ReJUVA
DERMATOLOGY, VEIN & SKIN CANCER CENTER

Dr. Sean Mazloom, MD, FAAD
Dr. Golta Rasouli, MD, RPVI, DABVLM

Dermatology Mohs Surgery Vein Therapy Cosmetic Dermatology Radiation Oncology

PATIENT INFORMATION FORM

Please Remember to Bring Your Insurance Card and Driver's License with You

Patient name (Last, First): _____ Date of Birth: ____ / ____ / _____ Age: _____

Mailing Address (on driver's license): _____City: _____State: ____ZIP:_____

Alternate/Seasonal address: _____City: _____State: _____ ZIP: _____

Cell Phone: _____ Home Phone: _____

Social Security #: _____ Gender: _____

Email Address: _____
(We will NOT give out your email address or any of your personal information via email without your permission).

Are you currently employed: _____

Emergency Contact: Name: _____ Relationship: _____Telephone: _____

Pharmacy Information:

Pharmacy Name: _____ Address/Cross Road: _____

Phone #: _____ City: _____ Zip code: _____

Primary Care Provider (PCP): _____ PCP Phone #: _____

Referring Provider Name (If different from above): _____ Referring Provider Phone #: _____

Did a doctor request this consultation? (Please circle): YES / NO

How Did you learn about ReJUVA Dermatology, Vein, and Skin Cancer Center? (Circle Any)

Physician Referral: _____ Magazine (Please Specify): _____
Website/Search Engines: _____ Facebook/Instagram: _____
Friends/Family Referral: _____ Other: _____

PARENT, Spouse, GUARDIAN, OR RESPONSIBLE PARTY (if different from patient)

Name: (Last, First) _____ Date of Birth: ___/____/_____

Social Security #: _____ Gender: Male /Female

Mailing Address: Street: _____City: _____ State: _____ZIP:_____

Alternate Address: _____

Home Phone: _____Cell Phone: _____ Email Address: _____

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If You Are Insured, Please Give Your Insurance Card to the Receptionist and Skip Sections A and B Below:

A. INSURANCE INFORMATION- PRIMARY

Insurance Company Name: _____ID#_____HMO/PPO (Circle one)

Policy Holder's Name (subscriber)_____Policy Holder's Date of Birth: _____

Relationship to You (Insured). Please circle one: SELF SPOUSE PARENT

Employer _____ Employer's Address _____

B. INSURANCE INFORMATION- SECONDARY:

Insurance Company Name: _____ID #_____HMO/PPO (Circle one)

Policy Holder's Name (subscriber)_____Policy Holder's Date of Birth: _____

Policy Holder's Social Security #:_____Policy Holder's Phone #: _____

Relationship to You (Insured). Please circle one: SELF SPOUSE PARENT

C. RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS:

I Authorize the release of medical information to my primary care or referring physician and to consultants if needed as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to ReJUVA Dermatology, Vein & Skin Cancer Center/ Provider if applicable.

Responsible Party Signature: _____DATE_____

For Medicare Patients Only

Medicare Authorization

I request that payment for authorized Medicare benefits be made on my behalf to ReJUVA Dermatology and Vein Center for any services furnished provided to me by my providers. I authorize ReJUVA Dermatology & Vein Center to release to the CMS and its agents any information needed to determine these benefits payable for related services.

Medicare is not always the primary insurance. Federal regulations requires that we obtain information to determine if another insurer may be primary to Medicare:

Yes NO

___ ____ Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at the job?
___ ____ Are you covered by an HMO/PPO which makes Medicare secondary?
___ ____ Is this illness/injury covered by the VA (Veterans Administration)?
___ ____ Is this illness/injury covered by the Federal Black lung or End Stage Renal Disease Program?
___ ____ Is this illness/injury due to an automobile accident?
___ ____ Is this illness/injury due to work related causes?

Patient Signature: _____Date:_____

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New Patient Medical History Questionnaire

Patient name (Last, First): _____ Date of Birth: _____ / _____ / _____ Age: _____

Reason for Today's Visit (Circle one): Skin Check Abnormal Mole New Lesion Itchy Scalp Rash Others: _____
Location of rash/lesion: _____Duration: _____ Severity (circle one): Mild Moderate Severe
Symptoms (Circle any): Itch/burn/pain/changing color or size Any Previous Treatment(s): _____

Past Medical History (Please Circle All That Apply)

NONE				
Anxiety	DVT (Blood clots)	Heart disease	Hypothyroidism	Pulmonary Embolism (blood clot to your lung)
Arthritis	Depression	Heart Valve Disorder (murmurs)	Kidney disease	Radiation Therapy Treatment
Asthma	Diabetes mellitus	Heavy Legs	Leukemia	Rheumatoid Arthritis
Atrial Fibrillation	Easy bruising	History of Hepatitis B	Lupus	Statis dermatitis
Autoimmune Disease	End Stage Renal Disease	History of Hepatitis C	Malignant Lymphoma	Swelling of Lower leg (Leg swelling)
Bipolar Disorder	Epilepsy (Seizure)	History of Herpes Zoster (Shingles)	Malignant Tumor of Colon (Colon Cancer)	Transplantation of Bone Marrow
Blood Coagulation Disorder	Functional Visual Loss (blindness)	History of Malignant Neoplasm of Breast (Breast Cancer)	Malignant Tumor of the Lung (Lung Cancer)	Type I Diabetes Mellitus
CVA (Stroke)	History of Hay Fever	HIV/AIDS	Malignant Tumor of Prostate (Prostate Cancer)	Type 2 Diabetes Mellitus
COPD	History of Hypertension (Elevated Blood pressure)	Hypercholesterolemia (High Cholesterol)	Open Wound of Leg with Complications (leg Wound)	Varicose Vein of Lower extremity
Cramp in Lower leg	History of Venous Leg Ulcers	Hyperthyroidism	Psoriasis	

Any Other Medical History: _____

Past Surgical History (Please Circle All That Apply)

None		
Cholecystectomy (gallbladder removal)	History of colectomy (colon cancer surgery)	Transplant of Kidney
Endovenous ablation of varicose veins	History of Mastectomy (breast cancer surgery)	Transplantation of heart
Excision of Melanoma	Prostatectomy (Prostate cancer surgery)	Transplantation of Liver
History of Spinal Surgery	Total abdominal Hysterectomy	Varicose Vein Stripping
Heart Valve replacement	Total Hip replacement prosthesis	Any Other:
History of Bone Marrow transplant	Total Knee replacement	

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Skin Disease History (Please Circle All That Apply)

None		
Acne	Dry Skin	Malignant Melanoma- skin cancer
Actinic Keratosis (precancerous spots)	Dysplastic Nevus of Skin (Atypical Mole)	Pruritis of scalp (flaking/itchy scalp)
Basal Cell Carcinoma of Skin	Eczema (Atopic Dermatitis)	Sunburn (Severe/Moderate)
Contact Dermatitis	Generalized Skin Eruption due to drugs/medications- Rash	Squamous cell carcinoma of skin

Any Other Skin Disease:_____

Do you wear sunscreen? YES NO If yes, what SPF? _____
Do you or have you ever used a tanning salon? YES NO
Do you have a family history of Melanoma? YES NO If yes, which family member? _____

Medications: (Please provide Your List of Medications or list them below)

_____

_____

_____

Allergies: (Please list all drug allergies)

_____

Social History (Important not to miss this section):
Cigarette Smoking: Never Smoked Currently Smokes (Packs/day): Former Smoker
Alcohol Use (drinks/day):
Pneumonia vaccine: Yes/No
Last Flu Vaccine (Year):
Shingles Vaccine (Year):

If you are unable to make medical decisions yourself, do you have someone designated to do that? Yes/No If yes, please provide us with the full name and phone number: _____

Family History: (First degree relatives ONLY)

- Family history of melanoma (Yes/No). If yes, which relative:_____
- Family history of autoimmune disease (Yes/No). If yes, which relative:_____
- Family history of psoriasis (Yes/No). If yes, which relative:_____
- Family history of varicose veins (Yes/No). If yes, which relative:_____
-

Review of Systems: Are you currently experiencing any of the following? (Please check "YES" or "NO")

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Abdominal Pain			Muscle Weakness		
Bloody Stool			Neck Stiffness		
Bloody Urine			Night Sweats		
Blurred Vision			Problems with bleeding		
Chest Pain			Problems with healing		
Anxiety/Depression			Scarring (Hypertrophic/keloid)		
Shortness of Breath/Wheezing			Seizures		
Hay Fever			Thyroid Problems		
Joint Aches			Unintentional Weight loss		
Fever or Chills			Leg cramps/charley Horse		
Headaches			Leg swelling		
Immunosuppression					

Alerts: (please circle all that apply)

Artificial heart valve	HIV/AIDS	Premedication prior to procedures (ex. Antibiotics)
Artificial Joints within the past 2 years	Iodine Allergy	
Allergy to adhesive	Lactating/Breastfeeding	
Blood thinners	Latex Allergy	
Defibrillator/Pacemaker	Lidocaine Allergy	
History of Hepatitis B/C	Medication Allergy – PLEASE MAKE SURE ALL ALLERGIES ARE LISTED ON PREVIOUS SHEET	
History of Melanoma	Pregnant or Planning Pregnancy	

Cosmetic Concerns

What are you skin care or cosmetic concerns? Please circle all that apply

Facial Concerns:

Acne Scars	Loose Skin	Redness	Sunspots	Unwanted Hair	Laugh Lines
Blackheads	Loss of Volume	Rosacea	Thin Lips	Unwanted Tattoo	Lipstick (Smoker's) Lines
Brown Spots	Loss of Elasticity	Spider Veins	Thinning Skin	Uneven Skin Texture	Droopiness
Enlarged Pores	Oily Skin	Sun Damage	Undereye Dark Circles	Wrinkles	Jowls

Body Concerns:

Age Spots	Excess Fat	Mole Removal	Spider Veins	Unwanted Hair	Others:
Brown Spots	Leg Veins	Scars	Stretch Marks	Unwanted Tattoos	
Excessive Sweating	Loose Skin	Skin Tag Removal	Thinning Hair	Vaginal Dryness	

HIPAA NOTICE /PROTECTED HEALTH INFORMATION (PHI) CONSENT

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice to obtain a current copy of the Notice of Privacy Practices. With my consent, ReJUVA Dermatology & Vein Center, may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. I understand and consent that ReJUVA Dermatology & Vein Center may email me, call me, or mail to my home appointment reminders, statements, insurance items or clinical documents such as laboratory results. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Can we call your home/ cell and leave a message to call our office back? (Please circle one): Yes No

I (please print your name), _____, am aware if call blocker is activated, I will miss a call back with my results.

Do we have permission to talk to family members or others? (Please circle one): Yes No
If yes, please provide the name, phone number & relation to you:

NAME: _____ PHONE_____ RELATION_____

By signing this form, I acknowledge that I have received or have been given the opportunity to receive a copy of the ReJUVA Dermatology, Vein & Skin Cancer Center Notice of Privacy Practices and have also been given an opportunity to ask questions. A copy of this will be included in my chart.

Name of Patient/Legal Guardian: _____Date: _____

Signature of Patient/Legal Guardian: _____ Date: _____

PATIENT COMMUNICATION CONSENT FORM

Text message alerts:

I authorize ReJUVA Dermatology & Vein Center to send appointment reminders and specials via text messages to me on my cell phone number. I understand that I may reply with various commands to receive account information. By accepting these terms, I agree to receive test messages from the practice. Text charges from your cell phone provider may apply.

My signature indicates that I represent and warrant that I am the person legally responsible for use of the account, and that I agree to the terms and conditions. I understand I may opt out of text message communication at any time.

I, _____, Accept/Decline (please circle one)

Mobile number_____

Patient signature: _____ Date: _____

ReJUVA Dermatology Pathology Notice

Please note: Additional pathology charges may be incurred in the event specialized testing is required to make a definitive diagnosis. Often this decision is determined by the dermatopathologist at the time of processing the lab specimen. These additional tests or staining procedures are done to ensure the most complete and accurate diagnosis is achieved.

A final bill from our office will not be determined until all pathology results and reports are completed.

_____ _____

Patient Signature Date

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Consent For Examination and Treatment

This consent provides ReJUVA Dermatology and Vein Center providers (physicians, nurse practitioners and physician assistants) and staff, with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that you consent to treatment that may include, but not limited to:

- COLLECTION OF MEDICAL INFORMATION
- EXAMINATION
- BIOPSY(S) OF LESION(S) AND RELATED PATHOLOGY SERVICES
- CRYOTHERAPY (AKA LIQUID NITROGEN, FREEZING OR CRYOSURGERY) TREATMENT
- ELECTRICAL, CHEMICAL, OR SHAVE REMOVAL OR DESTRUCTION OF LESIONS
- PHOTOS OF TREATMENT AREAS FOR CLINICAL DOCUMENTATION
- COMMUNICATION WITH PROVIDERS, PHARMACIES, LABORATORIES, ETC. INVOLVED IN CARE
- DATABASE IMPORT OF PHARMACY, LABORATORY, OR OTHER CLINICAL INFORMATION INTO THE MEDICAL RECORD
- ELECTRONIC COMMUNICATION USING THE PATIENT PORTAL

It is important to note that any biopsy or tissue specimen collected for diagnostic analysis must, by law, be analyzed by a laboratory, even if you wish to decline. Treatment(s) is/are based on the results of the testing (please reference Title XXXII, Chapter 483 of the Florida Statute).

You have the right to discuss the treatment plan with your provider including the purpose for the recommendation, the potential risks, and benefits of any test ordered for you, and any questions you have regarding these recommendations. I understand that photographs may be taken, and I consent to this as well. I understand that these photographs may be used for medical documentation, teaching, research or scientific publication.

Cryosurgery Alternative Treatment Options: Topical chemotherapy creams (used twice daily for 2-4 weeks), electrodessication and curettage, photodynamic therapy, chemical peels, and laser.
Biopsy Alternative Treatment Options: No reliable alternative.

I HAVE BEEN FULLY INFORMED AND UNDERSTAND THE RISKS AND COMPLICATIONS OF ANY OF THE ABOVE PROCEDURES WHICH MAY INCLUDE BUT NOT LIMITED TO: PAIN, INFECTION, SCARRING, PIGMENTATION CHANGES, NERVE DAMAGE, ABNORMAL SENSORY AND OR MOTOR FUNCTION DEFICIT, FURTHER REQUIRED TESTING AND TREATMENT INCLUDING POSITIVE MARGINS, RECURRENCE, AND LIFE-THREATENING ALLERGIC REACTION TO ANESTHESIA, ETC. OCCASIONALLY RARE AND UNEXPECTED COMPLICATIONS MAY OCCUR WITH ANY PROCEDURE AND I UNDERSTAND THAT IT IMPOSSIBLE FOR MY DOCTOR TO INFORM ME OF EVERY POSSIBLE COMPLICATION(S). NO GUARANTEES HAVE BEEN MADE REGARDING MY RESULTS AND OUTCOME(S). I consent to the disposal of any tissue not used for pathology.

This consent will remain fully effective until revoked in writing by the patient or the patient's representative(s). You have the right at any time to discontinue services.

I certify that I have read and fully understand the above statements and that my questions have been fully answered and that I consent to treatment by ReJUVA Dermatology and Vein Center providers and staff.

Patient/Lega Guardian **Name:** _____

Patient/ Legal Guardian **Signature:** _____

Witness Signature: _____ **Date:** _____

ReJUVA Dermatology and Vein Center Financial Policy and Privacy Act

Understanding your financial responsibility is an essential component in establishing and maintaining a strong patient/practice relationship. In order to achieve this, we offer the following information regarding our insurance and financial policies.

Your insurance is a contract between your insurer and you. It is your responsibility to know and understand the terms, guidelines and limitations of your plan. It is also your responsibility to advise us of any changes in your insurance, your address or your employer.

Medicare & Contracted Insurance Plans
If you are on traditional Medicare or are a member of a health plan that we participate with, we will submit your claim to your insurance company. Our staff will verify your benefits and collect any co-payment, co-insurance and/or deductible at the time services are rendered as required by your insurance carrier. You will be billed in full for any services that your health plan deems as "not a benefit" or a "non-covered service."

Secondary/Supplemental Insurance Plans
We are happy to file secondary and supplemental claims as a courtesy. In the case of non-contacted secondary carriers, the balance will become patient responsibility 30 days after that claim is filed.

Non-Contracted Insurance Plans
If we do not participate with your insurance carrier, payment in full will be required by you at the time services are rendered. Our billing department will file a claim to your insurance company as a courtesy to you upon request.

POS/HMO Commercial Insurance Plans
It is the responsibility of the patient to obtain a referral from your primary care physician before each visit to our office. If this is not done, you will be responsible for any unpaid balances due.

Medicaid
We are not contracted with any Medicaid plan. Medicaid patients seeking services are responsible for payment in full at the time of service.

Minors
A parent or legal guardian must accompany all patients under the age of 18 to authorize treatment and financial arrangements. If this is a custodial parent, we can submit the charges to another parent's insurance, however, the parent presenting the child for care will be billed for the balance not covered by the insurance. Any patient over the age of 18 will be held financially responsible for all charges incurred.

Missed Appointment
Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations must be made 24 hours in advance of the scheduled or we reserve the right to assess a $200.00 no show fee. This is not covered by your insurance and is patient responsibility.

Medical Records
Copies of pathology reports are provided to you or another physician at no charge. Any additional medical records requests and/or completion of forms (ex. disability, life insurance, cancer policies, etc.) are subject to processing fees determined by state law and contractual agreements. Please be advised that medical records requests require time to be processed and cannot be provided the same day requested.

Collection Fees
Statements are sent out monthly for patients with personal balances. Payment is due upon receipt of the statement. If you are unable to pay the balance in full, please contact our billing department (941) 529-0070. Personal balances over 90 days from the date of service will be sent to our collection agency. In the event an account is turned over to an outside collection agency, patients

will be responsible for any collection fees including court costs, attorney fees and collection agency charges.

Refunds
Refunds are processed upon verbal or written request from you. Any credit balances less than $25.00 will remain on the account as a credit to be used for future services or product.

Returned Check Fee
A $25 fee will be added to your account balance in addition to the amount of the check returned for insufficient funds. This total must be paid by cash or with credit card within 14 days.

Pathology Fees
ReJUVA Dermatology has an on-site lab and pathologist who perform the slide preparation and interpretation of our patients' biopsy specimens. Fees associated with this service are separate from the procedure performed by your treating provider.

Depending upon specific factors, your provider may send the specimen to an outside lab for slide processing and interpretation. In those instances, patients or their insurance will receive a bill from the outside lab.

ReJUVA Dermatology providers reserve the right to send their patients' specimens to the most qualified dermatopathologist of his or her choosing. Therefore, **if your insurance requires the use of a specific lab, it is your responsibility to provide us with that information prior to being seen. Failure to do so may results in additional out-of-pocket costs to you. Name of required lab (if applicable) _____**.

Cosmetic Services
Patients are financially responsible for all cosmetic procedures at the time of service. This office does not bill insurance companies for cosmetic procedures. For more detailed information, please see our cosmetic coordinator.

ReJUVA Dermatology and Vein Center offers comprehensive services and plans of treatment that may include care from multiple providers (Physicians, Physician Assistants, Nurse Practitioners). Some insurance policies may dictate that an additional copay be collected or higher out of pocket costs than anticipated. Ultimately it is the policy holder's responsibility to know and understand the terms, guidelines, and limitations of the individual plan they have selected with their chosen Health Insurance Carrier.

Should any questions arise regarding the specific terms of the selected policy you purchased, or any additional fees determined to be "member responsibility," please contact the Member Service line, set in place by your Health Insurance Carrier.

I also acknowledge that I have been offered a copy of the privacy practices at ReJUVA Dermatology & Vein Center and have declined a personal copy of the privacy practices. I further understand that Health Information Exchange grants providers involved in my healthcare access to my most recent visit and I allow ReJUVA Dermatology & Vein Center to share medical information pertinent to my care with my other doctors.

My signature below indicates that I have read, understand, and will comply with the information contained within this financial policy and privacy practices. A copy of these policies are available upon request.

I also understand that ReJUVA Dermatology & Vein Center requires a 48 hour cancelation notice for surgical procedures/vein consultations, otherwise there will be a $200 charge no show fee.

_____ _____
(Name of Patient or Guardian) **Date**

_____
Signature of Patient or Legal Guardian