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| Macintosh HD:Users:erikakornik:Library:Caches:TemporaryItems:msoclip:0:clip_image001.png**Lawrence A Schiffman, D.O., FAOCD, P.L****3650 N.W 82nd Avenue****Suite 306****Doral, FL 33166****Phone: 305.735.9474****www.miamiskindr.com**

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| **Patient Information: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial:\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_ Age: \_\_\_\_­­\_\_\_ Sex: \_\_\_\_\_­­\_\_ Marital Status: ­­\_\_\_\_\_\_\_\_\_\_\_Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Race**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Ethnicity**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Language**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone (Mobile):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (Home):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Email Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Email address is necessary for you to be able to access your medical records/ patient portal.)**Emergency Contact**:Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**PHARMACY INFO**: **ALL PRESCRIPTIONS ARE SENT ELECTRONICALLY!**(The doctor does **NOT** give written prescriptions. Please **specify one pharmacy** where they can be sent.)Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_**If the patient is under 18, please provide the following**:Name of Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Primary Care Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**How did you hear about us?** ◯Referred by Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_◯Family or Friend ◯Zocdoc ◯Internet: Google, Yahoo ◯Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**What is the reason for your visit today?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Do you currently have a non-healing sore or lesion? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_****ALLERGIES:** Please list all allergies and associated reactions.**MEDICATION ALLERGY:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**TOPICAL ALLERGY:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**FOOD ALLERGY:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you have an **ALLERGY** to any of the following items? (select all that apply) ◯**Neomycin** ◯**Xylocaine** ◯**Lidocaine** ◯**Epinephrine** ◯**Latex** Are you currently taking any of the medications listed below? (select all that apply)◯**Aspirin** ◯**Alcohol** ◯**Blood Thinner** ◯**Birth Control Pills**/**Implants**  ◯**Recreational Drugs**  **COSMETIC QUESTIONNAIRE:**◯Acne ◯Poison Ivy ◯Molluscum ◯Seborrhea/ Dandruff ◯Actinic Keratosis ◯Eczema ◯Precancerous Moles ◯Herpes ◯Basal Cell Skin Cancer ◯Flaking or itchy scalp ◯Psoriasis ◯Genital Warts ◯Blistering Sunburns ◯Hay Fever/ Allergies ◯Warts ◯Boils ◯Dry Skin ◯Cold Sore Have you ever been diagnosed with or treated for SKIN CANCER: Yes \_\_\_\_\_ No \_\_\_\_\_If yes, which type of Skin Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you have a family history of MELANOMA? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, which relative? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Do you wear sunscreen? Yes\_\_\_\_\_ No\_\_\_\_\_ If yes, what SPF?**\_\_\_\_\_\_\_\_\_**PAST DERMATOLOGICAL HISTORY :** Please check all that apply.**Are you interested in being added to our cosmetic database to receive emails for special promotions?****Yes ⃝ No ⃝**  Please check your areas of interest:◯ Skin Care Products ◯ Brown Spots ◯ Chemical Peels ◯A cne Scarring ◯ Hair Reduction ◯ Double-Chin ◯ Botox ◯ Kybella◯ Spider Veins ◯ Fillers ◯ Fine lines/Wrinkles ◯ Stretch MarksHave you ever had any of the following treatments or procedures done? (check all that apply)◯ Botox, Dysport, Xeomin, ◯ Dermal Fillers (Restylane, Juvederm, Radiesse, Voluma) ◯ Laser Treatments (Hair Reduction, Photo Therapy IPL, Scarring Treatment◯ Cosmetic Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**FEMALES:**  ◯ Pregnant ◯ Nursing Last Menstrual Period? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_**PAST MEDICAL HISTORY:**◯ Anxiety ◯ ALS (Amyotrophic Lateral Sclerosis ◯Arthritis ◯Artificial Joints ◯ Asthma ◯Autoimmune Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ◯ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ◯ COPD ◯ Depression ◯ Defibrillation ◯ Diabetes ◯Renal Disorder \_\_\_\_\_\_\_\_\_\_\_ ◯ GERD/Ulcer ◯Glaucoma ◯Hearing Loss ◯ Hepatitis / Liver Disease ◯Hypertension ◯HIV / AIDS ◯Hypercholesterolemia ◯Leukemia ◯ Hyper/Hypo Thyroids (please circle one) ◯Immunosuppression ◯Lupus ◯Lymphoma ◯ Multiple Sclerosis ◯ Myasthenia Gravis ◯Scleroderma ◯ Seizures ◯ Stroke ◯ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **PAST SURGICAL HISTORY:**◯ Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Exercise:**◯Several times a day◯Once a day◯A few times per week◯A few times per month◯Never**Caffeine Use:**◯Several times a day◯Once a day◯A few times per week◯A few times per month◯Never**SOCIAL HISTORY**: Please check all that apply.**Smoking**:◯Current Smoker- daily◯Current Smoker- not daily◯Smoked in the past◯Never SmokedTotal years smoked: \_\_\_\_\_\_\_\_Total packs smoked per day: \_\_\_\_\_\_\_\_Year you quit smoking. \_\_\_\_\_\_\_\_\_\_\_\_\_\_**Alcohol:**◯Alcohol - none◯Alcohol - < 1 drink daily◯Alcohol - 1-2 drinks daily◯Alcohol - 3 + drinks daily**Sexual Activity:**◯ Not sexually active◯ Sexually active with one partner◯ Sexually active with more than one partner**PERMISSION TO RELEASE OR DISCUSS MEDICAL RECORDS:**With HIPAA privacy rules we will require written permission to release/discuss any of your medical recordswith any family members and/or friends. If you are at least 18 years of age, please list anyone we can release your information to.Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of patient or guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |  | **Fecha:\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **IN ORDER FOR THE PATIENT TO RECEIVE TREATMENT IN MIAMI SKIN DR., ALL DOCUMENTS MUST BE AGREED UPON AND SIGNED AT THE BOTTOM:****PHOTO CONSENT:**I, the undersigned, do hereby agree to the following. I am allowing Dr. Schiffman, or a staff member, to take photos of my treatment and/ or treated areas to be used for the **purpose of monitoring my medical progress. These photos remain confidential unless otherwise specified by the patient.****FINANCIAL AGREEMENT:** The undersigned agrees, whether he/she signs as guardian, agent or as patient that in consideration of the services rendered to the patient, he/she hereby individually obligates himself/herself to pay the account, or “your part” of the charges of the physician at the time of service. We accept Visa, MasterCard, Discover, American Express, and Cash for your convenience. Personal checks are NOT accepted. Interest shall be charged beginning 45 days after the date of service until paid and will accrue at the rate of 12% per annum. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney’s fees and collection expenses. Your signature below indicated that you understand and accept this policy. Further, your signature authorizes payment of the medical benefits to the Doctor when an assigned claim is filed.**CANCELLATIONS / NO SHOW POLICY:**If you are unable to attend your appointment, please notify our office 24 hours prior to your scheduled appointment. If the appointment has not been cancelled at least 24 hours prior to your scheduled appointment, then a $30.00 No-Show Fee will be charged to your account. If the patient No-Shows for our laser or cosmetic treatments, a charge of $50.00 will be charged to your account. Please sign indicating that you understand and are aware of this office policy.Print Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |  |  |
| **PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)**With my consent, LAWRENCE A. SCHIFFMAN, D.O. FAOCD P.L., may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment, and Healthcare Operations (TPO). Please refer to LAWRENCE A. SCHIFFMAN, D.O. FAOCD P.L. Notice of Privacy Practices for 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. LAWRENCE A. SCHIFFMAN, D.O. FAOCD P.L., reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice may be obtained by forwarding a written request to LAWRENCE A. SCHIFFMAN, D.O. FAOCD P.L., Privacy Officer at 3650 NW 82nd Avenue, Doral, FL 33166.With my consent, LAWRENCE A. SCHIFFMAN, D.O. FAOCD P.L., may call my home or other designated location and leave messages on voice mail or in person references to any items that assist the practice to carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. With my consent, LAWRENCE A. SCHIFFMAN, D.O. FAOCD P.L., may mail and/or e-mail 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. I have the right to request that LAWRENCE A. SCHIFFMAN, D.O. FAOCD P.L, restricts how it uses or discusses my PHI to carry out TPO.I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, LAWRENCE A. SCHIFFMAN, D.O. FAOCD P.L., may decline to provide treatment to me. By my signature, I authorize LAWRENCE A. SCHIFFMAN, D.O. FAOCD P.L., to contact me by phone, email, or text by automated system to provide me with practice updates, specials on products, services, and other information. |  |  |
| Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Legal Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Legal Guardian Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Thank you for completing these forms, they will improve the quality of your care. We would like to welcome you to our office & hope your experience here is a pleasant one. We are a digital office, utilizing computers & iPads to document your visits. Our medical team will do our very best to ensure you received excellent medical care. Thank you for choosing Dr. Schiffman as your dermatologist.  |  |  |
| **APPOINTMENT REMINDER & OPT-IN CONSENT:**By supplying my home telephone number, mobile telephone number, email address, or other personal contact information. I authorize Lawrence A.Schiffman, DO. FAOCD, PL to use (including through a third-party automated outreach & messaging system) such contact information, the name of my care provider, the time & place of my scheduled appointment (s), & other relevant information (& to disclose such information to the provider of the automated outreach & messaging system), for the purposes of notifying me of a pending appointment, a missed appointment, an overdue wellness exam, balance due, lab results, & any other healthcare-related matter. I consent to receiving multiple such messages per day. I consented to allowing detailed messages being left on my voice mail, answering system, or with another providing my telecommunications services. I understand that I may cancel this consent & opt out of receiving such communications by responding “STOP” to such messages or notifying Lawrence A. Schiffman, D.O., F.A.O.C.D., P.L.Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**CREDIT CARD ON FILE AGREEMENT:**Lawrence A. Schiffman, D.O., F.A.O.C.D., PL. / Miami Skin Dr has implemented a credit card on file policy. Much like many other institutions such as hotels or car rental agencies etc. we now have similar policy where we ask for a credit card which may be used later to pay any balance that may be due on your bill. **Co Payments are still due at the time of service.** At check in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any. At that time, you will be sent a statement which you will have 30 days to pay. After 30 days, if the bill remains unpaid, we will bill your credit card. Your ability to dispute a charge or question your insurance company’s determination of payment will remain unchanged. If you have any questions about our policy, please do not hesitate to ask. By signing below, I authorize Lawrence A. Schiffman, D.O., F.A.O.C.D., PL dba Miami Skin Dr to keep my signature and my credit card information securely on file in my account. I authorize Lawrence A. Schiffman, D.O., F.A.O.C.D., PL dba Miami Skin Dr to charge my credit card for any outstanding balances when due. If the credit card that I give today changes, expires, or is denied for any reason, I agree to immediately give Lawrence A. Schiffman, D.O., F.A.O.C.D., PL dba Miami Skin Dr a new, valid credit card which I will allow them to charge over the telephone. Even though Lawrence A. Schiffman, D.O., F.A.O.C.D., PL dba Miami Skin Dr is not processing the new card in person, I agree that the new card may be used with the same authorization as the original card I presented. Visa ⃝ MasterCard ⃝ Discover ⃝ American Express ⃝ Care Credit ⃝Patient Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_/ \_\_\_/ \_\_\_Name on Card (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Credit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp. Date: \_\_\_/ \_\_\_  |  |  |
| Credit Card Holder Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  ◯ Please check here if you prefer not to receive a statement and would like us to bill your credit card immediately for any balances due after the processing of your insurance.  |  |  |
|  |  | **Telefono (Casa): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telefono Trabajo: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
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