

Kenneth R. Beer, M.D., P.A.
Kenneth R. Beer MD * Hillary Julius, PA-C
Board Certified Dermatology and *Dermatopathology
PLEASE COMPLETE BOTH SIDES OF THIS INFORMATION FORM

Name _____ Today's Date ____/____/____

First Middle Last

Local Address _____

Street Apt # City State Zip Code

Summer Address _____

Street Apt # City State Zip Code

Home Phone Number: () _____ Summer Phone Number: () _____

Mobile Phone Number: () _____ e-mail address _____

Single Married Divorced Widowed Drivers License _____ Exp _____

Age: _____ Sex: Male Female Date of Birth: ____/____/____ Social Security Number: ____/____/____

Where Employed: _____ Business Telephone Number:() _____

Spouses Name: _____ Spouse Employment: _____

Insured Name: _____ Insured Date Of Birth: ____/____/____

Party Responsible For Payment: _____ Address _____

Primary Insurance/Medicare _____ Policy Number _____

Do you have a secondary carrier? Yes No Copy of card in chart Yes No

Name of Company: _____ Policy Number _____ Group Number _____

Preferred Pharmacy: _____ Pharmacy Phone Number: _____

GUARANTOR AGREEMENT:

By signing this form as Patient/Guardian/Agent/or Guarantor, spouse or agent of the aforementioned parties, I hereby agree that any and all charges that arise within the treatment, past or future treatment if related to the incident or condition giving rise to this admission or service, not covered by any insurance, program, sponsorship, or other third party coverage I may have are due and payable by me at the time of discharge or discontinuation of treatment. I hereby acknowledge that Kenneth R. Beer, M.D., P.A.; Kenneth Beer MD; Hillary Julius, PA-C has agreed to bill my insurance or other third party carrier and has agreed to do so as a courtesy and Kenneth R. Beer, M.D., P.A.; Kenneth Beer MD; Hillary Julius, PA-C has the right to demand payment in full from me at any time prior to full payment from any insurance carrier or third party unless it is contractually stated that I will not be billed. I hereby acknowledge that I have been told, prior to receiving treatment, that I will be billed by Kenneth R. Beer, M.D., P.A.; Kenneth Beer MD; Hillary Julius, PA-C.

I further agree that if I am more than thirty (30) days late in the payment of any bill connected with this treatment, and past treatment, a finance charge of 1.5% per month will accrue on the unpaid balance; and if delinquent account is referred to a collection agency and/or an attorney, I agree to pay the attorney's fees, court costs, and collection agency fees associated with the collection process. I understand that any lab charges (including pathology services performed by my physician or another physician) are separate from the charges for my medical care. I understand that I am personally and fully responsible for any non-covered services, denied services, health insurance deductibles and co-insurance payments.

Note: If your secondary is an automatic crossover, Medicare will send the claim automatically to them. If not, you are responsible for your deductible and 20% copay at the time service is rendered. You will need to send your Medicare explanation of benefits in to your secondary carrier. If your secondary is a crossover but fails to pay in a timely fashion, you are ultimately responsible for the 20% copay that Medicare does not pay.

MISSED APPOINTMENTS:

In order to provide the best possible service and availability to all our patients, it is our policy to charge our office visit fee (**\$80.00**) for any appointments not cancelled at least 24 hours prior. Please call us as early as possible if you know you will need to reschedule your appointment.

CONSULT FEES:

There will be a charge payable at time of service for any cosmetic consultation or service performed. The charge is payable at time of service. In the instance the bill is unpaid, there is a service and collection fee as well as legal fees.

I have read and understand the financial policy stated above and authorize the release of any information necessary to process my claims. As a member of a managed care group, I assume all responsibility for any services rendered that are or are not a part of my referral, whether or not covered or paid by my insurance, and I will pay for those services at the time they are rendered.

Signed _____ Date ____/____/____

Medical History:

Who Referred You to Our Office? _____ Family Physician: _____

List All Medications Which You Now Take: _____

List All Allergies To Medications: _____

List All Other Known Allergies: _____

List All Surgery Within the Past 5 Years: _____

Female Patients Only: Are you taking oral contraceptives? Yes No

Are you pregnant or trying to become pregnant? Yes No

Check All Medical Conditions Which You Have Or May Have Had:

Basal Cell Carcinoma Squamous Cell Carcinoma of the skin Melanoma (Depth _____)

Blistering Sun Burns

Cancer (non skin) Type: _____ Date: _____ Treatment _____

Bleeding Tendency Diabetes HIV Heart Attack Hypertension

Stomach or duodenal ulcers Hay Fever Hepatitis (type: _____) Convulsions

Cataracts Glaucoma Asthma Eczema Psoriasis Lupus

Family History of skin disease: Yes Type: _____

Do you have an artificial heart valve, joint or other prosthesis that requires you to take antibiotics when you have dental procedures? Yes No If yes , what antibiotic _____

Are you allergic to Band-aids, tape or adhesive? Yes No

Have any members of your family had skin cancer? Yes No. If yes, what type? _____

Please list any other information that we need to know about: _____

We offer a full range of cosmetic procedures.

Please indicate whether you are interested in learning more about:

Botox Dysport Restylane Radiesse Sculptra Juvederm Perlane Isolaz for Acne

Fraxel Laser for Rosacea Laser Hair Reduction Intense Pulse Light Treatment Smoothshapes

Treatment of Veins Dr. Beer's new Proprietary Skincare Line Sunscreens Clinical Trials

If any of these are of interest to you, please let us know and we can discuss them with you.

Would you like us to give you information regarding SpaCara and the treatments available? Yes No

I hereby acknowledge that I have read this form and I understand its contents and agree to all of the provisions contained herein.

SIGNATURE: _____ DATE: _____

Kenneth R. Beer, M.D., P.A. Board Certified Dermatology

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1500 North Dixie Highway, Suite(s) 303, 305 West Palm Beach, Florida 33401
Telephone (561) 655-9055 Fax (561) 655-9233 www.palmbeachcosmetic.com

641 University Blvd., Suite 212 Jupiter, FL 33458
Telephone (561) 932-1707