upper west side DERMATOLOGY

277 West End Avenue, Suite 1B, New York, NY 10023
Phone: (212) 769-0069 Fax: (212) 769-0075

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 $100 medical or $150 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 $150 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.

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■ 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: ______________

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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: ______________________

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Patient Name: ______________________________ **Date of Birth:** ____________________

■ Review of Systems

	Yes	No
Pacemaker or Defibrillator	☐	☐
Artificial joints within past 2 years	☐	☐
Premedication prior to procedure	☐	☐
Allergy to topical antibiotic ointments	☐	☐
Pregnancy, or pregnancy planned	☐	☐
Please inform the doctor if you plan to become pregnant or become pregnant during treatment.		
Rapid heartbeat with Epinephrine	☐	☐

	Yes	No
Immunosuppression	☐	☐
Artificial heart valve	☐	☐
Allergy to adhesive	☐	☐
Yeast infections with antibiotics	☐	☐
GI upset with antibiotics	☐	☐
Blood thinners	☐	☐
Problems with hypertrophy or keloids	☐	☐

■ 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**:

____

____

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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 received the Shingles vaccine? Yes No

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