LASER.MOHS.DERMATOLOGY
NEW YORK

130 WEST 42ND STREET, SUITE 1900 NEW YORK, NEW YORK 10036 T 212.391.8600 F 212.391.8601 WWW.LASERANDMOHS.COM

PATIENT'S PERSONAL DATA **PLEASE PRINT CLEARLY**

Name: _____ **Date:** _____

Address: _____**City:** _____**State:** _____**Zip:**_____

Home Phone: _____**Cell Phone**: _____ **Marital Status**: _____

E-mail:_____ **DOB:** _____ **SSN:** _____

Referred by: _____ **If doctor referred, please provide name, address,**

and telephone: _____

Family Doctor: _____ **Phone:** _____

Address/City/State/Zip: _____

Pharmacy: _____ **Phone**: _____ **Fax:** _____

PATIENT'S BUSINESS DATA

Employer: _____ **Occupation:** _____

Address: _____ **City/State**: _____

Zip: _____ **Business Phone:** _____

EMERGENCY CONTACT (Spouse/Parent/Nearest Relative/Friend)

Name: _____ **Relationship to patient**: _____

Address: _____ **City/State/zip**: _____

Home/Mobile Phone: _____ **Business Phone**: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? **Check all that apply:**

☐ **Yelp** ☐ **CitySearch** ☐ **Yellowpages.com**

☐ **Insurance** ☐ **Patient/Physician referral** ☐ **Google**

☐ **RateMD** ☐ **Vitals** ☐ **ZocDoc**

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PATIENT INFORMATION

Patient Name: _____

Date: _____/_____/_____ **Last Total Skin Exam**: _____/_____/_____

Reason for Consultation:_____

Duration: ___days ____wks ____mths ____yrs Location: _____

Check ALL that apply:

☐Persistent ☐Episodic ☐Recurrent ☐Bleeding ☐Scabbing/Crusting
☐Burning ☐Itching ☐Flaking ☐Redness ☐Blisters ☐Spreading
☐New Lesions ☐Change in Color/Shape ☐Roughness ☐Painful

Check ALL that apply or write N/A to the ones that do not apply to you.

MEDICATIONS	SOCIAL HISTORY	FAMILY HISTORY	ALLERGIES
☐ NONE	☐ Married	☐ NONE	☐ NONE
	☐ Widowed	☐ MELANOMA	☐ ASPIRIN
	☐ Divorced	☐ DYSPLASTIC NEVI	☐ PENICILLIN
	☐ Single		☐ SULFA
	☐ Partnered	**PACEMAKER:** Y○N○	☐ LATEX
Occupation:	**Weight:** _____ **Height:** _____	**PRE MEDICATION:** Y○N○	

MEDICAL HX		SURGERIES
☐NONE	☐HIV	☐NONE
☐CANCER	☐ASTHMA	
☐RADIATION	☐CHOLESTEROL	
☐BLOOD TRANSFUSION	☐THYROID DISEASE	
☐COLLAGEN VASCULAR DISEASE	☐CARDIAC DISEASE	
☐BLEEDING DIATHESES	☐HEPATITIS A○B○C○	**Tanning Beds:** ○No ○Yes
☐DIABETES	☐HIGH BLOOD PRESSURE	**Smoke:** ○Cig ○Cigar ○No
	☐OTHER	**Alcohol:** ○Social ○Daily ○No

Who should we thank for referring you:_____

Past Cosmetic Procedures: ☐**Laser** ☐**Botox** ☐**Fillers** ☐**Peels** ☐**Blepharoplasty** ☐**Face Lift** ☐**Tattoo**

If Women: **Menses:** ○ Regular ○ Irregular **Last Menstrual Period**: _____ **Pregnant: Y○N○**
Breastfeeding: Y○N○

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INSURANCE ACCEPTANCE AGREEMENT

IN-NETWORK/OUT OF NETWORK AND/OR PRIVATE INDEMNITY INSURANCE ALLOWANCE AGREEMENT:

I fully understand that, even though I have a referral authorization from my primary care physician, if my insurance carrier deems that the visit/procedure is cosmetic or not medically necessary, I will accept full responsibility for payment. In addition, should my carrier deny payment due to the fact that I have a pre-existing condition, I will accept full responsibility for payment. Accepting your insurance allowance means that you are responsible for the payment of all deductible and co-insurance(s), if applicable, which is the difference between the insurance carrier approved/allowed amount and the paid amount. Each individual has an annual deductible amount which must be satisfied prior to insurance benefits commencing. If my insurance carrier determines that the visit/procedure is deemed cosmetic or not medically necessary, I will accept full responsibility for payment. In conclusion, should my carrier deny payment due to the fact that I have a pre-existing condition, I will accept full responsibility for payment.

ALL PATIENTS PLEASE READ AND SIGN THE FOLLOWING:

If I have unknowingly provided the incorrect information, such as the primary carrier, effective date of coverage or I have not provided your office with necessary identification card and/or referral authorization at the time services are rendered, I agree to be fully responsible for the charges incurred. Furthermore, if it is later ascertained that I am insured by a carrier of which you are not a participating provider, I understand that I will only be reimbursed the insurance payment issued and not the charges I have incurred and paid.

I authorize the release of any information necessary to process my insurance claim. I request that payment be made directly to the physician for services rendered. A copy of this authorization may be used in place of the original. This is also an authorization for the doctor to take, or direct to be taken, any photograph required for the completion or records. These photographs shall be the sole property of Dr. Quintana and may be used for educational or promotional purposed. It is also understood that these photographs may be used in medical or lay publications or shown at scientific meetings. The patient's identity will be concealed.

I am aware that the office policy states that I must notify the office at least 24 hours in advance, should I need to reschedule my appointment. In the event that I do not call the office within 24 hours of my scheduled appointment or I simply do not show, I understand that I will be billed $25* for that visit and I will accept full financial for that payment.
*$50 is billed for cosmetic/aesthetic appointment not canceled 24 hours in advance.

PATIENT'S SIGNATURE: _____ **DATE:** _____

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Date: _____

Patient: _____

ID #: _____

DOS: _____

CLAIM #: _____

I hereby authorize Dr. Adelle Quintana to appeal my insurance company's

_____determination

concerning _____ on my behalf, as my

designated representative, and as part of the appeal, I hereby authorize my insurance company

_____to disclose and furnish to my designated representative:

All medical and financial information contained in my insurance file including but not limited to treatment for VD, alcoholism, drug abuse, abortion, mental disorder, or development disability, Cancer & HIV status relating to my exam, treatment and hospital confinement in connection with the determination which is being appealed. I understand this information is privileged and confidential and will only be released as specified in this authorization. This authorization is valid for a period of one year.

_____ _____
Signature of Member/Legal Guardian Date

_____ _____
Signature of witness Date

_____ _____
Name of Designated Representative (Office Use) Date

_____
Title (Staff) or Relationship to Member

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HIPAA Consent Form

This consent form allows Laser and Mohs Surgery of New York to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

Laser and Mohs Surgery has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing the form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by mail or by an update on our web site.

I understand that I have the right to request, now and in the future, how protected health information is used or disclosed to carry out treatment, payment and health care operations. I understand that while Laser and Mohs Surgery is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that the service may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information.

I understand that Laser and Mohs Surgery of New York may refuse me further service if I revoke the consent.

I request the following individuals to have access to my medical records, information on my condition, and any of my protected health information:

_____
Patient's Name

_____ _____
Patient's Signature (Legal Guardian if a minor) Date

_____ _____
Privacy Office (For office use) Date

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RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I, _____ (Patient's Name) have received a copy of the Notice of Privacy Practices.

Patient Signature: _____ Date: _____

==========

I, _____ (Patient's Name) authorize as follows:

☐ **I hereby authorize you to discuss my medical condition and/ or treatment with the following person(s)**

#1

Name: _____ Relationship: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

#2

Name: _____ Relationship: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

☐ **I <u>DO NOT</u> authorize you to discuss my medical condition and/ or treatment with anyone other than myself.**

Patient's Signature: _____ Date: _____