

# ASSOCIATES IN DERMATOLOGY

PATIENT REGISTRATION. COMPLETE ALL ITEMS. PLEASE PRINT CLEARLY.

## A. PATIENT INFORMATION.

Today's Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

NAME \_\_\_\_\_

LOCAL ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PERMANENT ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_ CELL/ALTERNATE ( ) \_\_\_\_\_ - \_\_\_\_\_

E-MAIL \_\_\_\_\_ D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_ AGE \_\_\_\_ SEX \_\_\_\_ MARITAL STATUS \_\_\_\_ SS# \_\_\_\_ / \_\_\_\_ / \_\_\_\_

EMPLOYER NAME \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

REFERRING DOCTOR \_\_\_\_\_ PHONE # ( ) \_\_\_\_\_ ADDRESS \_\_\_\_\_

## B. PRIMARY INSURED PARTY (If different from patient above) Check here if Patient is the responsible party and go to C.

NAME \_\_\_\_\_

LOCAL ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PERMANENT ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_ CELL/ALTERNATE ( ) \_\_\_\_\_ - \_\_\_\_\_

E-MAIL \_\_\_\_\_ EMPLOYER NAME \_\_\_\_\_ JOB TITLE \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_ AGE \_\_\_\_ SEX \_\_\_\_ MARITAL STATUS \_\_\_\_ SS# \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## C. INSURANCE INFORMATION (Please present insurance card at time of check in.)

Check here if you are self-pay (cash) Patient. You will be given a good faith estimate of charges prior to service and will be required to pay in full before the service is provided.

WHO IS YOUR PRIMARY INSURANCE? \_\_\_\_\_ SECONDARY INSURANCE? \_\_\_\_\_

PRIMARY CARE DOCTOR \_\_\_\_\_ PHONE # ( ) \_\_\_\_\_ ADDRESS \_\_\_\_\_

NEAREST LIVING RELATIVE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMERGENCY CONTACT? \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PHONE # ( ) \_\_\_\_\_ ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

OTHER THAN YOURSELF, WHO MAY WE DISCUSS YOUR ACCOUNT/CONDITION WITH? \_\_\_\_\_

RELATIONSHIP? SPOUSE \_\_\_\_\_ PARENT \_\_\_\_\_ POWER OF ATTORNEY \_\_\_\_\_ OTHER \_\_\_\_\_

The information provided above is current and correct. I am responsible for informing Associates in Dermatology of changes.

\_\_\_\_\_  
Patient / Patient's Personal Representative Relationship to Patient Date



# ASSOCIATES IN DERMATOLOGY

## **General and Surgical Dermatology MOHS Micrographic Surgery**

1 AGREEMENT TO ARBITRATE CLAIMS REGARDING FUTURE CARE & TREATMENT. The patient agrees that any controversy, including without limitation, claims for medical malpractice, personal injury, loss of consortium, or wrongful death against Michael Steppie, MD, William A. Steele, MD or Associates in Dermatology, Inc., or any person employed by either of them, arising out of or in any way relating to the diagnosis, treatment, or care of the patient by Michael Steppie MD, William A. Steele, MD or any person employed by, through, or under Michael Steppie MD, William A. Steele, MD or Associates in Dermatology, Inc., shall be submitted to binding arbitration.

2 AGREEMENT TO ARBITRATE CLAIMS REGARDING PAST CARE & TREATMENT. The patient further agrees that any controversy, including without limitation, claims for medical malpractice, personal injury, loss of consortium, or wrongful death against Michael Steppie, MD, William A. Steele, MD or Associates in Dermatology, Inc., or any person employed by either of them, arising out of or in any way relating to the past diagnosis, treatment, or care of the patient by Michael Steppie, MD, William A. Steele, MD or any person employed by, through, or under Michael Steppie MD, William A. Steele, MD or Associates in Dermatology, Inc., shall be submitted to binding arbitration.

3 WAIVER OF RIGHT TO JURY TRIAL. BOTH PARTIES TO THIS AGREEMENT, BY ENTERING INTO IT, ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

4 ALL CLAIMS MUST BE ARBITRATED BY ALL CLAIMANTS. All claims based upon the same occurrence, incident, or care shall be arbitrated in one proceeding. It is the intention of the parties that this Agreement bind all parties whose claims may arise out of or relate to treatment or services provided by Michael Steppie, MD, William A Steele, MD or any person employed by, through, or under Michael Steppie MD, William A. Steele, MD or Associates in Dermatology, Inc., including the patient, the patient's estate, any spouse or heirs of the patient, and any children of the patient, whether born or unborn, at the time of the occurrence giving rise to the claim. By signing this Agreement, the parties consent to the participation in this arbitration of any person or entity that would otherwise be a proper additional party in a court action.

5 ARBITRATION PROCEDURES. The parties agree and recognize that the provisions of Florida Statutes, Chapter 766, governing medical malpractice claims shall apply to the parties and/or claimant(s) in all respects except that at the conclusion of the pre-suit screening period and provided there is no mutual agreement to arbitrate under Florida Statutes, 766.106 or 766.207, the parties and/or claimant(s) shall resolve any claim through arbitration pursuant to this Agreement. Within (15) fifteen days after a party to this Agreement has given written notice to the other of a demand for arbitration of said dispute or controversy, the parties to the dispute or controversy shall each appoint an arbitrator and give notice of such appointment to the other. Within a reasonable time after such notices have been given the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator. The parties agree that the arbitration proceedings are private, not public, and the privacy of the parties and of the arbitration proceedings shall be preserved.

# ASSOCIATES IN DERMATOLOGY

## General and Surgical Dermatology

### MOHS Micrographic Surgery

6. **ARBITRATION EXPENSES.** Expenses of the arbitration shall be shared equally by the parties to this Agreement.
7. **APPLICABLE LAW.** Except as herein provided, the arbitration shall be conducted and governed by the provisions of the Florida Arbitration Code, Florida Statutes, Section 682.01 et seq. In conducting the arbitration under Florida Statutes, Section 682.01 et seq., all substantive provisions of Florida law governing medical malpractice claims and damages related thereto, including but not limited to, Florida's Wrongful Death Act, the standard of care for medical providers, the applicable statute of limitations and the application of collateral sources and setoffs shall be applied.
8. **EFFECT OF REFUSAL TO PROCEED WITH ARBITRATION.** In the event that any party to this Agreement refuses to go forward with arbitration, the party compelling arbitration reserves the right to proceed with arbitration, the appointment of an arbitrator, and hearings to resolve the dispute, despite the refusal to participate or absence of the opposing party. Submission of any dispute under this agreement to arbitration may only be avoided by a valid court order, indicating that the dispute is beyond the scope of this arbitration Agreement or contains an illegal aspect precluding the resolution of the dispute by arbitration. Any party to this Agreement who refuses to go forward with arbitration hereby acknowledges that the arbitrator will go forward with the arbitration hearing and render a binding decision without the participation of the party opposing arbitration or despite that party's absence at the arbitration hearing.
9. **SEVERABILITY.** If any provision of this Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.
10. **ACKNOWLEDGEMENTS BY PATIENT.** The patient, by signing this agreement, also acknowledges that he or she has been informed that:
- a) **NO DURESS.** The Agreement may not be submitted to a patient for approval when the patient's condition prevents the patient from making a rational decision whether or not to agree;
  - b) **AGREEMENT BASED UPON OWN FREE WILL.** The decision whether or not to sign the agreement is solely a matter for the patient's determination without any influence by the physician or practice;
  - c) **BINDING ARBITRATION AND EFFECT ON RIGHT OF APPEAL.** Binding arbitration means that the parties give up their right to go to court to assert or defend a claim covered by this Agreement. The resolution of claims covered by this Agreement will be determined by a neutral panel of arbitrators and not a judge or jury. Each party is entitled to a fair hearing, but the arbitration procedures are simpler and more limited than rules applicable in court. Arbitration decisions are as enforceable as any court order. The decision of an arbitration panel is final and there will generally be no right to appeal an adverse decision.

**ASSOCIATES IN DERMATOLOGY**  
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11. READ AGREEMENT AND UNDERSTOOD. I have read and understand the above Agreement. I understand that I have the right to have my questions about arbitration or this Agreement answered and I do not have any unanswered questions. I execute this Agreement of my own free will and not under any duress.

12. SIGNATURE OF AGREEMENT. This Agreement shall be effective upon the patient's and/or the patient's representative's signature below. Upon such signature, this Agreement shall be deemed to be fully executed and binding upon all parties.

PATIENT:

Print Name

Patient Signature

\_\_\_\_\_, 20\_\_\_\_  
Date

PARENT OR GUARDIAN IF PATIENT IS A MINOR:

Print Name

Parent or Guardian Signature

\_\_\_\_\_, 20\_\_\_\_  
Date

Witness