# Resnik Skin Institute Patient Information

**Dr. Barry I. Resnik M.D**
2630 NE 203 STREET. SUITE 105 AVENTURA, FL 33180. Tel: 305-692-8998 Fax: 305-692-8606

## Patient Information

Name: _____

Home #_____Cell # _____

Home Address: _____

_____

_____

○ Male ○ Female Age: _____Birth Date: _____

○ Single ○ Married ○ Divorced ○ Widowed

Email: _____

Can we email you? ○ Yes ○ No

Social Security Number : _____

Referred By: _____

Occupation: _____Employer: _____

## Spouse Or Parent Information

Name : _____

Phone: _____

## Emergency Contact

Name : _____

Phone: _____

## Medical History

Please Check Yes or NO then circle all that apply

Yes No

○ ○ Melanoma: Personal and/or Family History?

Do you have a Personal History of the following?

○ ○ Basal Cell or Squamous Cell Carcinoma
○ ○ Excessive Bleeding from Cuts or Sugery
○ ○ Have you ever fainted or almost fainted
○ ○ Asthma, Hayfever, Eczema
○ ○ Heart Disease or Irregular Heart Beats
○ ○ High Blood Pressure
○ ○ Cardiac Pacemaker or Artificial Joint
○ ○ Hepatitits / Liver Disease
○ ○ Diabetes, Kidney or Thyroid Disease
○ ○ HIV Infection or AIDS
○ ○ Do you Smoke or Use Tobacco Products

Surgeries : _____

_____

## Medical History

Drug Allergies : _____

_____

Current Medical Problems: _____

_____

Medications : _____

_____

## Pharmacy Information

Pharmacy : _____

Address : _____

_____

Phone : _____

## Insured Person / Responsible Party

Primary Insured Person ( Check One )

○ Patient ○ Spouse ○ Parent ○ Other

Name: _____

Home:_____Cell: _____

Birth Date: _____

Social Security: _____

## Consent for Exam & Treatment Assignment of Benefits

I give my consent for examination, treatment, biopsy &/ or excision, and the exchange of medical information for purposes of medical treatment & second opinions. I hereby assign all medical benefits to which I am entitled to Barry I. Resnik MD. I understand that I am financially responsible for al charges incurred, whether or not paid by insurance. I authorize the release of any necessary medical information to my insurance carrier to process my claim. I acknowledge that I have read the Notice of Privacy Practices. I agree to be charged $25 no-show/cancellation fee if I miss an appointment without notifying the office at least 24 hours prior to my appointment. I attest that the information I have provided in this form is correct

Signature : _____

Date: _____MA Initials: _____

**Barry I. Resnik, MD**
2630 Center 2630 NE 203 St Suite 105
Aventura, FL 33180
T (305) 692-8998 F (305) 692-8606
info@DrResnik.com
www.DrResnik.com

Adult, Pediatric & Cosmetic
Board Certified, American Board of Dermatology
Diplomate, American Academy of Dermatology
Fellow, American Society for Dermatologic Surgery


**Team Dermatologist, MLB Florida Marlins**

## POLICY ON INSURANCE AND ASSIGNMENT OF BENEFITS

Name _____

**As physicians, our relationship is with you**, **not your insurance company**. Please understand that:

- **Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract**.
- Our fees fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50%, or 80%) of "usual, customary, and reasonable fees" for this region. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees which bears no relationship to the current standard and cost of care in this area.
- Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover, and do not readily disclose this fact until after the service has been rendered.
- Only one procedure is done per visit. If necessary, a follow-up visit may be scheduled to discuss results.

**For our HMO patients: Your insurance carrier permits 5 visits without a referral and thereafter requires you to have a referral for every visit to Dr. Resnik. It is your responsibility to obtain your referral prior to your visit with Dr. Resnik. If you do not have your referral, your visit will be deferred, delaying your treatment and care.**

**I hereby instruct and direct my Insurance Company, to pay by electronic deposit of funds or check made out to Resnik Dermatology Aventura, P.A.**
If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it to the address above, for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

- A photocopy of this assignment shall be considered as effective and valid as the original.
- I authorize Resnik Dermatology Aventura, P.A. to deposit checks received on my account.
- I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.
- I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ _____

Signature of Patient/Policyholder Date

**Barry I. Resnik, MD**
2630 Center 2630 NE 203 St Suite 105
Aventura, FL 33180
T (305) 692-8998 F (305) 692-8606
info@DrResnik.com
www.DrResnik.com

Adult, Pediatric & Cosmetic
Board Certified, American Board of Dermatology
Diplomate, American Academy of Dermatology
Fellow, American Society for Dermatologic Surgery

**Team Dermatologist, MLB Florida Marlins**


## FINANCIAL POLICY

We are committed to providing you with the best possible care. In order to achieve these goals, we need to ensure your understanding of our payment policy.

Payment for services is due at the time services are rendered. We accept cash, checks, American Express, MasterCard, Visa and Discover. To **ensure a stress- free visit, please verify that Dr. Resnik participates with your insurance plan.** It is not possible to keep up with all the individualized plans available today.

Claims for insurance companies with which Dr. Resnik participates, are submitted electronically. For those insurance companies with whom we do not participate, we are pleased to provide you with and itemized bill which you can submit for reimbursement.

Dr. Resnik **does not participate with Medicaid** as primary or secondary coverage. Please notify the secretary before your appointment if you are a Medicaid patient.

If your check is returned unpaid, charge will be added to your account balance. Please be courteous to us and you fellow patients when you are unable to keep your appointment. Missed appointments and appointments cancelled without 24 hours advance notice may incur a $25.00 charge.

All co-pays and coinsurance amounts are due at the time for service, and cannot be waived. All patient balances, as determined by your insurance company, are due and payable within 30 days of your invoice. All balances over 30 days are **automatically** forwarded to our billing company **ACCELERATOR SERVICES.** All balances over 60 days are automatically referred to a collections agency and assessed a $35 collection fee. **Please pay your balance promptly**. If you have financial difficulties, please notify us as soon as possible to avoid this eventuality.

_____ _____

Signature of Patient/Policyholder Date

_____ _____

Signature of Policyholder if other than patient Witness

I have read Resnik Dermatology's Notice of Privacy Rights.

Signature:_____

Date:_____