upper west side DERMATOLOGY

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

■ 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
Who may we thank for referring you? _____
Primary Care Physician _____ Phone _____
Preferred language _____ Race _____
Preferred Pharmacy Name _____ Phone _____

■ Guarantor's Information

Only for dependent children under the age of 18. Please insert the information of the accompanying guardian.

Name (Last, First, Middle) _____ **Home Phone** _____
Date of Birth _____ **Soc. Sec. #** _____ Work Phone _____
Address _____ **Apt #** _____ Cell Phone _____
City _____ **State** _____ **Zip** _____ **Sex:** ☐ M ☐ F
Employer's Name _____
Employer's Address _____

■ 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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FINANCIAL POLICIES

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 1 full business day in advance, **you will be charged $50 for each no-show occurrence**.

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 to understand the provisions of your health insurance plan and coverage. We recommend contacting your carrier prior to receiving services in order to verify your financial responsibilities.

Referrals: You are responsible to obtain 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.

Financial Security: It is our policy to request 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 two invoices in the mail. Instead of a third 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 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 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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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, and all other PHI, may be left for me on voicemail systems, answering machines, email (Klara), 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.

**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: _____

Upper West Side Dermatology, P.C

NYULMC HIE, CARE EVERYWHERE and HEALTHIX CONSENT FORM

UPPERWESTSIDE

Before signing the NYULMC HIE Consent Form below, please ensure that you have read the laminated NYULMC HIE Disclaimer Page

For detailed information please request for an HIE Information Sheet or call 212-404-4101.
This form has to be signed only once per practice.

PATIENT INFORMATION (PRINT CLEARLY)

First Name

Last Name

Date of Birth (MM/DD/YYYY)

/ /

Patient ID/MRN

Please check Box 1 or 2: ☑

☐ **1. I GIVE CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access ALL of** my electronic health information through the **NYULMC HIE** and **I GIVE CONSENT to ALL employees, agents and members of the medical staff of NYU Hospitals Center to access ALL of** my electronic health information through **HEALTHIX** in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.

☐ **2. I DENY CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access** my electronic health information through the **NYULMC HIE** or **HEALTHIX** for any purpose, *even in a medical emergency*.

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the NYULMC HIE. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by New York State Law.

Signature of Patient or Patient's Legal Representative

Today's Date (MM/DD/YYYY)

/ /

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative (if applicable)

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

■ Review of Systems

	Yes	No		Yes	No
Pacemaker	☐	☐	Defibrillator	☐	☐
Artificial joints within past 2 years	☐	☐	Artificial heart valve	☐	☐
Premedication prior to procedure	☐	☐	Allergy to adhesive	☐	☐
Allergy to topical antibiotic ointments	☐	☐	Problems with bleeding	☐	☐
Pregnancy, or pregnancy planned	☐	☐	Allergy to Lidocaine	☐	☐
Rapid heartbeat with Epinephrine	☐	☐	Yeast infections with antibiotics	☐	☐
GI upset with antibiotics	☐	☐	Blood thinners	☐	☐
Problems with healing	☐	☐	Problems with hypertrophy or keloids	☐	☐
Wheezing	☐	☐	Changing mole	☐	☐
Immunosuppression	☐	☐	Abdominal pain	☐	☐
Rash	☐	☐	Bloody urine	☐	☐
Anxiety	☐	☐	Chest pain	☐	☐
Blurry vision	☐	☐	Fever or chills	☐	☐
Cough	☐	☐	Hay fever	☐	☐
Headaches	☐	☐	Muscle weakness	☐	☐
Shortness of breath	☐	☐	Seizures	☐	☐
			Thyroid Problem	☐	☐

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

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Artificial joints	End Stage Renal Disease	Lymphoma
Asthma	GERD	Pacemaker
Atrial fibrillation	Hearing Loss	Prostate Cancer
BPH	Hepatitis	Radiation Treatment
Bone Marrow Transplantation	Hypertension	Seizures
Breast Cancer	HIV / AIDS	Stroke
COPD	Hypercholesterolemia	Valve Replacement
Coronary Artery Disease	Hyperthyroidism	None

Other: _____

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

Acne	Precancerous Moles	Psoriasis
Actinic Keratosis	Flaking or Itchy Scalp	Poison Ivy
Asthma	Hay Fever / Allergies	Dry Skin
Basal Cell Skin Cancer	Melanoma Surgery	Eczema
Blistering Sunburns	Squamous Cell Skin Cancer	None

Other: _____

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

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

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Testicle Removed (Right, Left, Bilateral)
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left, Bilateral)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
PTCA
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None

Other: _____

■ Additional Questions

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

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**:

_____

_____

Please list all **allergies**:

_____

_____

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

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

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AESTHETIC INTEREST QUESTIONNAIRE

OPTIONAL

Name: _____ Date:_____

Areas of concern or interest to you (please check all that apply):

- ☐ Frown lines between brows
- ☐ Lines around nose and mouth
- ☐ Tired-looking skin / Uneven skin tone
- ☐ Clogged or large pores
- ☐ Brown patches / Melasma
- ☐ Scars (acne or surgical)
- ☐ Leg vein removal
- ☐ Dark circles under the eyes
- ☐ Double chin / Fullness under chin
- ☐ Stubborn areas of fat (lower abdomen, love handles)
- ☐ Facial vein removal
- ☐ Red spots / Rosacea
- ☐ Excessive sweating
- ☐ Brown spots / Age spots / Sun damage
- ☐ Eyelash length
- ☐ Other, please specify: _____

Which aesthetic procedures are you interested in?

- ☐ Botox
- ☐ Chemical peels
- ☐ Fractionated laser resurfacing
- ☐ Laser treatment of facial veins
- ☐ Laser treatment of facial redness
- ☐ Dermal filler (Juvederm, Radiesse, Voluma)
- ☐ Kybella
- ☐ SculpSure
- ☐ Laser rejuvenation
- ☐ Microneedling
- ☐ Laser facial / Intense Pulsed Light (IPL)
- ☐ Other, please specify: _____

Would you be interested in a skin care regimen for home use?

- ☐ Yes
- ☐ No