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

工卡號碼 Soc. Sec. #: _____ – _____ – _____

名字 **:** _____ _____ _____
Name Last (姓) First (名) M.I.

地址 : _____ Apt. #(公寓號碼): _____
Street Address (街道地址)

City (城市): _____ State(州): _____ (郵政編碼)Zip: _____

年齡**:** _____ 出生日期**:** _____月_____ 日 _____ 年 婚姻狀況**:** ☐單身 ☐ 已婚 ☐ 其他 性別**:** ☐ 男 ☐ 女
Age Date of Birth: MM DD YY Marital Status: Single Married Other Sex: Male Female

電話號碼 **:** (_____) _____ – _____ 手機號碼**:** (_____) _____ – _____
Home Phone Cellular Phone

緊急聯繫名字**:** _____ 緊急聯繫電話號碼**:** (_____) _____ – _____
Emergency Contact Emergency Phone

轉診醫生**:** _____ 電話**:** (_____) _____ – _____
Referring Doctor Phone

電郵地址(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.

主要保险 **Primary Insurance** 你的保险需要专疹单看专科吗? Does your insurance require a referral to see the specialist? ☐ **Yes (是)** ☐ **No(不是)**

保險公司**:** _____ 保險號碼**:** _____
Insurance Carrier Insurance ID #

保單持有人**:** _____ _____ _____
Subscriber's Name Last (姓) First (名) M.I.

持有人出生日期**:** _____ 月 _____ 日 _____ 年 與病人關係**:** _____
Subscriber's DOB MM DD YY Relationship to Patient

第二保險 **Secondary Insurance (If Applicable)**

保險公司**:** _____ 保險號碼**:** _____
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.
3. _____

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

Date of Birth: ____/____/_____

Patient Health Questionnaire (ROS)

Please answer ALL questions

您是否曾有以下病症或病例? Do you have now or have you ever had diseases or conditions of: (Please check YES or NO)

	是Yes	否No		是Yes	否No
人工关节置换 Artificial joint	❑	❑	糖尿病 Diabetes	❑	❑
人工心脏瓣 Artificial heart valve	❑	❑	甲状腺疾病 Thyroid problems	❑	❑
点击起搏器或点击去纖顫器 Pacemaker or defibrillator	❑	❑	多发性硬化病 / 麻痹 Multiple sclerosis/numbness	❑	❑
血块，血栓， 血凝块 Blood clots	❑	❑	输血 Blood transfusion	❑	❑
肺结核 Tuberculosis	❑	❑	癌症 Cancer	❑	❑
艾滋病 HIV/AIDS	❑	❑	贫血 Anemia	❑	❑
乙型肝炎或丙型肝炎 Hepatitis B or C	❑	❑	关节炎 / 肌肉痛 Arthritis/muscle pain	❑	❑
肝病 Liver problems	❑	❑	红斑性狼疮 Lupus	❑	❑
肾病 Kidney problems	❑	❑	风湿性疾病 Rheumatic disease	❑	❑
高血压 High blood pressure	❑	❑	气喘 / 花粉热，甘草热 Asthma/hay fever	❑	❑
胸口疼痛 / 闷 Chest pain	❑	❑	肺气肿 Emphysema	❑	❑
心脏病 Heart attack	❑	❑	唇疱疹 Fever blisters/cold sores	❑	❑
咳嗽气促或呼吸困难等病徵 Shortness of breath	❑	❑			
中风 Stroke	❑	❑	生体不适，压抑 Malaise (feel sick)	❑	❑
体重下降 Recent weight loss	❑	❑	发烧，发冷（现行） Fever or chills (currently)	❑	❑
忧郁症 Depression	❑	❑	头疼（现行） Headache (currently)	❑	❑

请列写任何以上以外的病史或病症：
List of any other diseases or conditions: _____

_____

_____

您是否曾有以下皮肤病症或病例? Skin: Have you ever had any of the following?

- ❑ 皮肤恶性黑色素瘤 Melanoma
- ❑ 皮肤癌 Skin cancer
- ❑ 发育不良痣，非典型痣 Unusual moles
- ❑ 银屑症 / 牛皮癣 Psoriasis
- ❑ 疤痕体质 Excessive scarring
- ❑ 瘢痕瘤 / 瘢痕疙瘩 Keloid
- ❑ 阳光烧伤性水泡 Blistering sunburn
- ❑ 湿疹 / 异位性皮炎 Eczema/Atopic dermatitis

您的职业是? What is your occupation? _____

病人签名: _X_____ Patient Signature

日期 ____/____/_____ Date

医疗人员签名 _____ Staff Print Signature

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

Date of Birth: ____/____/_____

Patient Health Questionnaire (PFSH) 病人健康问卷

Medical History

❖**您是否对任何药物敏感？** Are you allergic to any medication(s)? ❑ 是 Yes ❑ 否 No

如是，请列写让您敏感的药物名称
If yes, list allergic medications(s) _____

❖**您是否对牙科专用的麻醉素敏感？** Do you have allergy to dental anesthesia? ❑ 是 Yes ❑ 否 No

❖**您是否对创口贴敏感？** Do you have a band age allergy? ❑ 是 Yes ❑ 否 No

❖**您是否对乳胶(latex)／乳胶手套敏感？** Do you have latex allergy? ❑ 是 Yes ❑ 否 No

❖**请列写任何手术或住院病史：** Any recent surgeries or hospitalizations? ❑ 是 Yes ❑ 否 No

如是，请列写
If yes, what are they? _____

❖**您现在是否在服用任何药物 （包括中药或维他命）？** ❑ 是 Yes ❑ 否 No
Are you taking any medications currently (including over the counter medications such as multi-vitamins)?

如是， 请列写药物名称
If yes, what are they? _____

_____

❖**您是否在服用以下药物？** Do you take any of these medications? ❑ 是 Yes ❑ 否 No

如是， 请打勾 ❑ Vitamin E ❑ Aspirin ❑ Motrin/Ibuprofen
If yes, please check ❑ Aleve ❑ Coumadin ❑ 其他

Family History

家族病史是否有包括以下病症? Have any close relatives had any of the following? ❑ 是 Yes ❑ 否 No

如是，请打勾 ❑ 皮肤恶性黑色素瘤 Melanoma ❑ 发育不良痣／非典型痣 Unusual Moles
If yes, please check ❑ 皮肤癌 Skin Cancer ❑ 严重痤疮，俗称青春痘 Severe acne ❑ 湿疹／特应性 Eczema
❑ 银屑病，俗称牛皮癣 Psoriasis

Social History

❖**您是否喝酒?** Do you drink alcohol?
❑ 从来不喝 Never ❑ 偶尔，少量 Socially (few weeks)
❑ 每周 Moderately (weekly) ❑ 每周数次 Heavily (More than weekly)

❖**您是否抽烟?** Do you smoke tobacco?
❑ 从来不抽 Never ❑ 已戒 Previously, but quit
❑ 抽烟 Currently smoking 每天 ____包 packs / day

您是否有娱乐性吸毒? Do you use recreational drugs? ❑ 是 Yes ❑ 否 No
您是否涂用防晒产品? Do you use sunscreen? ❑ 是 Yes ❑ 否 No
您是否有穿戴帽子? Do you wear hats? ❑ 是 Yes ❑ 否 No

病人签名 Patient Signature X_____ 日期 ____/____/_____ Staff Print Signature _____

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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 Lee 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
- Annual deductibles
- Coinsurances
- 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. 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)