Adult & Pediatric Dermatology

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Welcome to our practice!

Please complete the enclosed forms and bring them with you to your appointment. Completion of this information in advance and arriving 15 minutes prior to your scheduled appointment time will speed your check-in process and will ensure that your appointment runs smoothly. Please have your forms completed before you arrive. Our office uses electronic medical records and if you register in one of your office locations we will be able to view your records at our other location as well.

If you wait until the time of your visit to complete your forms we may not be able to see you on time.

If your insurance requires a referral from your primary care physician, please be sure that you bring the referral form with you or have it faxed to our office.
If your referral is not in our office at the time of your visit, you will not be seen that day and you will have to reschedule your appointment.

Please note that free patient parking is available on the ground floor of our Great Neck office. Street parking is available at the Forest Hills office. Please note that a parking lot in front of our Forest Hills office is for Associated Supermarket customers only.
If you have any questions or concerns, please do not hesitate to give our office a call.

We look forward to seeing you.

Sincerely,
Michael Paltiel M.D.

PATIENT INFORMATION __New Patient __Name Change __Address Change __ Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date ____/____/____

Name ____ Preferred nickname ___________
Last *First* *M.I.*

Date of Birth: ____/____/____ Age: ____ Social Security # ________________________ Sex: __Male __Female

ADDRESS:
Mailing Address ____
City *State* *Zip*

Home Phone: (_______)____________________________________ Work Phone: (_______)____________________________________

Cell Phone: (_______)____________________________________ email: ____

Marital Status: __Single __Married __Divorced __Widowed __Separated __GLBT

PARENT, SPOUSE, OR RESPONSIBLE PARTY (*if different from patient)*

Name: ____ Date of Birth ____________
Last *First* *M.I.*

Address: ____
City *State* *Zip*

Home Phone: (_______)____ Work Phone: (_______)______________________________

INSURANCE COVERAGE - PRIMARY:

Insurance Co. Name:____ Phone: (_______)____________________________

Address of Claim Center:____

____
City *State* *Zip*

Name of Policy Holder (Insured):____
Last *First* *M.I.*

Policy Holder (Insured) Date of Birth: _____/_____/_____ SS# ____ Sex: __Male __Female

Policy #:____ Group Name or # ____

Policy Type: __HMO __PPO

Employer Name: ____

Employer Address:____

INSURANCE COVERAGE - SECONDARY:

Insurance Co. Name:____ Phone: (_______)________________________

Address of Claim Center:____

____
City *State* *Zip*

Name of Policy Holder (Insured):____
Last *First* *M.I.*

Policy Holder (Insured) Date of Birth: _____/_____/_____ SS# _________________ Sex: __Male __Female

Policy #:____ Group Name or # ____

Policy Type: __HMO __PPO

Employer Name: ____

Employer Address:____

REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

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

Other family members that are patients ____

Referred by: ____

Primary Care Physician: ____ Phone:______________________________

EMERGENCY CONTACT INFORMATION:

In case of emergency, who should be notified? ____ Phone ______________________________

Do you give our office permission to discuss your medical information with family members?

__YES __NO / If yes, please provide their names and phone numbers below.

Name:____ Relationship:____

Phone # day _______________________________________ Phone # evening ____

May we leave personal medical information on your answering machine <u>at home</u>?
__YES __NO

May we leave personal medical information on your answering machine <u>at work</u>?
__YES __NO

May we email personal medical information to you?
__YES __NO

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature ____Date_________________________________

PAYMENT POLICY:

HMO, PPO or other managed care patients: **You will be responsible for paying your annual deductible, copayment and charges for any non-covered, cosmetic services.**

Commercial Patients: Patients who are covered by private, commercial plans in which our physician is not a provider will be required to pay 35% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient of Responsible Party Signature ____Date _________________________________

ADULT & PEDIATRIC DERMATOLOGY

Name: ___________________________________
Date of Birth: ____________________________
Primary Care Physician: ___________________

Are you allergic to any medications? __ Yes __No If yes, list below:

1.____________________________ 2. ______________________________

Have you ever had a bad/allergic reaction to: (Circle) Latex / Lidocaine / Epinephrine / Betadine / Iodine / Adhesives ?

List all medications you are currently taking (including prescriptions, over-the-counter meds, Vitamins, and herbals):

1.____________________________ 3.____________________________ 5. ___________________________

2.____________________________ 4.____________________________ 6. ___________________________

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

	YES	NO		Other Systemic:	YES	NO
Bronchitis/Emphysema				Diabetes		
Asthma				Thyroid condition		
Shortness of Breath				Kidney disease		
High blood pressure				Dialysis		
Heart attack / angina				Bladder problem		
Chest pain				Gastrointestinal problems		
Heart murmur				Nausea/Vomiting from Oral antibiotics		
Irregular heartbeat						
Phlebitis / Blood clots				Yeast infection from Oral antibiotics		
PACEMAKER						
Fainting with medical procedures				Arthritis		
Allergies / Hay fever				Artificial Joint		
Ear/nose/sinus/throat problems				Convulsions / epilepsy		

List any other diseases or conditions: ____

List surgical procedures you have had: ____

	YES	NO	DETAILS
Have you ever had skin cancer?			
Has anyone in your family had skin cancer?			
Has anyone in your family had Melanoma?			
Do you have a history of any other skin diseases?			
Do you have problems with healing?			
Do you develop keloid scars after surgery?			
Do you bleed easily?			

Do you drink alcohol? __YES __ NO If YES, ___________ drinks per day
Do you use IV drugs? __YES __ NO If YES, what? _____________________ How often?__________________________
Do you smoke? __YES __ NO If YES, how much: ____
Have you had or have you been exposed to HIV (AIDS)? __YES __ NO
Are you: __Single __Married __Separated/Divorced __Widowed __GLBT
(Women) Are you pregnant? __YES __ NO Due Date: ___/___/___
What is your occupation? _________________________________ Hobbies? ___________________________________

Have you had sunburns in the past? __Yes __ NO If yes estimate how many?

________________________ ____/____/_____
PATIENT SIGNATURE Date

________________________ ____/____/_____
Reviewed by Date

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

Signature: ___________________________________Date: ____________________

Printed Name - Patient or Representative _____________________________________

Relationship to Patient (if other than patient): __________________________________

ADULT & PEDIATRIC DERMATOLOGY
MICHAEL PALTIEL MD PC.

Office Financial Policy

Patient Name: ___________________________________ Date of Birth: _____/_____/_____

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

1. We are Medicare Participating providers. We will bill Medicare and Medigap carriers. You will be responsible at the time of service for payment of:
   a. The annual deductibles
   b. Copayments
   c. Charges for noncovered or cosmetic services (You will be asked to sign an Advance Beneficiary Notice of Liability (ABN) Form in the event that a service is provided which we know is not covered by Medicare.)

   If you have Medicare, as well as secondary coverage with a commercial plan that is not Medigap or is an insurance company with which we have no contract, we will file a claim to your secondary/supplemental carrier. If no payment is received from your secondary/supplemental carrier within 60 days after we file a claim, you will be sent a bill and will be responsible for the balance.

2. If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for all covered, medically necessary services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible at the time of service for payment of:
   a. The annual deductibles
   b. Copayments
   c. Charges for noncovered or cosmetic services.

   In the event that you, as the patient, or we, as the physicians, are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.

3. For non-Medicare patients who have insurance coverage with an insurance carrier with which we do not have a contractual relationship, please note the following:
   a. We will file both your primary and secondary insurance. If we receive payment from the primary, we will file a claim with your secondary. If we do not receive payment from your primary carrier within 60 days of filing, you will be billed for the entire amount. Payment is due 10 days after receipt of the statement.
   b. If you only have primary insurance (e.g., no secondary/supplemental coverage), you will be asked to pay 100% of the bill on the day of service. This can be done by cash, check, Mastercard, or Visa. We will still notify your insurer of the visit and the amount that you paid, which may therefore be applied to your deductable, or which may be refunded to you, in all or in part, should the insurer choose to do so based on your particular plan. Please understand that since we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits. Any balance remaining after your primary carrier has paid will be billed to you and is due and payable 10 days after receipt of the statement.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

____ _________________________

Patient signature *Date*