do you plan to become pregnant soon? _____

Work or home exposure to chemical (pesticides, insecticides)? _____

Any prior episodes of this problem? _____

Extended (4 of 6) **Rash**
Any history of prior treatment? _____ Any response to this treatment? _____

Current medication? _____

What aggravates this condition? _____

Any prior episodes of this problem? _____Any exposure to any known topical irritants? _____

Extended **Growth**
Does the growth burn/ itch/ sting or bleed? _____ Is the growth enlarging or changing? _____

Any history of prior treatments? _____ Any history of tans/ burns/ injury? _____

Review of Systems:

Problem **Acne** or **Rash**
Any history of prior skin problems? _____ Any known allergies of skin sensitivities? _____

Any other problems of the skin, eyes, mouth, genitalia, hair or nails? _____

Any other relevant problems (endocrine or hormonal)? _____

Problem **Growth**
Any history of prior pre-malignant lesions? ___Any history of prior malignant lesions? _____

Any history of prior skin surgery? _____

Are there any other skin areas with significant sun damage? _____

Are there other skin, eye, mouth, genital, hair or nail problems?_____

Past Medical, Family and Social History:

Have you had any past history of any other skin diseases?_____

Is there any history of skin disease in your family? _____

Are there similar problems among co-workers in your occupation?_____

Any exposure to cancer causing agents in prior occupations _____

This record reviewed by:

_____

Michael C. Margulies, M.D.

Michael C. Margulies, M.D., P.A.

Patient Consent for Use and Disclosure
Of Protected Health Information

I hereby give my consent for Michael C. Margulies, M.D., P.A.to use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Michael C. Margulies, M.D., P.A.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Michael C. Margulies, M.D., P.A. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Michael C. Margulies, M.D., P.A. Privacy Officer at 8940 N. Kendall Dr. Suite #704E Miami, FL 33176.

With this consent, Michael C. Margulies, M.D., P.A. may call my home or other alternative 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 calls pertaining to my clinical care, including laboratory results among others.

With this consent, Michael C. Margulies, M.D., P.A. may mail to my home or other alternative 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 this consent, Michael C. Margulies, M.D., P.A. may e-mail to my home or other alternative 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 Michael C. Margulies, M.D., P.A. 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 consenting to Michael C. Margulies, M.D., P.A.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Michael C. Margulies, M.D., P.A. may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

Person(s) (Family or Guardian) Authorized to receive information pertaining to my (PHI) protected health information and (TPO) treatment, payment, and healthcare operations.

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

Michael C. Margulies, M.D.

List of Medications Currently Taking

Pt Name: _____Date of Birth: _____

Pharmacy Name: _____ Phone #: _____

Pharmacy Address: _____ Zip code: _____

Allergies: _____

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

MICHAEL C. MARGULIES MD., PA

I am a patient of MICHAEL C. MARGULIES MD., PA. I hereby acknowledge receipt of MICHAEL C. MARGULIES MD., PA. 's Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR (IF PT'S UNDER THE AGE OF 18 YEARS OLD)

I am a parent or legal guardian of _____
Patient Name

I hereby acknowledge receipt of MICHAEL C. MARGULIES MD., PA.'s Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: □ Parent □ Legal Guardian

Signature: _____

Date: _____