
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 11372

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Last First M.I.**

**Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_ /\_\_\_\_\_\_ /\_\_\_\_\_\_ Social Security \_\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_**

**Marital Status: □Single □Married □Others Sex: □ Male □ Female**

**EmailAddress:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cell Phone #: ( \_\_\_\_\_\_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_ – \_\_\_\_\_\_\_\_\_\_\_\_\_ □ Request opt-out of receiving**

**text for appointment reminders**

**Home # : ( \_\_\_\_\_\_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_ – \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EmergencyPhone:(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary/ Referring Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dr. Phone:(\_\_\_\_) \_\_\_\_\_\_\_ – \_\_\_\_\_\_\_\_\_**

**Preferred Language: □ English □ Español □ 한국어 □ 國 語 □ 廣東語 □ 日本語 □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did you hear about us?: □ Doctor Referral □ Family / Friend Referral**

**□ Insurance Directory □ Online Advertisement**

**□ Paper Advertisement □ TV / Radio Advertisement**

**Preferred Pharmacy**

**Pharmacy Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pharmacy Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_**



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In accordance with the Health Insurance Portability and Accountability Act (HIPAA) ,Privacy Rule, we do not disclose your Protected Health Information (PHI) without your permission. Please provide the name(s) and phone number(s) of any person(s) other than yourself with whom we can discuss the following;

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

Authorized Individuals Names (Print) Phone Numbers

**By signing this form** I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **AUTHORIZE and/or ACKNOWLEDGE as followings**: (Patient name/Guardian)

1. Metro Dermatology may submit all claims on my behalf. I also authorize assignment of benefits directly to this office and release of any records requested by my insurance carrier(s). \_\_\_\_\_\_\_\_\_\_

 **Initials**

1. IF PAYMENT IS NOT RECEIVED I AM RESPONSIBLE FOR THE ENTIRE BALANCE OF THE BILL (***Copay, co-insurance, deductible, including terminated coverage charges***). I FUTHER 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 \_\_\_\_\_\_\_\_\_\_\_\_\_ **Initials**

1. Medical photographs may be taken of me or my child (or person for whom I am legal guardian).

I understand that the information may be used needed, for purposes of Pre-authorization for procedures or prescription approval. 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 the practice. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⎕ **I CONSENT** ⎕ **I REFUSE**

 **Initials**

1. Metro Dermatology Practice Policy, version 100915 is available for review upon my request.

 \_\_\_\_\_\_\_\_\_\_ **Initials**

1. I acknowledge I have seen a copy of the “Notice of Privacy Practices” posted in the office lobby.

HIPAA Notice of Privacy Practices is available for review upon my request. **\_\_\_\_\_\_\_\_\_\_\_\_**

 **Initials**

|  |  |  |
| --- | --- | --- |
|  x |  | / / |
| **Print and Signature/Patient or legal representative** |  | Date |