# METRO DERMATOLOGY

500 Grand Ave., Suite 201, Englewood, NJ 07631 (201)886-9000 Fax: (201)227-1789
41-61 Kissena Blvd., Suite 5A, Flushing, NY 11355 (718)886-9000 Fax: (718)961-0666
220 East 161st Street, Bronx, NY 10451 (718)292-9197 Fax: (718) 292-4429
40-12 80th St ,Elmhurst , NY 11373 (718)886-9000 Fax: (718)961-0666

Soc. Sec. #: _____ – _____ – _____

**성명 (영문):** _____ _____ _____
Name Last (성) First (이름) M.I.

Street Address: _____ Apt. #: _____
주소
City: _____ State: _____ Zip: _____

**나이:** _____ **생년월일:** _____**월** _____ **일** _____ **년** **결혼여부:** ☐ 미혼 ☐ 기혼 ☐ 기타 **성별:** ☐ 남 ☐ 여
Age Date of Birth: MM DD YY Marital Status: Single Married Other Sex: Male Female

**전화번호 1 :** ( _____ ) _____ – _____ **전화번호 2 :** ( _____ ) _____ – _____
Home Cell Phone #

**응급시 연락자 성명:** _____ **응급시 연락처:** ( _____ ) _____ – _____
Emergency Contact Emergency Phone

**주치의:** _____ **주치의 연락처:** ( _____ ) _____ – _____
Referring Doctor Phone

**이메일 주소** (Email Address) **:** _____ @ _____

Preferred Language: ☐ English ☐ Español ☐ 한국어 ☐ 國 語 ☐ 廣東語 ☐ 日本語 ☐ Other: _____

**PLEASE PRESENT TO THE RECEPTIONIST WITH ALL INSURANCE CARDS WHEN RETURNING THIS FORM.**

## Primary Insurance

**Does your insurance require a referral to see a specialist? ☐ Yes ☐ No**

**보험 이름:** _____ **가입 번호:** _____
Insurance Carrier Insurance ID #

**보험 가입자:** _____ _____ _____
Subscriber's Name Last (성) First (이름) M.I.

**가입자 생년 월일:** _____ **월** _____ **일** _____ **년** **환자와의 관계:** _____
Subscriber's DOB MM DD YY Relationship to Patient

## Secondary Insurance (If Applicable)

**보험 이름:** _____ **가입 번호:** _____
Insurance Carrier Insurance ID #

## Patient Privacy Directive

In our efforts to comply with the Health insurance Portability and Account Activity (HIPAA), we need to be certain that we guard your privacy according to your wishes. Please provider names and phone number of assigned person(s) we can discuss the matters with.

1. Leave message regarding appointments, treatments and/or test results.
2. Discuss your appointments and billing issues.

_____
Authorized Individual (Print) Phone Number

I acknowledge I have seen a copy of the "Notice of Privacy Notices" posted in the office lobby._____
Initial

**I AUTHORIZE, Metro Dermatology TO SUBMIT ALL CLAIMS ON MY BEHALF. I ALSO AUTHORIZE ASSIGNMENT OF BENEFITS DIRECTLY TO HIS OFFICE AND RELEASE OF ANY RECORDS REQUESTED BY MY INSURANCE CARRIER(S). I ALSO ACKNOWLEDGE THAT IF PAYMENT IS NOT RECEIVED THAT I WILL BE HELD RESPONSIBLE FOR THE ENTIRE BALANCE OF THE BILL. I AGREE TO BE RESPONSIBLE FOR ANY COLLECTION AND COURT COSTS SHOULD MY ACCOUNT BE TURNED OVER TO AN ATTORNEY OR COLLECTION AGENCY. I AGREE TO PAY $35.00 FOR ANY RETURNED CHECK.**

**SIGNED:** __**X**_____ **DATE:** _____/_____/_____

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Patient Name:_____ Date of Birth :_____

# Practice Policy

## Treatment Consent

I hereby authorize and consent to treatment at Metro Dermatology (MD). This may include the administration of medication, diagnostic tests and procedures as deemed necessary by my physician, or his assistants or designees, for purposes of diagnosis or treatment.

## Authorization & Assignment

I authorize Metro Dermatology and/or my physician to furnish information to my insurance carriers concerning my diagnosis and treatment. If I do not make payment in full for such services, I assign to Metro Dermatology all payments for services rendered to my dependents or me.

## Medicare Claims

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

## Payment Guarantee

*** Patient Responsibility.** I understand that I am responsible for any amount not covered by insurance. I agree to provide payment within 30 days of notification by statement of this responsibility. Failure to do so will incur additional billing charges. This applies whether covered by an HMO, PPO, or a traditional group health plan.
If my account becomes delinquent, I understand that it is subject for placement with an outside collection agency. A collection fee, not to exceed 30% of the unpaid balance including, but not limited to collection agency fees, attorney's fees, filing fees, and court costs when necessary, will be added to the balance referred. If your account is placed with a collection agency, we will terminate the availability of our services to you and you will be dismissed from the practice.

*** Contracted Insurers.** If we participate (are contracted) with your insurance plan, we file claims as a courtesy to you. You will be responsible for:

- Co-payments
- Coinsurances
- Annual deductibles
- Non-covered services

*** Non-Covered Services.** Insurers routinely state, "The determination of coverage is made at the time the claim is submitted." We often do not know if treatments will be covered until we receive the insurer's EOB (explanation of benefits). After the EOB for your submitted claim has been received at Lee Dermatology, you will be billed for any items not covered by your insurance plan. Services may be denied for coverage because the carrier considers the services: 1) medically unnecessary 2) preexisting condition 3) cosmetic. In the event that Medicare or any insurance carrier should deny payment, I agree to be personally and fully responsible for payment.

**Initial** _____

*** Transfer of Credit Balance.** A credit balance resulting from payment to Metro Dermatology from insurance or other sources may be applied to any other accounts owed by the insured and/or family of the insured.

*** Pathology & Laboratory Charges.** Final laboratory charges cannot be anticipated at the time of service and are not within our control. Clinical laboratories will perform all needed tests to clarify or confirm a diagnosis. This can result in significant additional fees. You will be responsible for any amount not covered by insurance.

## Fees

*** Co-Pay Rebilling Charge.** Our contract with your insurer requires us to collect any co-payments in full at the time of service. If for any reason the correct co-pay is not collected at the time of service, a $10 service charge will apply for additional billing to collect the correct co-pay.

*** Insurance Rebilling Charge**. If your insurance claim requires a second submission because of incorrect insurance policy information, there will be an additional $15 charge. This charge will be the patient's responsibility. If the correct insurance information is not obtained before your insurer's claim filing deadline, you will become responsible for the full cost of the visit.

*** Rebilling Charges.** After the first 30 days, any outstanding charges will be subjected to an additional $5 charge each billing period for mailing and handling fees.

*** Returned Checks.** A $35 processing fee will be charged for returned checks. Returned checks may also be forwarded to our collection agency for further action.

***Transfer of Records**.

An administrative charge for processing in the following States:

**New York:** Seventy-Five cents ($.75) per page for paper copies and a reasonable charge for diagnostic images, plus postage.

**New Jersey:**$1.00 per page for first 100 pages
$.25 per page thereafter to a maximum charge of $200.00 for the entire record

*** Appointment Cancellation or 'No Show'.** As a courtesy, our office has an automated appointment reminder system that calls 2 days before and a day before to verify your appointment. This provides adequate time to cancel or change your appointment if needed. Twenty four hour notice is required to avoid the $20 late cancellation or no-show charge. This charge is not billable to any insurance carrier.

## Medication Refills

Patients are given enough medication to sustain them until their next visit. A follow up visit is usually required for prescriptions written over 6 months ago. Depending on the medication, a one-time refill may be given.

## No Insurance Card

If you arrive without your insurance card for your first visit, you will be charged our standard commercial fee. We are not able to provide an insurance discount or contracted fee without that card and supporting identification. No refunds or insurance discounts will be provided after the fact. Refund of the full amount patient paid is done **only** after the insurance pays.

**A copy of this authorization shall be valid as the original.**

X _____ / /

Print and Signature/Patient or legal representative | Date

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Patient name: _____ Date: _____

□ check here if minor or unable to provide consent

I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals as I have designated below. By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact:

_X_____ (Signature) _____ (Witness)

By signing this form below I confirm that this consent form has been explained to me in terms which I understand.

1) I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

   _X_____ (Signature) _____ (Witness)

2) I agree for my image to be shown for teaching purposes **AND** to be used for my medical record but **NOT FOR** medical publication:

   _X_____ (Signature) _____ (Witness)

   For patients between ages 7 and 18 years, a signature below indicates that the information in this consent form has been explained to me, and I assent to use my images as outlined above:

   _X_____ (Signature) _____ (Witness)

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성명 (영문)Patient Name: _____ Today's Date: ____/____/_____

생년월일 Date of Birth: ____/____/_____

# Patient Health Questionnaire (PFSH)

□□□□□□□□□□

## Medical History

❖약에 대한 알레르기가 있습니까?Are you allergic to any medication(s)? ❑예 Ye s ❑아니요 No

있으시면적어주세요
If yes, list allergic medications(s) _____

❖마취주사약에 알레르기가 있습니까? Do you have allergy to dental anesthesia? ❑예 Yes ❑아니요 No

❖대일밴드에 알레르기가 있습니까? Do you have a band age allergy? ❑예 Yes ❑아니요 No

❖레이택스 (고무) 알레르기가 있습니까?Do you have latex allergy? ❑예 Yes ❑아니요 No

❖병원에 입원했거나 수술을 한적이 있습니까? Any recent surgeries or hospitalizations? ❑예 Yes ❑아니요 No

있으시면 적어주세요
If yes, what are they? _____

❖현재 복용하시는 약이있습니까? Are you taking any medications currently (including over the counter medications such as multi vitamins)? ❑예 Yes ❑아니요 No

있으시면 적어주세요 If yes, what are they? _____

❖다음 약중에 복용하시는 약이 있습니까? Do you take any of these medications? ❑예 Yes ❑아니요 No

있으시면 체크해주세요. ❑ Vitamin E ❑ Aspirin ❑ Motrin/Ibuprofen
If yes, please check ❑ Aleve ❑ Coumadin ❑다른혈액응고방지제

## Family History

가족중에 다음질환을 앓았거나 현재 앓고있는 분이있습니까? ❑예 Ye s ❑아니요 No

Have any close relatives had any of the following?

있으시면 체크해주세요. ❑흑색종 Melanoma❑피부암 Skin Cancer❑비정상점 Unusual Moles
If yes, please check) ❑환홍성여드름 Severe acne❑건선 Psoriasis❑습진/아토피 Eczema

## Social History

❖술을하십니까? ❑전혀안합니다 Never❑가끔합니다 Socially (few weeks)
Do you drink alcohol? ❑자주합니다. Moderately (weekly)❑많이합니다 Heavily (More than weekly)

❖담배를 피우십니까? ❑전혀안합니다 Never❑더이상안합니다 Previously, but quit
Do you smoke tobacco? ❑합니다. Currently smoking 매일 ____곽 packs / day

마약을 사용합니까?Do you use recreational drugs? ❑예 Yes ❑아니요 No

선크림을 사용합니까?Do you use sunscreen? ❑예 Yes ❑아니요 No

모자를 쓰십니까? Do you wear hats? ❑예 Yes ❑아니요 No

서명 X_____ 날짜 Date ____/____/_____ Staff Print Signature_____

Patient Signature

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Patient Name: _____ Today's Date: ____/____/_____

Date of Birth: ____/____/_____

## Patient Health Questionnaire (ROS)

Please answer ALL questions

**다음 질환을 앓고 있거나 앓은 적이있습니까?** **Do you have now or have you ever had diseases or conditions of**: (Please check **YES** or **NO**)

| | 예Yes | 아니요No | | 예Yes | 아니요No |
|---|---|---|---|---|---|
| **인공관절**Artificial joint | ❑ | ❑ | 당뇨Diabetes | ❑ | ❑ |
| **인공심장밸브**Artificial heart valve | ❑ | ❑ | 갑상선질환Thyroid problems | ❑ | ❑ |
| **맥박조정장치**Pace maker or defibrillator | ❑ | ❑ | 빈혈증Anemia | ❑ | ❑ |
| **혈액응고**Blood clots | ❑ | ❑ | 수혈Blood transfusion | ❑ | ❑ |
| **결핵**Tuberculosis | ❑ | ❑ | 암Cancer | ❑ | ❑ |
| **에이즈**HIV/AIDS | ❑ | ❑ | 다발성경화증 Multiple sclerosis/numbness | ❑ | ❑ |
| **B형/C형간염**Hepatitis B or C | ❑ | ❑ | 루푸스Lupus | ❑ | ❑ |
| **간질환**Liver problems | ❑ | ❑ | 관절염/근육통Arthritis/muscle pain | ❑ | ❑ |
| **신장질환**Kidney problems | ❑ | ❑ | 류마티스질환Rheumatic disease | ❑ | ❑ |
| 고혈압High blood pressure | ❑ | ❑ | 천식/아토피Asthma/hay fever | ❑ | ❑ |
| 가슴통증Chest pain | ❑ | ❑ | 기종Emphysema | ❑ | ❑ |
| 심장마비Heart attack | ❑ | ❑ | 헤르페스Fever blisters/Cold sores | ❑ | ❑ |
| 호흡곤란Shortness of breath | ❑ | ❑ | | | |
| 뇌출혈Stroke | ❑ | ❑ | Malaise (feel sick) | ❑ | ❑ |
| 최근체중감소Recent weight loss | ❑ | ❑ | 발열/오한(현재) Fever or chills (currently) | ❑ | ❑ |
| 우울증Depression | ❑ | ❑ | 두통(현재) Headache (currently) | ❑ | ❑ |

**다른질환을 앓고 있거나 앓은적있으면나열해주세요**

list of any other diseases or condition: _____

_____

_____

**다음의 피부질환이 있습니까** ? Skin: Have you ever had any of the following?

❑흑색종 Melanoma ❑피부암 Skin cancer ❑비정상인 점 Unusual

❑건 선 Psoriasis ❑심한상처 Excessive ❑킬로이드 Keloid

❑일광욕화상 Blistering sunburn ❑습진 /아토피Eczema/Atopic dermatitis

**직업이 무엇입니까**? What is your occupation?_____

서명: X_____ 오늘날짜____/____/_____ 직원서명_____

Patient Signature Date Staff Print Signature