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 80thSt ,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: _____

약국 인포메이션

약국 이름_____약국 전화번호/동네_____

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

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, DR. LEE 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 Lee 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. <u>This charge is not billable to any insurance carrier.</u>

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

생년월일 Date of Birth: ____/____/_____

Patient Health Questionnaire (PFSH)

Please answer ALL questions

앓고 있으신 질환에 표시해주세요 Select any of the following medical conditions that you have

- ❑ 없음 None
- ❑ 불안장애 Anxiety
- ❑ 관절염 Arthritis
- ❑ 천식 Asthma
- ❑ 심방세동 Atrial Fibrillation (Irregula Heartbeat)
- ❑ 골수 이식 Bone Marrow Transplantation
- ❑ 전립선 비대증 BPH
- ❑ 유방암 Breast Cancer
- ❑ 대장암 Colon Cancer
- ❑ 만성폐쇄질환 COPD
- ❑ 관상 동맥질환 Coronary Artery Disease
- ❑ 우울증 Depression
- ❑ 당뇨 Diabetes
- ❑ 신장질환 말기 End Stage Renal Disease
- ❑ 식도 역류 질환 GERD
- ❑ Other: _____
- ❑ 청력손실 Hearing Loss
- ❑ 간염 Hepatitis
- ❑ 고혈압 Hypertension
- ❑ 에이즈 HIV / AIDS
- ❑ 고콜레스테롤 혈증 Hypercholesterolemia
- ❑ 갑상선 항진증 Hyperthyroidism
- ❑ 갑상선 저하증 Hypothyroidism
- ❑ 백혈병 Leukemia
- ❑ 폐암 Lung Cancer
- ❑ 림프종 Lymphoma
- ❑ 전립선암 Prostate Cancer
- ❑ 방사선 치료 Radiation Treatment
- ❑ 발작 Seizures
- ❑ 뇌졸증/뇌출혈 Stroke

과거에 받으신 수술에 표시해주세요 Past Surgeries: Have you had any surgeries on the following organs?

- ❑ 없음 None
- ❑ 맹장수술 Appendix (Appendectomy)
- ❑ 방광절제수술 Bladder (Cystectomy)
- ❑ 유방: 유방 조직검사 Breast : Breast Biopsy
- ❑ 유방: 종양절제술 (양쪽)Breast : Lumpectomy (Both Breasts)
- ❑ 유방: 종양절제술(왼쪽)Breast : Lumpectomy (Left Breast)
- ❑ 유방: 종양절제술(오른쪽)Breast : Lumpectomy (Right Breast)
- ❑ 유방:유방절제술(양쪽)Breast : Mastectomy (Both Breasts)
- ❑ 유방:유방절제술(왼쪽)Breast : Mastectomy (Left Breast)
- ❑ 유방:유방절제술(오른쪽)Breast : Mastectomy (Right Breast)
- ❑ 결장: 대장암 절제술 Colon (Colectomy) : Colon Cancer Resection
- ❑ 결장: 대장염증 Colon (Colectomy) : Diverticulitis
- ❑ 결장:염증성 장질환 Colon (Colectomy) : Inflammatory Bowel Dz
- ❑ 결장: 결장루 Colon: Colostomy
- ❑ 담낭 절제술 Gallbladder (Cholecystectomy)
- ❑ 심장: 인공판막수술 Heart : Biological Valve Replacement
- ❑ 심장:관동맥우회술 Heart : Coronary Artery Bypass Surgery
- ❑ 심장: 심장이식 Heart : Heart Transplant
- ❑ 신장: 신장조직검사 Kidney : Kidney Biopsy
- ❑ 간: 션트 Liver: Shunt
- ❑ 난소: 난소절제술:자궁내막증 Ovaries (Oophorectomy) Endometriosis
- ❑ 난소: 난소절제술:난소암 Ovaries (Oophorectomy) Ovarian Cancer
- ❑ 난소: 난소 절제술:난소 난종 Ovaries (Oophorectomy) Ovarian Cyst
- ❑ 난소: 난관결찰 Ovaries: Tubal Ligation
- ❑ 췌장: 췌장절제술 Pancreas: Pancreatectomy
- ❑ 전립선:전립선 조직검사 Prostate (Prostatectomy) : Prostate Biopsy
- ❑ 전립선:전립선절제술:전립선암 Prostate (Prostatectomy) Prostate Cancer
- ❑ 전립선:경요도 전립선 절제술 Prostate (Prostatectomy)
- ❑ 직장:복회음 절제술 Rectum: APR
- ❑ 직장:저위 전방 절제술 Rectum: Low Anterior Resection
- ❑ 피부: 기저세포암 Skin : Basal Cell Carcinoma
- ❑ 피부:흑색종 Skin : Melanoma
- ❑ 피부:피부 조직검사 Skin : Skin Biopsy
- ❑ 피부:편평세포암종 Skin : Squamous Cell Carcinoma
- ❑ 비장: 비장 절제술 Spleen (Splenectomy)

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과거에 받으신 수술을 표시해주세요

Past Surgeries: Have you had any surgeries on the following organs?

- ❑ 심장: 기계밸브 대체 Heart : Mechanical Valve Replacement
- ❑ 심장: 피부 경유 혈관 성형술 Heart : PTCA
- ❑ 관절대체수술:엉덩이 (양쪽)Joint Replacement : Hip (Both)
- ❑ 관절대체수술:엉덩이(왼쪽)Joint Replacement : Hip (Left)
- ❑ 관절대체수술:엉덩이(오른쪽)Joint Replacement : Hip (Right)
- ❑ 관절 대체 수술:무릎(양쪽)Joint Replacement : Knee (Both)
- ❑ 관절 대체 수술:무릎(왼쪽)Joint Replacement : Knee (Left)
- ❑ 관절 대체 수술:무릎(오른쪽)Joint Replacement : Knee (Right)
- ❑ 고환절제수술 Testicles (Orchiectomy)
- ❑ 자궁근종절제수술 Uterus (Hysterectomy) : Fibroids
- ❑ 자궁 적출수술:자궁암 Uterus (Hysterectomy) : Uterine Cancer
- ❑ 자궁 적출 수술:자궁경부암 Uterus (Hysterectomy) : Cervical Cancer
- ❑ Other: _____

다음 중 해당되는 스킨 컨디션에 표시해주세요 Have you had any of the following skin conditions?

- ❑ 없음 None
- ❑ 여드름 Acne
- ❑ 광선 각화증 Actinic Keratoses
- ❑ 천식 Asthma
- ❑ 기저세표피부암 Basal Cell Skin Cancer
- ❑ 썬번에 의한 물집 Blistering Sunburns
- ❑ 건성피부 Dry Skin
- ❑ 습진 Eczema
- ❑ 두피비듬 혹은 가려움증 Flaking or Itchy Scalp
- ❑ 건초열/알러지 Hay Fever/Allergies
- ❑ 흑색종 Melanoma
- ❑ 옻 Poison Ivy
- ❑ 비정상인 점 Precancerous Moles
- ❑ 건선 Psoriasis
- ❑ 편평세포 피부암 Squamous cell skin cancer

선크림을 사용하십니까?Do you wear sunscreen? ❑ Yes ❑ No

If Yes, what SPF? _____

태닝 살롱을 이용하십니까?Do you tan in a tanning salon? ❑ Yes ❑ No

가족력 Family History:

가족분들중에 흑생종을 가지고 계신분이 있습니까?Do you have a family history of melanoma? ❑ Yes ❑ No

있다면, 관계?If yes, which relative?

- ❑ 어머니 Mother
- ❑ 아버지 Father
- ❑ 여자형제 Sister
- ❑ 남자형제 Brother
- ❑ 딸 Daughter
- ❑ 아들 Son
- ❑ 삼촌 Uncle
- ❑ 이모 Aunt
- ❑ 남자 조카 Nephew
- ❑ 여자 조카 Niece
- ❑ 할머니 Grand mother
- ❑ 할아버지 Grand father
- ❑ 손자 Grand son
- ❑ 손녀 Grand daughter

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Social History:

흡연 Smoking

- ❑ 모름 Unknown if ever smoked
- ❑ 매일 흡연 Current everyday smoker
- ❑ 파이프 흡연 Current some day smoker (tobacco)
- ❑ 담배 흡연 Current some day smoker (cigarette)
- ❑ 예전에 흡연 Former smoker
- ❑ 피운적 없음 Never smoker
- ❑ 담배를 피우긴하나 잘 모름 Smoker, current status unknown
- ❑ 시가 흡연자 Cigar smoker
- ❑ 매우 많이 피움 Heavy tobacco smoker
- ❑ 적당히 피움 Light tobacco smoker

Other

- ❑ 없음 None
  - ❑ 성생활을 하지 않습니다 Not sexually active
  - ❑ 한명과 성생활을 합니다.Sexually active with one partner
  - ❑ 한명 이상과 성생활을 합니다.Sexually active with more than one partner
  - ❑ 똑같은 파트너와 성생활을 합니다.Same sex partner
  - ❑ 마약을 사용합니다 Drug use
  - ❑ 혈관 마약을 사용합니다. IV Drug Use
  - ❑ 에탄올 술 안마심 EtOH none
  - ❑ 에탄올 술 하루에 한잔 EtOH less than 1 drink per day
  - ❑ 에탄올 술 하루에 1-2 잔 EtOH 1-2 drinks per day
  - ❑ 에탄올 술 하루에 3 잔이상 EtOH 3 or more drinks per day
  - ❑ 집에서 안전함을 느낍니다.Patient feels safe at home
  - ❑ 집에서 불안함을 느낍니다.Patient feels unsafe at home

운전 Driving Status

- ❑ 낮에 운전을 합니다.Drive in the daytime
- ❑ 밤에 운전을 합니다. Drive at night

Review of Systems:

Yes	No	Name	System
❑	❑	고혈압 High blood pressure	Cardiovascular
❑	❑	가슴 통증 Chest pain	Cardiovascular
❑	❑	심장 마비 Heart attack	Cardiovascular
❑	❑	호흡곤란 Shortness of breath	Respiratory
❑	❑	뇌출혈 Stroke	Cardiovascular
❑	❑	체중감소 Unintentional weight loss	Constitutional / Symptom
❑	❑	우울증 Depression	Psychiatric
❑	❑	당뇨 Diabetes	Endocrine
❑	❑	갑상선 질환 Thyroid problems	Endocrine
❑	❑	빈혈 Anemia	Hematologic / Lymphatic

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Yes	No	Name	System
❑	❑	수혈 Blood transfusion	None
❑	❑	암 Cancer	Other
❑	❑	다발성 경화증 Multiple sclerosis/numbness	Neurological
❑	❑	루프스 Lupus	Allergic / Immunologic
❑	❑	관절염/근육통 Arthritis/muscle pain	Musculoskeletal
❑	❑	류마티스 질환 Rheumatic disease	Allergic / Immunologic
❑	❑	천식/ 건초열 Asthma/hay fever	Allergic / Immunologic
❑	❑	기종 Emphysema	Respiratory
❑	❑	불쾌감(아픈거 같은 기분)Malaise (feel sick)	Constitutional / Symptom
❑	❑	발열 또는 오한 Fever or chills	Constitutional / Symptom
❑	❑	두통 Headaches	Neurological
❑	❑	헤르피스 Fever blisters/cold sores	Other
❑	❑	피 안멈춤 Problems with bleeding	Hematologic / Lymphatic
❑	❑	상처가 잘 낫지 않음 Problems with healing	Integumentary
❑	❑	흉이 짐 Problems with scarring (hypertrophic or keloid)	Integumentary
❑	❑	발진 Rash	Integumentary
❑	❑	면역억제 Immunosuppression	Allergic / Immunologic
❑	❑	식은땀 Night sweats	Constitutional / Symptom
❑	❑	목 아픔 Sore throat	ENT and Mouth
❑	❑	흐린 시야 Blurry vision	Eyes
❑	❑	복통 Abdominal pain	Gastrointestinal (G.I.)
❑	❑	혈변 Bloody stool	Gastrointestinal (G.I.)
❑	❑	혈뇨 Bloody urine	Genitourinary (G.U.)
❑	❑	근육 약함 Muscle weakness	Musculoskeletal
❑	❑	목 당김/목결림 Neck stiffness	Musculoskeletal
❑	❑	발작 Seizures	Neurological
❑	❑	기침 Cough	Respiratory
❑	❑	천명 Wheezing	Respiratory
❑	❑	불안장애 Anxiety	Psychiatric

METRO DERMATOLOGY

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Alerts:

Yes	No	Name
❑	❑	인공 관절 Artificial joints
❑	❑	인공 심장 밸브 Artificial heart valve
❑	❑	피스메이커/맥박조정장치 Pacemaker/defibrillator
❑	❑	혈액응고 Blood clots
❑	❑	결핵 Tuberculosis
❑	❑	에이즈 HIV/AIDS
❑	❑	B 형 또는 C 형 간염 Hepatitis B or C
❑	❑	간질환 Liver problem
❑	❑	신장질환 Kidney problems
❑	❑	마취약/치과 마취에 대한 알러지 Allergy to lidocaine/dental anesthesia
❑	❑	접착제에 대한 알러지 Allergy to adhesive
❑	❑	고무 알러지 Allergy to latex
❑	❑	항생연고 알러지 Allergy to topical antibiotic ointments
❑	❑	혈액응고 방지제 Blood thinners
❑	❑	멀싸 MRSA
❑	❑	Premedication prior to procedures
❑	❑	에피네프린에 의한 가파른 심장박동 Rapid heart beat with epinephrine
❑	❑	임신중 또는 임신 계획 Pregnancy or planning a pregnancy

현재 복용중이신 약:Current Medications:

알러지:Allergies:

Patient/Guardian Signature : X_____ **Date:**_____