ADVANCED DERMATOLOGY LASER & COSMETIC SURGERY

35 West End Avenue Brooklyn, NY 11235
718-375-7546 (Tel) 718-513-4561 (Fax)

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name:______________________________ First Name:______________________
DOB: ______________ SS: ______________________ Sex: __________________
Home Address: ____________________ Apt:_______ City:__________ State:_____ Zip :_________
Home Phone: _________________ Cell Phone: ____________________
Work Phone: _________________ Can we contact you at work? Y___ N___
E-mail:____
Emergency Info: Contact Person:__________________Phone Number: __________________
Referring Doctor: _________________________ Phone Number: __________________
Race: American Indian ___ Asian ___ Black ___ Native Hawaiian ___ Type-Unknown ___ White___
Ethnicity: Hispanic Origin ___ Non-Hispanic Origin ___ Type-Unknown ___
Preferred Language: ____
Smoking Status: Smoker ___ Never Smoker ___ Former Smoker ___ Current Every Day Smoker ___

PRIMARY INSURANCE

Name of Insurance Plan: _________________________Insurance ID#:__________________
Employer Name: _________________________ Address: ______________________
Work Phone: _________________ Can we contact you at work? Y___ N___
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________________

GUARANTOR INFORMATION

Last Name: _________________ First name: _________________ DOB:___________
SS: ___________ Relationship to Patient: ___Self ___Spouse ___Child ___Other_______________
Home Address: ___________________________________ Home Phone: ______________
Employer Name: ____
Employer Address: _______________________________ Work Phone: ______________

SECONDARY INSURANCE

Name of Insurance Plan: ____________________________Insurance ID#_______________
Name of Insured: ____ DOB:____________
SSN:_______________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other __________
Employer of Insured: _________________________ Phone: ________________________

I hereby authorize and direct my physician, having treated me, to release to government agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care, all information needed to substantiate payment for such care and treatment.

I request that payment of authorized benefits be made either to me or on my behalf to Dr. Eyal Levit for my service(s) provided by Advanced Dermatology Laser & Cosmetic Surgery if insurance will deny payment for the service(s).

PATIENT AGREES TO PAY ADVANCED DERMATOLOGY LASER & COSMETIC SURGERY ALL DENIED, UNPAID OR RECOVERED AMOUNTS IF THE LISTED INSURANCE INFORMATION IS DETERMINED TO BE INACCURATE OR INCOMPLETE, INCLUDING, BUT NOT LIMITED TO, BY STATING AN INCORRECT PRIMARY INSURER.

I agree that Advanced Dermatology Laser and Cosmetic Surgery may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

Pharmacy Name: ______________________________ **Pharmacy Phone:** ____________________

_________________________ _________________________ _______________
Patient's Signature Patient's Name (Print) Date

____ _______________
Signature of Patient's Representative/ Relationship Date

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PATIENT OFFICE VISIT AGREEMENT

I hereby attest that the information given to the Front Desk is **complete** and **current**.

Any Bills resulting from inappropriate information including but not limited to inaccurate insurance card, inactive insurance card, and other insurance cards available not handed, or missing referral are my responsibility.

Any bills resulting from **Incomplete**, **inaccurate**, or **missing information** will be my responsibility and will be paid by me in full.

Any bills resulting from outstanding balance of **Insurance Deductible** will be my responsibility and have to be paid in full before I can see the Doctor.

________________________________ __________________
Patient's Signature Date

________________________________ __________________
Patient's Name (print) Date

________________________________ __________________
Signature of Patient's Representative/ Relationship Date

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NOTIFICATION PRIVACY FORM

As a courtesy to our patients, we remind and/or notify our patients about their upcoming appointments, biopsy results, and/or cosmetic procedures over the phone. If you do not wish for us to disclose this information to your relatives or leave a message on your answering machine, please, let us know how else we may contact you.

We may use your e-mail to inform you of news updates in dermatology or on special events offered in our office.

Please check if Agree _____ Please check if Disagree _____

If you do not give us other ways of notifying you, then we are going to use the information given on your PATIENT REGISTRATION FORM in order to contact you.

Method of Notification that you prefer:

_____ Home Phone: ___________________________

_____ Cell Phone: ___________________________

_____ Work Phone: ___________________________

_____ E-Mail: ___________________________

Your understanding and cooperation in this matter is sincerely appreciated.

Signature of Patient:_______________________________ Date:______________________

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CONSENT FOR OUTPATIENT TREATMENT

AUTHORIZATION

- I hereby authorize Advanced Dermatology Laser & Cosmetic Surgery, the physicians and other healthcare professionals to provide such medical care and to administer such treatment, including immunization as deemed necessary or advisable to me or the named patient every time I or the named patient present to an ambulatory care service. To the extent possible I have been informed of risks and complications that may occur and alternatives that may be available.

- I acknowledge that no guarantees or assurances have been made to me concerning the results intended from my treatment.

- I authorize any holder of medical or other information about me to release the Social Security Administration and/or its intermediaries or carriers any information needed for this or a related claim.
- I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

GUARANTEE OF ACCOUNT

- For and in consideration of service(s) rendered to_______________________________________(Patient Name) by Advanced Dermatology Laser & Cosmetic Surgery.
  I hereby agree to pay for procedures that may possibly be denied by my insurance carrier.
  I have been instructed beforehand of this possibility and I am in compliance with this policy.
  After my primary insurance pays, I agree to pay the balance if my secondary insurance (coinsurance) fails to meet its responsibility.

RELEASE OF INFORMATION

- I permit Advanced Dermatology Laser & Cosmetic Surgery to use and disclose protected health information (PHI) for the purposes of treatment, payment, and healthcare operations, including quality assessment and measurement, and disease management activities

ASSIGNMENT OF BENEFITS

- **For Medicare patients only:** I request that payment of authorized Medicare benefits be made to me or on my behalf to Advanced Dermatology Laser & Cosmetic Surgery for services furnished to me by the provider. I authorize any holder of medical information about me to release it to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.
  Patient Signature____Date____________________

- I assign to Advanced Dermatology Laser & Cosmetic Surgery all benefits from all corporation agencies and person for these services.
  Additionally, I authorize payment of these benefits directly to Advanced Dermatology Laser & Cosmetic Surgery.
- I confirm that I have read and fully understood the above.

Patient/Relative or Guardian*: ____________________ ______________________ _____________
Signature Print Name Date

Relationship (if signed by the person other than patient: ____

Interpreter (if required): ____________________ ________________________________
Signature Print Name

Witness: ________________________ ____________________________ ______________
Signature Print Name Date

*The Patients signature must be obtained unless the patent is an unemancipated minor under the age of 18 or is incompetent to sign

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PATIENT NOTIFICATION RECORD OF CONFIDENTIALITY POLICY AND ADVANCE DIRECTIVES

PATIENT NAME_______________________________________

DOB_____________________________

INSURANCE_________________________

THE PATIENT NAMED ABOVE OR THE PATIENT'S FAMILY OR REPRESENTATIVE HAS BEEN GIVEN THE FOLLOWING NOTICES AS REQUIRED BY STATE AND FEDERAL REGULATIONS:

Confidentiality policy effective April 14, 2003
as required by HIPPA of 1996
Yes_____ NO_____

ADVANCE DIRECTIVES PACKET
Yes_____ NO_____

Does patient have Advance Directives?
Yes_____ NO_____

If YES specify:
Health Care proxy_____ Living Will_____ DNR_____ Other______________

COPY OF ADVANCE DIRECTIVES PLACED IN PATIENT'S MEDICAL RECORD:
YES_____ NO_____

INFORMATION COULD BE OBTAINED AND/OR PROVIDED AT THIS VISIT:
YES_____ NO_____

DOES PATIENT WISH ADDITIONAL INFORMATION:
YES_____ NO_____

PATIENT/ PATIENT'S REPRESENTATIVE REQUESTING ADDITIONAL INFORMATION AND REFERRED TO:
M.D. ___ R.N.___ Patient Representative___

_______________________________ ____________________
Patient's Signature Date

_______________________________ ____________________
Signature of Patient's Representative/ Relationship Date

_______________________________ ____________________
Witness/ Front Desk Representative Date

Advance Directives

What Are Advance Directives?

- They are legal documents that ensure your wishes are followed if you cannot make decisions for yourself. New York State recognizes three types of advance directives:
- New York State Health Care Proxy
- It lets you name a health care agent who will make decisions if you cannot make them yourself.
- It takes effect only after two doctors decide you are not able to make your own decisions.
- There is a Standard New York State form. When it is completed, give copies to your health care agent, your close family members, your doctors and others involved in your care.

Living Will

- It lets you say what care you want – or don't want – at the end of the life.
- It takes effect when you cannot make your own decisions, and your doctor confirms that you have an incurable condition.
- There is no Standard New York form. There are some sample forms available on-line. You can also write special instructions on your Health Care Proxy form.

Do Not Resuscitate (DNR) Order

- It tells health care providers and emergency workers not to revive you if you stop breathing or your heart stops beating.
- It takes effect when signed by your doctor.
- There is a Standard New York form.
- Hospitals have their own forms.
- Anyone not in a hospital can use a "Nonhospital Order Not to Resuscitate". Keep the form where everyone can see it.
- If you are too sick to agree to DNR, your health care agent or your closest family member can agree.
- You can also write DNR instructions on your Health Care Proxy form or Living Will.

Advance Directives Are Not Just for the Elderly

- There are times when people – even young, healthy people – cannot make their own decisions about medical care.
- You could be injured in an accident and arrive at the hospital unconscious.
- You might be under general anesthesia for routine surgery when something unexpected happens.
- You could have an illness that leaves you unable to speak, or you are comatose.

Who Will Speak for You?

- Friends or family members can always tell health care providers what they think you would want. *But in New York State, they cannon direct your medical care unless you appoint them in writing.*
- No one – not even your spouse – can act on your behalf unless you appoint them using the New York Health Care Proxy form. "Proxy" means "Substitute" – a person who can act as your agent.
- The New York Health Care Proxy form is an **advance directive** that lets you express your wishes in advance.
- You can say what care you do – or do NOT – want. Your health care proxy (your agent) must follow your directions.

Gain More Control Over Your Care.

- Everyone 18 and older should have a health care agent.
- When you appoint an agent, you help your family avoid confusion and conflict. There is no doubt about who will make decisions.
- When you appoint an agent, you claim your legal right to ask for – or refuse – medical care.
- Hospitals, nursing homes, doctors and other health care providers must follow your agent's decisions as if they were your own.

How to Appoint a Health Care Agent

- Select an adult you trust, such as a family member or a friend, as your agent on the New York State Health Care Proxy form. You can also name an alternate agent who will take over if your primary agent is not available.
- Discuss your wishes with your health care agent. Talk about your values and beliefs.
- No one can plan for every scenario. The more your agent knows, the easier it will be for that person to make decisions for you.
- If you wish, you can use the New York State Health Care Proxy form for write specific directions about the kind of care you want or don't want, just as you would in a *Living Will* or a *Do Not Resuscitate (DNR) Order.*
- If you like, you can simply write, "*my agent knows my wishes*".
- You can also use the New York State Health Care Proxy form to give instructions about organ donation, you wish.
- You do not need a lawyer or a notary to sing the form – just two adult witnesses.
- You can change your New York State Proxy form or appoint a new health care agent whenever you want. Simply fill out a new form.

Hospice: Care and Comfort at the End of Life

- Hospice is a service for people with terminal illness who are expected to live 6 months or less.
- Hospice care is designed to meet the physical, mental, spiritual, social and economic needs of patients and their families during the final stages of illness, dying and bereavement.
- Hospice care is given in hospitals, nursing homes, assisted-living facilities or at home.
- You or your health care agent can choose a hospice program in advance to meet your needs.
- Medicare, Medicaid and other health insurance plans often cover hospice care.

Resources:

- Call 311 and ask for Health Care Proxy forms.
- Health Care Proxy – Who Will Speak for You? (Health Care Proxy form and instructions available in English, Spanish, Chinese and Russian): 1-800-628-5972 or NYS Department of Health.
- New York State Hospice Information
- New York Legal Assistance Group

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CANCELLATION AND BROKEN APPOINTMENTS POLICY

If you are unable to keep an appointment, kindly, please give us:
48 hours notice for appointment cancellation. This courtesy will allow us to utilize the time for other patients.
For Monday appointments the latest cancellation is Friday 12:00 PM (afternoon).

If you do not cancel before **48 hours** or do not keep you appointment, we will have to charge you for a broken appointment.

The minimal charge is **$50**.
If we reserved extra time for you, the charge is **$75**.

If you have made an appointment for a cosmetic procedure (e.g. laser, facial, sclerotherapy, etc…), the broken appointment charge is **$75-$150** depending on the amount of time reserved for you.

You will be reminded about your appointment over the phone. If the receptionist leaves a message on your answering machine, **PLEASE CALL BACK** to confirm your appointment and to avoid the need for further phone calls.

A failure to confirm your appointment will result in the cancellation of the appointment.

Please, understand that this charge only partially covers our expenses associated with lost time.

We are not able to make any exceptions to this policy.

I fully understand and agree with the above policy.

____________________________________ ____________________
Patient's Signature Date

Advanced Dermatology, Laser and Cosmetic Surgery

EYAL LEVIT, M.D., F.A.A.D., F.A.C.M.S.
Diplomate, American Board of Dermatology
Associate Clinical Professor, Columbia University
Adjunct Associate Clinical Professor, Mt. Sinai School of Medicine
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Fellow American College of Mohs Micrographic Surgery and Cutaneous Oncology

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www.nyskinclinic.com

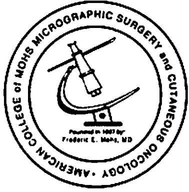
PATIENT FINANCIAL OBLIGATION CONFIRMATION AND AUTHORIZATION

Dear Patient:

We value you as a patient and appreciate that you have entrusted us with your health care needs. Our office will be pleased to work with your health benefit plan for pre-certification. All patients, however, are responsible for presenting referrals at the time of their visit.

As you know, there are charges for each of the medical care services that we will provide to you. The co-payments, deductibles, and co-insurance amounts that we are obligated to collect from you are determined by the type and extent of health benefit coverage that your health benefit plan provides. Please be aware that your health benefits, including your responsibility for co-payments, deductibles and co-insurance, are decisions made by your employer or your health plan – not this office. (For your information, all information regarding charges related to a visit will appear on the explanation of benefits (EOB) that you will receive from the insurance company after being seen by the doctor.) Please also be aware that your health plan does not guarantee the accuracy of its confirmation of coverage or benefits.

Since you are ultimately responsible for payment of the medical services provided to you, it is our policy to obtain your credit card number and authorization to process a claim for payment should your health plan not honor the claim we submit for the services provided to you.



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In providing credit card information below, you authorize payment by credit card for services in the absence of coverage by your health benefit plan (including, but not limited to co-payments, co-insurance, deductibles, no-show fees for both medical and/or aesthetic services, and/or uncovered services). Without this authorization from you, the doctor and/or aesthetician will be unable to see you.

We appreciate you for your understanding and cooperation.

Patient Name:____

Card Type (Visa) (MasterCard) (American Express)

Card Number:____

Expiration Date:____________________ CVC __________ ZIP Code ______

Signature:_________________________________ Today's Date:_________