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. #: _____ – _____ – _____

Name: _____ _____ _____
Last First M.I.

Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: _____ /_____ /_____ Marital Status: ☐ Single ☐ Married ☐ Others Sex: ☐ Male ☐ Female

Cell Phone #: (_____) _____ – _____ Home # : (_____) _____ – _____

Emergency Contact: _____ Emergency Phone: (_____) _____ – _____

Referring Doctor: _____ Phone: (_____) _____ – _____

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**

Subscriber's Name: _____ _____ _____
Last First M.I.

Subscriber's DOB: _____ /_____ /_____ Relationship to Patient: _____

Secondary Insurance (If Applicable)
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 Metro 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. <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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Patient Name: _____ Today's Date: ____/____/_____

Date of Birth: ____/____/_____

Patient Health Questionnaire (PFSH)

Please answer ALL questions

Medical History

❖Are you allergic to any medication(s)? ❑ Yes ❑ No

If yes, list allergic medications(s) _____

❖Do you have allergy to dental anesthesia? ❑ Yes ❑ No

❖Do you have a bandage allergy? ❑ Yes ❑ No

❖Do you have latex allergy? ❑ Yes ❑ No

❖Any recent surgeries or hospitalizations? ❑ Yes ❑ No

If yes, what are they?

_____

❖Are you taking any medications currently (including over the counter medications such as multi-vitamins)? ❑ Yes ❑ No

If yes, what are they? _____

_____

❖Do you take any of these medications? ❑Yes ❑ No

If yes, please check ❑ Vitamin E ❑ Aspirin ❑ Motrin/Ibuprofen

❑ Aleve ❑ Coumadin ❑Other blood thinner

Family History

Have any close relatives had any of the following? ❑ Yes ❑ No

If yes, please check) ❑ Melanoma ❑ Skin Cancer ❑ Unusual Moles

❑ Severe acne ❑Psoriasis ❑ Eczema

Social History

❖ Do you drink alcohol? ❑Never ❑ Socially (few weeks)

❑ Moderately (weekly) ❑ Heavily (More than weekly)

❖ Do you smoke tobacco? ❑ Never ❑ Previously, but quit

❑ Currently smoking ____packs / day

Do you use recreational drugs? ❑ Yes ❑ No

Do you use sunscreen? ❑ Yes ❑ No

Do you wear hats? ❑ Yes ❑ No

Patient Signature X_____ Date ____/____/_____ Staff Signature_____

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

Date of Birth: ____/____/_____

Patient Health Questionnaire (ROS)

Please answer ALL questions

Do you have now, or have you ever had diseases or conditions of: (Please check **YES** or **NO**)

	Yes	No		Yes	No
Artificial joint	❑	❑	Diabetes	❑	❑
Artificial heart valve	❑	❑	Thyroid problems	❑	❑
Pace maker or defibrillator	❑	❑	Anemia	❑	❑
Blood clots	❑	❑	Blood transfusion	❑	❑
Tuberculosis	❑	❑	Cancer	❑	❑
HIV/AIDS	❑	❑	Multiple sclerosis/numbness	❑	❑
Hepatitis B or C	❑	❑	Lupus	❑	❑
Liver problems	❑	❑	Arthritis/muscle pain	❑	❑
Kidney problems	❑	❑	Rheumatic disease	❑	❑
High blood pressure	❑	❑	Asthma/hay fever	❑	❑
Chest pain	❑	❑	Emphysema	❑	❑
Heart attack	❑	❑	Fever blisters/Cold sores	❑	❑
Shortness of breath	❑	❑			
Stroke	❑	❑	Malaise (feel sick)	❑	❑
Recent weight loss	❑	❑	Fever or chills (currently)	❑	❑
Depression	❑	❑	Headache (currently)	❑	❑

List of any other diseases or conditions: _____

_____

_____

Skin: Have you ever had any of the following?

❑ Melanoma ❑ Skin cancer ❑ Unusual moles

❑ Psoriasis ❑ Excessive scarring ❑ Keloid

❑ Blistering sunburn ❑ Eczema/Atopic dermatitis

What is your occupation? _____

Patient Signature:X_____ Date: ___/____/_____ Staff Print Signature:_____