

■ Patient Information

Name (Last, First, Middle) _____ Today's Date _____
Date of Birth _____ Soc. Sec. # _____ Home Phone _____
Email address _____ Work Phone _____
Address _____ Apt # _____ Cell Phone _____
City _____ State _____ Zip _____ Sex: M F
Marital Status: Single Married Divorced Widowed Separated Work Status: F/T Work P/T Work Student Retired Disability
Emergency contact name, relationship and phone number _____
Who may we thank for referring you? _____
Primary Care Physician _____ Phone _____
Preferred language _____ Race _____
Preferred Pharmacy Name _____ Phone _____

■ Primary Insurance

Insurance Carrier _____
Please give the receptionist your card, to scan into our files. If the patient is the policyholder, check this box and skip to the next section.
Policyholder's Name (Last, First, Middle) _____ Sex: M F
Relationship to Patient _____ Soc. Sec. # _____ Date of Birth _____

■ Secondary Insurance *Please complete section if applicable.*

Insurance Carrier _____
Please give the receptionist your card, to scan into our files. If the patient is the policyholder, check this box and skip to the next section.
Policyholder's Name (Last, First, Middle) _____ Sex: M F
Relationship to Patient _____ Soc. Sec. # _____ Date of Birth _____

■ Assignment and Release

I hereby authorize payment directly to Upper West Side Dermatology, PC of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me or for my dependents. If my insurance plan requires an authorization or referral, and I do not obtain one for the services I receive, I understand that I am responsible for all charges, even if the provisions of my plan stipulate I otherwise wouldn't be. I authorize the doctors and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above.

If the patient is a minor, I, the guarantor, stipulate that I am his/her legal guardian or parent, and I agree to all the above on behalf of the patient. I understand and agree that the minor may be evaluated and/or treated by Upper West Side Dermatology, PC staff, and I hereby give consent for such evaluation and treatment in my absence, including, but not limited to, physical examination, skin tests, laboratory tests, allergy tests, and the prescription of medication. This agreement shall remain in effect until revoked by me in writing.

Signature: _____ Today's Date: _____

FINANCIAL POLICIES

Financial Security: Our policy requires patients to keep a credit card on file as financial security against deductibles, co-insurance and other instances of patient balances due to us as outlined in this document. You shall be sent three invoices in the mail. Instead of a fourth invoice, the card you provide shall be charged for the amount due. However, if the card you provide is not valid or funded when we attempt to use it, your account shall be sent to collections. In that event, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs and expenses, including reasonable attorneys' fees, which we incur in such collection efforts. You may be dismissed as a patient by our practice for failure to meet your financial obligations. Please provide your credit card information to a receptionist who will enter the information into our secure e-payment system. (Although only the last 4 digits of the credit card are written below, we shall record the entire card number for this purpose.)

Visa MC AMX Disc Last 4 digits of Card #: _____ Expiry: _____ Security #: _____ HRA or Flex Spend? Y / N

Credit card billing address: _____

Health Insurance Cards: Please bring your most current health insurance membership card to each and every appointment. Intentionally failing to notify us of changes to your insurance coverage may constitute fraud, and we may be obliged to report it.

Keeping Appointments: Should you not arrive for a scheduled appointment, unless that appointment has been cancelled at least 24 hours prior, **you will be charged a \$50 medical or \$100 cosmetic no show/same-day cancellation fee (This fee is not billable to your insurance).** A cancellation made with less than a 24 hour notice significantly limits our ability to make the appointment available for another patient in need. As a courtesy, we send reminders (text and email) for appointments one to two days in advance. Please note, if a reminder call or message is not received, the cancellation policy remains in effect. A message can always be left with our answering service or email (info@uwsdermatology.com) to avoid a cancellation fee being charged.

Cosmetic consultation and procedures: Cosmetic consultation fees and cosmetic treatments are NON-REFUNDABLE. A \$100 deposit is required to book a cosmetic appointment. The deposit will be forfeited if you no-show or cancel within 24 hours of your appointment. The deposit will ONLY be honored if appointments are rescheduled at least 24 hours in advance.

Health Insurance Plans: Although we will advise you whether we believe we participate with your insurance carrier, we are not responsible for any verbal assurances made to you regarding whether particular services rendered in this practice are covered by your plan. You and you alone are responsible for understanding the provisions of your health insurance plan and coverage. We recommend contacting your carrier prior to receiving services to verify your financial responsibilities.

Referrals: You are responsible for obtaining all necessary referrals prior to your appointment, if required by your health plan. We will do our best to ensure you have one if you need one, but the ultimate responsibility is yours. If your plan requires a referral or authorization that you do not obtain, and your health plan refuses to pay for any claim for lack of a referral or authorization, you explicitly agree to be responsible for our charges for any affected visits, even if the provisions of your plan stipulate you otherwise wouldn't be (you are waiving that defense).

Copayments: If your plan has a copayment, it is your responsibility to pay it at the time of service, even if the amount is not printed on your insurance card. Please have your payment ready upon check-in.

Health insurance non-payment: Services that have not been paid by your health insurance carrier within 60 days of claim submission will become your financial responsibility to pay in full. In cases of retroactive disenrollment, you are responsible immediately upon notification to us by the carrier. This policy applies equally to in-network and out-of-network plans.

Laboratory Testing: If you are a member of an insurance plan that requires you to have your laboratory specimens sent to a particular laboratory, and this office is so informed by you, we will happily send your specimens to that laboratory, unless the provider determines that another laboratory is preferred for medical reasons. However, regardless of which laboratory patient specimens are sent to for analysis, you are entirely responsible for all charges assessed by the laboratory and shall handle financial matters directly with the laboratory.

I have read, fully understand, accept and explicitly agree with all the above policies at and of Upper West Side Dermatology, PC. I fully understand and accept my financial responsibility for the charges I or my dependents may incur at this office. My signature also acts as authorization to use the credit card provided in this document as explained in the Financial Security section.

Patient Name (Please print clearly): _____

Signature: _____ Date: _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian shall sign above, and accepts responsibility on behalf of the patient.

PRIVACY PRACTICES ACKNOWLEDGEMENT

◆ Upper West Side Dermatology, PC and its staff and providers, may use and disclose my Protected Health Information* ("PHI") to carry out treatment, payment and healthcare operations (TPO). I understand and acknowledge that Upper West Side Dermatology, PC's Notice of Privacy Practices has a more complete description of such uses and disclosures.

◆ I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it. I understand and acknowledge that Upper West Side Dermatology, PC reserves the right to revise its Notice of Privacy Practices at any time, and that a revised version of that notice may be obtained sending a written request to the Privacy Officer at the practice.

◆ I permit Upper West Side Dermatology, PC to leave telephone messages regarding my appointments, prescription renewals, lab results, invoices and all other PHI, may be left for me on voicemail systems, answering machines, email, or given the person or persons who answer the phone, at the following telephone numbers, in addition to any other numbers provided to you by me:

(_____) _____ - _____ Home / Office / Cell / Other: _____
(_____) _____ - _____ Home / Office / Cell / Other: _____
(_____) _____ - _____ Home / Office / Cell / Other: _____

[If we need to contact you with lab results, please place a check mark next to the preferred contact number, if any.]

- ◆ I agree that my PHI may be shared with my spouse.
- ◆ I agree that my PHI may be shared with my other medical providers.
- ◆ I agree that my PHI may be shared with the following other people:

◆ I understand that I can change or revoke any of the foregoing agreements, at any time, by giving written notice to Upper West Side Dermatology, PC to the attention of the HIPAA Compliance Officer. I understand and acknowledge that Upper West Side Dermatology, PC may decline to provide me with any services should I decline to sign this agreement, or should I later revoke this agreement.

◆ I agree that my PHI may be shared with my credit card vendor(s) if I contest any credit card charges, so that Upper West Side Dermatology, PC can submit records to support its charges.

◆ I agree that Upper West Side Dermatology, PC may contact me at any email addresses provided to you by me regarding both PHI and non-PHI, including prescriptions and invoices.

*as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time ("HIPAA")

Patient Name (Please print clearly): _____

Signature: _____ Date: _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian shall sign above, and complete the information below.

Parent/Guardian Name (print): _____ Relationship to Patient: _____

Patient Name: _____ Date of Birth: _____

■ Review of Systems

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Pacemaker or Defibrillator.....	<input type="checkbox"/>	<input type="checkbox"/>	Immunosuppression.....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints within past 2 years	<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valve.....	<input type="checkbox"/>	<input type="checkbox"/>
Premedication prior to procedure	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to adhesive.....	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to topical antibiotic ointments	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infections with antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy, or pregnancy planned	<input type="checkbox"/>	<input type="checkbox"/>	GI upset with antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
<i>Please inform the doctor if you plan to become pregnant or become pregnant during treatment.</i>			Blood thinners	<input type="checkbox"/>	<input type="checkbox"/>
Rapid heartbeat with Epinephrine	<input type="checkbox"/>	<input type="checkbox"/>	Problems with hypertrophy or keloids.....	<input type="checkbox"/>	<input type="checkbox"/>

■ Past Medical History *Please circle all that apply.*

- | | | |
|------------------------------|----------------------|------------------|
| Arthritis | Hearing Loss | Seizures |
| Atrial fibrillation | Hepatitis | Stroke |
| Autoimmune disease (specify) | Hypertension | Cancer (specify) |
| Coronary Artery Disease | HIV / AIDS | None |
| Anxiety/Depression | Hypercholesterolemia | |
| Diabetes | Thyroid Disorder | |

Other/Specify: _____

■ Skin Disease History *Please circle all that apply.*

- | | | |
|------------------------------------|--------------------|------------------------------|
| Acne/Rosacea | Precancerous Moles | Eczema |
| Actinic Keratosis | Allergies | Autoimmune disease (specify) |
| Basal/Squamous Cell Skin Cancer | Melanoma | Itching |
| Blistering Sunburns/Indoor Tanning | Psoriasis | None |

Other: _____

■ Past Surgical History *Please list prior hospitalizations and surgeries (with dates).*

Do you wear sunscreen? Yes No If Yes, what SPF? _____

Do you have a family history of Melanoma? Yes No If Yes, which relatives? _____

Do you have a family history of Cancer? Yes No
If yes, which type and which relatives? _____

Please list all **medications**:

Patient Name: _____ **Date of Birth:** _____

Please list all **allergies:**

■ **Past Social History**

Do you currently smoke or chew **tobacco**? Yes No

If Yes, how many per day? _____

If No, did you smoke in the past? Yes No

Do you currently drink **alcohol**? Yes No

If Yes, how many drinks per day? _____

If No, did you drink in the past? Yes No

Have you been vaccinated against the COVID-19 virus? Yes No

If Yes, which vaccine and when was your last dose? _____

Have you received the Shingles vaccine? Yes No

(For patients 65 and older only) Did you received a Pneumonia vaccination? Yes No