ADVANCED DERMATOLOGY, P.C.
CENTER FOR LASER & COSMETIC SURGERY

Please fill out completely and return to the front desk.

Today's date: ____ /_____ / _____

First Name: _____Middle:_____

Last Name: _____

Date of Birth: ____/_____/_____ Age: _____

S.S. #: _____-_____-_____

Address: _____ Apt: _____

City: _____State: _____Zip: _____

Cell Phone ( ) _____

Home Phone *(Land)* ( )_____

Work Phone ( )_____

E-mail: _____

☐ You are granting Advanced Dermatology, P.C. permission to use your e-mail for emergency contact, educational material, and other communications and promotions. You are also granting permission to send text and voice appointment reminders to your phone.

☐ Would you like to enroll in our **Patient Portal** to access test results, prescription refills, etc. online? For additional benefits please see the following page.

Occupation: _____

Sex: ☐ M ☐ F ☐ Check if minor (younger than 18)

Marital Status: ☐ Single ☐ Married ☐ Divorced

☐ Widowed ☐ Separated

Race _____ Ethnicity _____

Preferred Language _____

Referred by: Doctor / Sign / Friend / Family / Article / Internet Search / Insurance Website / Our Website / ZocDoc / Yelp / Healthgrades / Mailing, Postcard

Other: _____

Name of referring friend: _____

Name of referring doctor: _____

Address: _____

City: _____ State: _____

Zip: _____ Phone #: ( ) _____

Name of Primary Care Doctor: _____

Employer: _____

Employer Address: _____

City: _____State: _____ Zip: _____

Work Phone #: ( ) _____

Spouse/Parent/Guardian's Name:_____

Employer: _____

Phone #: ( ) _____

Medical Emergency Contacts (List names and phone #s)

Name: _____ Phone #: ( )_____

Name: _____ Phone #: ( )_____

Pharmacy Name: _____

Address: _____

Health Insurance Information

Primary Insurance Name: _____

Name of Insured: _____

Relationship to patient: ☐ Parent ☐ Spouse ☐ Self ☐ Other

Date of birth:_____/_____/_____ ☐ Male ☐ Female

Insurance ID #: _____

S.S. # of insured:_____

Employer/Group name:_____

Group #: _____ Co-pay amount $_____

Do you have a prescription drug plan? ☐ Yes ☐ No

Secondary insurance name: _____

Name of insured: _____

Relationship to patient: ☐ Parent ☐ Spouse ☐ Self ☐ Other

Date of birth: _____/_____/_____ ☐ Male ☐ Female

Insurance ID #: _____

S.S. # of insured:_____

** If ever a change in insurance information or medical condition it is important you inform us.*

PLEASE READ THIS STATEMENT BELOW CAREFULLY AND SIGN: All information on all sections of this form including the Medical History & Financial Policy are true and complete. I agree to inform you on subsequent visits if any Medical History or Insurance Information changes, or if I move. My signature will also be used as "signature on file" for insurance purposes including any medical information necessary to process the claim. I give permission for medical photographs to be taken and they may be used for educational purposes. **I hereby assign my insurance benefits to be paid directly to Advanced Dermatology, P.C.** I have read Advanced Dermatology P.C.'s **updated** financial policy and agree that I am ultimately responsible for all non-covered services, and broken appointments, rendered to me or my dependents.

_____
Print Patient's Name

SIGN HERE → _____
Patient's or Guardian's Signature

I have read the HIPAA consent and if I do not sign this form below, Advanced Dermatology, PC may decline to provide treatment to me. My signature below states that I agree with its contents.

_____
Print Patient's Name

SIGN HERE → _____
Patient's or Guardian's Signature

Modified: 02/22/2018

Financial Policy

Thank you for selecting Advanced Dermatology, P.C. for your dermatological cares. In order to prevent any misunderstanding concerning the responsibility regarding payment for medical/ surgical and/or any laboratory fees, the following is provided.

HMO/PPO/Other Insurance Coverage: If you have insurance through a company we have contracted with, we will require a copy of your insurance card and a driver's license. **All co-payments are due prior to seeing the physician.** If your insurance carrier requires a referral from your primary care physician, this must be present at the time of service. Failure to provide all necessary information may require you to pay in full on the date of the visit. It is your responsibility to keep track of the referral expiration dates and the number of visits given by your primary care physician. You will be responsible for any services denied by your insurance carrier as not medically necessary and/or not covered. If you have coverage with an insurance carrier with which we do not participate ("out of network"), payment is due at the time of service. We will provide you with a receipt that you can submit to your carrier for reimbursement, if applicable.
Medicare: Our physicians are participating Medicare providers and accept Medicare assignment, which is the ALLOWABLE charge approved by Medicare. Medicare will pay 80% of the allowable charges after you pay for your annual deductible. You are responsible for any amounts applied to your deductible and the 20% co-insurance. If you have a secondary insurance, as a courtesy we will submit to that particular carrier any remaining balance. You will also be responsible for any services denied by your insurance carrier as not medically necessary and/or not covered.
Laboratory: Depending on your insurance carrier's policy, you may be required to pay a separate co-payment for any specimen taken during your visit.
Self-Pay Patients (Will Pay): Patients with no insurance, the guarantor is responsible for the bill at the time of service.
Cosmetic Patients: Deposits are required prior to the date of the procedure. The balance of the payment is required prior to the procedure being performed.
Payments: We utilize a guaranteed check service, which automatically deducts the amount of your check from your account immediately. This is similar to how your credit or debit card works by showing us if funds are available in your account.
Refund Policy: We do not offer refunds on medical and cosmetic procedures.
Cancellation Policy: A $25 charge will be made for all no-show appointments unless 24 hours notice is given. A $100 charge will be made for all no-show surgical appointments unless 24 hours notice is given.
Returned Checks & Collections: A charge of $25 will be made for all returned checks. In the event that any action is brought to collection, you agree to pay any reasonable collection costs and/or attorney fees.

It is our policy to maintain credit card charge authorizations on file, in order to secure payment for insurance-related patient balances. This practice saves our patients the hassle of paying mailed invoices, and avoids the potential risk to our patients of collection agencies and credit bureaus. You can feel secure sharing this informaiton with us - it is our policy to treat your financial information with the same respect and privacy guidelines as your medical records. We do not keep copies of your credit card. This informatio is stored in an encrypted system through our credit card merchant.

In providing your information, you authorize payment by credit card services in the abscene of coverage by your health benefit plan (including but not limited to, co-payment, co-insurance, deductible, terminated coverage, cosmetic procedures, products, failure to provide student status, and any other patient financial responsibilites as outlined in our Billing and Collection policy forms signed by each patient), for charges up to $250.00 per each date of service obtained by the patient at any of our offices, if services pertain to MOHS, charges will be up to $1000.00. If your financial responsibility exceeds that amount, the first $250.00 or $1000.00 per date of service will be charged to your card upon our receipt of your insurer's Explanation of Benefits (either via mail or electronically), and you will be billed for any remaining balance by mail.

Modified: 02/22/2018

HIPAA Consent

Patient Consent for use and Disclosure of Protected Health Information

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With my consent Advanced Dermatology, P.C. may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Advanced Dermatology, P.C.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices. Advanced Dermatology, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Advanced Dermatology, P.C.'s Privacy Officer.

With my consent Advanced Dermatology, P.C. may call or text my home or cell phone, or other designated location, and leave a message on voicemail in reference to any items that assist the practice in carrying out TPO such as appointment reminders, prescription renewals, lab results, insurance items, all other PHI and return calls requesting a call back.

Other designated numbers:

( ) _____
Home / Cell / Office / Other

( ) _____
Home / Cell / Office / Other

( ) _____
Home / Cell / Office / Other

With my consent on the front page, Advanced Dermatology, P.C. may mail to my home or other designated location or e-mail me any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked Personal and Confidential. I agree that my PHI may be shared with my spouse and the following other people.
1. _____
2. _____
3. _____

I have the right to request that Advanced Dermatology, P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions. If it does, it is bound by this agreement. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent.

** We have a larger print copy of the Financial Policy and the complete HIPPAA guidelines available for your review, if requested.*

We offer a wide variety of services. Are you interested in any of the following?

- ☐ Acne Scarring / Enlarged Pores
- ☐ Age Spots / Sun Spots
- ☐ Breast Augmentation
- ☐ Broken Blood Vessels/Spider Veins
- ☐ Cellulite
- ☐ Double Chin Reduction
- ☐ Earlobe Repair
- ☐ Eyelid Lift
- ☐ Exessive Sweating
- ☐ Facelift
- ☐ Facial Contouring
- ☐ Fat Reduction (Non-Surgical)
- ☐ Fat Reduction (Surgical)
- ☐ Hair Removal
- ☐ Lip Augmentation
- ☐ Lip Rejuvenation
- ☐ Skin Tightening
- ☐ Stretch Marks
- ☐ Tattoo Removal
- ☐ Under Eye Darkness
- ☐ Vaginal Rejuvenation
- ☐ Wrinkles

Are you interested in any of our skin care lines?

- ☐ Acne
- ☐ Skin Rejuvenation
- ☐ Skin Discoloration
- ☐ Moisturizer
- ☐ Reducing Fine Lines
- ☐ Hair Products
- ☐ Sun Screens

Are there any other products you are interested in?

_____

_____

_____

This office is now accredited to dispense custom medication at reduced cost at the time of your visit. Are you interested?

☐ Yes ☐ No

IMPORTANT PLEASE READ INSTRUCTIONS FOR EXAM ROOM

- Please remove chewing gum, candies, or any food prior to the exam.
- Please turn off all electronic devices when leaving the waiting room.
- Please take facial make-up off prior to being examined.
- If nail disorder, please remove nail polish (we can provide remover)
- If getting undressed, please put clothing on chair and not on counter.
- Please keep on only underpants and bra (optional) when undergoing complete body exam.
- If any hand problems we usually like to examine feet, so please remove your shoes and socks.

Thank you for choosing Advanced Dermatology, P.C., a premier dermatology practice specializing in conditions of skin, hair, and nails in adults and children. In addition to medical conditions we are famous for our laser and cosmetic surgery and for the latest in medical treatments. We presently feature the most skin and cosmetic lasers of any multi-facility group practice in New York.

Please visit our very informative website www.GetMeGreatSkin.com. On the website we invite you to view our before and after procedure book, brochures, and videotapes on cosmetic and medical conditions, and articles written by our doctors and interviews of our doctors in the press. We also offer, on our website, information on most skin conditions, fact sheets on medications, and other resources. You can check our website for upcoming events and other informative information.

www.GetMeGreatSkin.com

Patient Portal Enrollment

☐ Yes! I would like to enroll in Patient Portal

We are happy to announce our new private and secure communication system/Patient Portal that allows you to correspond with our office via a protected and encrypted website. Sign up for Portal Access and you will have the ability to:

✓ Receive test results
✓ Request prescription refill
✓ Contact our appointment staff
✓ Contact procedure coordinators

For any non-urgent questions regarding your health care, medications, appointments, insurance issues, and surgical scheduling, send us an e-mail and we will respond promptly. For all urgent matters, please continue to call the office directly.

We encourage you to participate in this program to enhance our service to you. If you check yes above, you will receive an e-mail whose subject will be "An Important Message from Advanced Dermatology." Within that e-mail, there will be several links that will enable you to connect to the portal in order to complete your registration. If you do not receive any message, please be certain to check your spam folder and your spam settings.

Modified: 02/22/2018

MEDICAL HISTORY

Print name: _____

Reason for today's visit/chief complaint: _____
_____
_____

When was your last physical examination (date)?
____/ ____ / _____

Physician's name:_____
Phone #: ( ) _____

We strongly recommend a complete body exam for skin cancer screening. Would you like to schedule an appointment for that exam?
☐ Yes ☐ No

PERSONAL SKIN HISTORY

Basal Cell Carcinoma	☐ Yes	☐ No
Squamous Cell Carcinoma	☐ Yes	☐ No
Melanoma	☐ Yes	☐ No

Location/Year/Depth: _____
_____

Allergies	☐ Yes	☐ No
Food	☐ Yes	☐ No

If yes, what type? _____

Environment	☐ Yes	☐ No

If yes, what type? _____

Psoriasis	☐ Yes	☐ No
Radiation Therapy	☐ Yes	☐ No
Eczema	☐ Yes	☐ No

Have you ever had a sunburn? ☐ Yes ☐ No
# of times _____

Other skin conditions: _____
_____
_____

Have you ever had any laser, cosmetic, or plastic surgery procedures performed on you? ☐ Yes ☐ No
Procedures/when: _____
_____

List other operations, surgery, or diseases:
_____
_____
_____
_____

Have you ever been seen in any Advanced Dermatology, P.C. office? ☐ Yes ☐ No
When? _____ / _____ / _____
Which office? _____

Seen by any other dermatologist? ☐ Yes ☐ No
Who/When/For what problems? _____
_____
_____

Have you ever had or have allergies to these medications?

Reaction to: (*Please Check*)			Reaction Type/Date
Penicillin	☐ Yes	☐ No	_____
Lidocaine	☐ Yes	☐ No	_____
Latex	☐ Yes	☐ No	_____
Other _____			_____

Tobacco use (circle one): Former smoker / Never smoker
Current Everyday Smoker / Current Some Day Smoker / Unknown If Ever Smoked

Medications ☐ Yes ☐ No
Current oral medications, herbs, health foods, supplements, birth control pills, etc. _____
_____
_____

Aspirin/Aleve/Advil/etc.	☐ Yes	☐ No
Blood thinners	☐ Yes	☐ No
Accutane	☐ Yes	☐ No
Past use of Accutane?	☐ Yes	☐ No

If yes, when? _____
Current topical and over-the-counter medications and creams:
_____
_____
_____

PAST MEDICAL HISTORY

Arthritis	☐ Yes	☐ No
Asthma/Bronchitis	☐ Yes	☐ No
Bleeding Problems	☐ Yes	☐ No
Cancer	☐ Yes	☐ No

Type/when _____

Chemotherapy	☐ Yes	☐ No
Chicken Pox	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Insulin Dependent	☐ Yes	☐ No
Drug or Alcohol Abuse	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Hepatitis Type	☐ Yes	☐ No
Herpes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Keloid/Enlarged Scars	☐ Yes	☐ No
Latex Sensitivity	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Low Platelet Condition	☐ Yes	☐ No
Lung Disease	☐ Yes	☐ No
Mitral Valve Prolapse/ Valve Replacement	☐ Yes	☐ No
Pacemaker/Defibrillator	☐ Yes	☐ No
Poor/Non-Healing Wounds	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Venereal/Sexual Disease	☐ Yes	☐ No

FAMILY HISTORY

Basal cell carcinoma	☐ Yes	☐ No
Squamous cell carcinoma	☐ Yes	☐ No
Melanoma	☐ Yes	☐ No

Who/location: _____
_____

Allergies	☐ Yes	☐ No

Type: _____

Asthma/Bronchitis	☐ Yes	☐ No
Psoriasis	☐ Yes	☐ No
Eczema	☐ Yes	☐ No
Lupus	☐ Yes	☐ No

Other skin conditions/explain:
_____
_____

Social History

Do you drink alcohol?	☐ Yes	☐ No

How much? _____

Do you use drugs?	☐ Yes	☐ No
Regular periods?	☐ Yes	☐ No
Use birth control?	☐ Yes	☐ No
Are you pregnant now?	☐ Yes	☐ No
Are you breastfeeding now?	☐ Yes	☐ No
Ever been pregnant?	☐ Yes	☐ No

Number of pregnancies: _____

Height:_____ Weight (lbs)_____

Other pertinent information: _____
_____
_____

Modified: 02/22/2018