THE DERMATOLOGY CENTER

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_____

THE DERMATOLOGY CENTER

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_____

THE DERMATOLOGY CENTER

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 #:** _____

THE DERMATOLOGY CENTER

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_____


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