DERMATOLOGY,
LASER & SURGERY
OF FLATIRON PLLC

REGISTRATION FORM

PATIENT INFORMATION

Patient's Last name: **First:** **Middle:**			❑ Mr. ❑ Mrs.	❑ Ms. ❑ Dr.	**Marital Status (Circle One):** Single / Mar / Div / Sep / Wid
Birthdate: / /	**Age:**	**Sex: ❑M ❑ F**			**Social Security #:**
Language: ❑English ❑ Spanish ❑French ❑ Chinese ❑Italian ❑ Other	**Ethnicity: ❑ Asian ❑ Caucasian ❑ Hispanic ❑African American ❑ Other**				**Religion:**
Street address:		**City:**	**State:**		**Zip Code:**
Home Phone :	**Cell :**	**Work :**			**Fax:**
Email:					
Primary Care Physician (First /Last):	**Primary Care Physician #:**	**Pharmacy Name:**			**Pharmacy #:**
Occupation:	**Emergency Contact Name:**				**Emergency Contact #:**
Referred By: ❑ Friend/Family	**❑ Dr.**	**❑ Online**			**❑ Insurance Plan**

MEDICAL HISTORY

Reason For Today's Visit:

Drug Allergies:

Current Medications:

Skin History:

❑ Acne	❑ Basal Cell Cancer	❑ Dysplastic Nevi	❑ Eczema	❑ Keloids
❑ Melanoma	❑ Psoriasis	❑ Squamous Cell Cancer	❑ Warts	❑ Other: _____

Medical History: **Height :_____** **Weight:_____**

❑ Diabetes	❑ Heart Murmur	❑ Heart Valve	❑ Hepatitis B	❑ Hepatitis C
❑ High Blood Pressure	❑ High Cholesterol	❑ HIV	❑ Pregnant/Nursing	❑ Other: _____

Surgical History:

Family History:

❑ Basal Cell Cancer	❑ Eczema	❑ Melanoma	❑ Psoriasis	❑ Squamous Cell Cancer

Social History: **Smoker: ❑ Yes ❑ No**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance and co-payments are due at the time of service. I also authorize Dermatology, Laser and Surgery of Flatiron PLLC or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature **Date**

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CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Records Release: I authorize the release of my prior medical records if needed to Dermatology, Laser and Surgery of Flatiron PLLC

I acknowledge that I have reviewed Dermatology, Laser and Surgery of Flatiron PLLC. Notice of Privacy Practices for Protected Health Information (PHI).

I hereby give my consent for Dermatology, Laser and Surgery of Flatiron PLLC to use and disclose PHI about me to carry out treatment, payment and health care operations (TPO). Dermatology, Laser and Surgery of Flatiron PLLC reserves the right to revise its notice of Privacy Practices at any time. A revised notice of Privacy Practices may be obtained by forwarding a written request to Dermatology, Laser and Surgery of Flatiron PLLC Privacy Officer at 928 Broadway, Suite 204, New York, NY 10010.

With this consent, Dermatology, Laser and Surgery of Flatiron PLLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Dermatology, Laser and Surgery of Flatiron PLLC may mail or email to my home or other alternative location in reference to any items that assist the practice in carrying out TPO such as appointment reminder cards, practice updates and patient statements.

I have the right to request that Dermatology, Laser and Surgery of Flatiron PLLC restricts how it uses or discloses my PHI to carry out TPO. However the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

- ♦ I have received the Notice of Privacy Practices and/or have been provided an opportunity to review it.

- ♦ I agree that I can be contacted regarding my appointments, prescription renewals, lab results, and all other Protected Health Information* (“PHI) as defined in the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and its regulations, as may be amended from time-to-time.

- ♦ I understand that it is your policy not to reveal PHI to my spouse. I understand that it is your policy, in compliance with the law, to reveal PHI with my other physicians.

- ♦ I understand that from time to time we may email you information regarding your care.

- ♦ I understand In the event that I choose to discuss my care by this office on the internet, in social media or any other venue, Dermatology, Laser And Surgery Of Flatiron PLLC reserves the right to respond with detailed relevant information to clarify the care administered. In choosing this venue, I also agree to waive my privacy rights and I further confirm that HIPAA will no longer apply with regard to the information posted.

By signing this form, I am consenting Dermatology, Laser and Surgery of Flatiron PLLC use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the event that the practice has already made disclosures in reliance upon my prior consent. If I don’t sign this consent or later revoke it, Dermatology, Laser and Surgery of Flatiron PLLC may decline to provide treatment to me.

_____
Print Patient or Legal Guardian Name/Guarantor

_____
Signature of Patient or Legal Guardian/Guarantor

_____
Date

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OFFICE POLICY ON INSURANCES AND PAYMENTS

As a courtesy service to you, our office employs a billing service and participates with several insurance carriers. Please familiarize yourself with your insurance's guidelines and policies.

1. If your insurance carrier requires you to pay a portion of your healthcare visits (i.e.co-pays), we are legally required to collect these and no exceptions will be made. You are required to pay your co-pay at the time of your visit.
2. Please confirm whether your insurance requires you to have a referral in order to be seen in our office, so that you may be able to submit the referral at or before your appointment.
3. If your insurance requires you to meet an annual deductible before healthcare is covered, you will be billed for all services rendered until you meet your deductible.
4. Please leave your credit card information when you check-in at our front desk. Your credit card information will be securely stored with end-to-end encryption with our credit card company which is PCI DSS compliant. You are responsible for your co-payment, co-insurance, any denied claims by your insurance, and any deductible that hasn't been met. After your insurance carrier has notified us of your portion, we will notify you of your balance by paper statement. If payment is not received within 30 days your card will be charged.
5. If you cancel your appointment with less than 24 hours notice or fail to show up to your scheduled appointment you will be charged a "Cancellation/No Show Fee." The fee is $50. This fee will be automatically charged to the card on file.

I _____(print name) authorize Dermatology, Laser and Surgery of Flatiron PLLC to charge outstanding balances to the credit card I have left on file.

Name on Card:_____

Billing Address:_____

Billing Zip Code:_____

Print Name:_____ Date:_____

Signature_____