

Account # _____

Date _____

PATIENT INFORMATION:

Last Name _____ First Name _____ M.I. _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____ Business Phone(____) _____

Social Security # _____ - _____ - _____ Email Address _____

Date of Birth _____ Age _____ Sex: Male / Female Marital Status: Married / Single/Divorced/Separated/Widow

Employer _____ Employer Address _____

Employer Phone # (____) _____ Patient's Occupation _____

What are your hobbies? _____

Emergency Name and Phone Number (spouse/parent/etc)

Name: _____ Relation: _____ Phone #: _____

If you are age 65 or older, do you have a Health Care Proxy? YES NO, If yes, Name/Phone _____

INSURANCE INFORMATION

Primary Insurance Co. _____ **Policy #** _____ **Group #** _____ **Copay** _____

Name of Policy Holder _____ DOB _____ SS# _____ - _____ - _____

Employer of Policyholder _____ Relationship to Patient _____

Secondary Insurance Co. _____ **Policy #** _____ **Group #** _____

Name of Policy Holder _____ DOB _____ SS# _____ - _____ - _____

Employer of Policyholder _____ Relationship to Patient _____

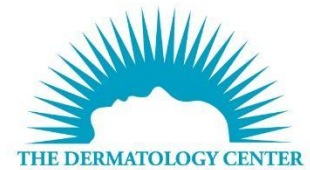
Primary Care Physician (Referring Doctor) _____

Address: _____ PCP Phone # (____) _____ PCP Fax # (____) _____

How did you find our office? (circle)

Referred by a Doctor Referred by a Friend/Relative Internet Our Website ZocDoc

Insurance Directory Specify Other _____



Financial Policy Assignment of Benefits and Responsibility of Charges

Thank you for selecting The Dermatology Center for your dermatological needs. The following information is provided to prevent any misunderstanding regarding payment and financial responsibility.

Medicare

Our physicians are participating Medicare providers and accept Medicare assignment. Our office agrees to accept the charge determination of the Medicare carrier as the full charge. You will be responsible for the deductible, 20% co-insurance, and any non-covered services. If you have a secondary insurance, we will submit to the carrier any remaining balance.

HMO/PPO/Other Insurance Coverage

If you have Insurance through a company we have contracted with, we will require a copy of your insurance card and your driver's license. **ALL CO-PAYMENTS ARE DUE PRIOR TO SEEING THE PHYSICIAN/PA/NP.** If your insurance carrier requires a referral from your primary care physician, this must be present at the time of service. **It is your responsibility to keep track of the referral expiration dates and the number of visits given by your primary care physician. You will be responsible for any services denied by your insurance carrier as not medically necessary and/or not covered.** You are also responsible for any copayment, deductible, co-insurance and non-covered services. It is your responsibility to notify us if you have changed insurance carriers, since your last visit, and to provide us with your new insurance card and information. **In addition, if you do not have a valid referral at the time of service or do not have active insurance, you will be responsible for all charges incurred.**

Laboratory

Depending on your insurance carrier's policy, you may be required to pay separate co-pays and/or deductibles for any specimen taken during your visit.

Self-Pay Patients

If you have no insurance and are a self-pay patient, you are responsible for the balance due at the time of your visit.

Cosmetic Procedures

A deposit may be required for certain cosmetic procedures. Payment in full is required before the procedure is performed. **Deposits are non-refundable unless your appointment is cancelled at least 24 hours in advance.**

Refunds

There are no refunds given on any medical or cosmetic procedures.

Cancellation Policy

If you cannot make your appointment, you are required to cancel your appointment at least 24 hours in advance. If you miss your appointment (without cancelling at least 24 hours in advance), there will be a **\$25 charge billed to you for each missed general dermatology appointment, and \$100 for each missed surgical appointment.**

Returned Checks and Collection

A charge of \$20 will be made for all returned checks.

Your bill will be automatically sent to a third-party collection agency if your patient balance is not paid within 3-6 months of the original due date.

I understand the financial policy of the office and will follow all rules set above. I hereby request payment of all authorized benefits be made on my behalf to New York Dermatology PC for the services rendered.

Patient Name (print) _____

Patient Signature _____

Date _____



HISTORY AND INTAKE FORM

Patient Name _____ Date of Birth: _____

Past Medical History: (please circle all that apply)

Anxiety	Depression	Inflammatory Bowel Disease (Crohn's / UC)
Arthritis – Type:	DIABETES ***	Leukemia
Asthma	End Stage Renal disease	Lymphoma
Atrial Fibrillation	HEART FAILURE (CHF) ***	Psychiatric Treatment
Bone Marrow Transplant	Hepatitis – Type A, B or C	Radiation Treatment
Breast Cancer	High Blood Pressure	Seizures
COPD ***	HIV /AIDS	Stroke
CORONARY ARTERY DISEASE ***	High Cholesterol	Thyroid Problems
Other:		

Skin Disease History: (please circle all that apply)

Abnormal Moles (Dysplastic)	Dry Skin	Poison Ivy
Acne	Eczema	Poor Wound Healing
Actinic Keratoses	Flaking or Itchy Scalp	Precancerous moles
Asthma	Hay Fever / Allergies	Psoriasis
Basal Cell Skin Cancer	Keloids/Thick Scars	Squamous Cell Cancer
Blistering Sunburns	Melanoma	Other:

Do you wear Sunscreen? Yes No If Yes, what SPF? _____
Have you ever regularly used a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____

Do you have a family history of Basal Cell Carcinoma or Squamous Cell Carcinoma? Yes No
If yes, which relative(s)? _____

Do you have asthma, hay fever, allergies, eczema, or dry skin? Yes No
If yes, please explain: _____

Have you ever fainted in a Doctor's office? Yes No

Have you ever had any laser, cosmetic, or plastic surgery procedures performed on you? Yes No
If Yes, Date: _____ Procedure: _____

Have you received your influenza vaccination during the current season? Yes No

If 65 years of age or older, have you ever received a pneumonia vaccination? Yes No

Medications: (please list all current prescriptions, over the counter medications, vitamin and herbal or other supplements)

Allergies: (please enter all allergies)

Social History: (please circle all that apply)

Cigarette Smoking: Currently Smokes Has smoked in the past Never smoked Former smoker

Alcohol Consumption: YES or NO, if YES, How much? _____ How often? _____

Preferred Language: _____

Race: _____ Ethnic Group: _____

Preferred Pharmacy Name: _____ Address: _____

Pharmacy Phone #: _____ Pharmacy Fax #: _____



Patient Name _____

HIPPA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. Implementation of HIPPA requirements began on April 14, 2003. This form is an abbreviated version of the complete policy, which is available in the office. HIPPA provides certain rights and protections to you as the patient. There are rules and restrictions on who may see or be notified of your protected health information. We balance these needs with our goal of providing you with quality professional service and care:

1. Patient information will be kept confidential except as necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This includes the sharing of information with other healthcare providers, laboratories, health insurance payers and government agencies, as is necessary.
2. You agree to bring any concerns regarding your privacy to the attention of the Office Manager or Doctor.

I acknowledge my agreement to the terms set forth in the information above. I understand that this consent shall remain in force from this time forward.

_____ I do not authorize The Dermatology Center to discuss my medical condition and/or treatment with anyone other than myself.

_____ I authorize The Dermatology Center to discuss my medical condition and/or treatment with the following person(s)

Name _____
Relationship _____
Address _____
Phone #: _____

Name _____
Relationship _____
Address _____
Phone #: _____

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I hereby give my consent for The Dermatology Center/ New York Dermatology P.C. to use and disclose protected health information about me to carry out treatment, payment and healthcare operations. The Dermatology Center's "Notice of Privacy Practices" provides a more complete description of such uses and disclosures. This notice describes how medical information about me may be used and disclosed and how I can get access to this information. I have the right to review the "Notice of Privacy Practices" prior to signing this consent. The Dermatology Center reserves the right to revise its "Notice of Privacy Practices" at any time.

Date _____

Print Patient Name _____

Patient (or Legal Guardian) Signature _____

Print Name of Legal Guardian _____

Print Name of Party Responsible for Payment _____