LONG ISLAND SKIN CANCER & DERMATOLOGIC SURGERY, PC

NAME:____ SS# ________________________

ADDRESS: __________________________ CITY: _______________ STATE: _____ ZIP: ________________

HOME PHONE: __________________ WORK PHONE: ____________________ CELL PHONE: ______________________

DATE OF BIRTH: ______________ AGE: ____________ OCCUPATION: ________________________________

EMPLOYER: ____________________________________ SPOUSE'S/PARENT'S/GUARDIAN NAME: ______________________________

EMPLOYER ADDRESS: ____ CITY: ____

STATE: ______________ ZIP: ________________ SEX: ( ) M ( ) F MARITAL STATUS: single married divorced widowed other

MEDICAL EMERGENCY CONTACTS: NAME: ____________________________ PHONE: ________________________

NAME: ____________________________ PHONE: ________________________

REFERRED BY: (Circle 1) DOCTOR / YELLOW PAGES / INS. PLAN / FRIEND / FAMILY / OTHER: ____

DR. OR FRIEND'S NAME: __________________________________ PHONE NUMBER: ________________________________

ADDRESS: ____ STATE: ______________ ZIP: _______

FAMILY PHYSICIAN (OMIT IF ABOVE) __________________________________

ADDRESS: ____ STATE: ______________ ZIP: _______

HEALTH INSURANCE INFORMATION: FINANCIAL POLICY:

PRIMARY INSURANCE NAME: ____

NAME OF INSURED: ____

DATE OF BIRTH: _________________ INSURANCE ID# _________________ SS# OF INSURED: __________________________________

CERTIFICATE # _________________ GROUP # _______________ EMPLOYER/GROUP NAME: ______________________________________

2005/ 2006 / 2007 AMOUNT OF DEDUCTIBLE: ___________ HAS THIS BEEN MET? YES / NO CO-PAY AMT $ _________________

SECONDARY INSURANCE NAME: ____

NAME OF INSURED: ____ CO-PAY AMT $ _________________

DATE OF BIRTH: _________________ INSURANCE ID# _________________ SS# OF INSURED: ________________________

CERTIFICATE # _________________ GROUP # _______________ EMPLOYER/GROUP NAME: ________________________________

<u>**REASON FOR VISIT:**</u> ____ <u>**LESION GROWING**</u>: **SLOW FAST**

<u>**WHERE ON THE BODY:**</u> ________________________ <u>**HOW LONG HAVE YOU HAD IT:**</u> ___________ **(ie. days, months, years, don't know)**

<u>**MEDICAL HISTORY**</u>: (PLEASE CIRCLE) BLOOD THINNERS (aspirin, vit. E, coumadin, plavix) PACEMAKER DEFIBRILLATOR PREGNANT IRREGULAR HEARTBEAT ABNORMAL BLEEDING PROSTHETICS ABNORMAL SCARRING NUMBNESS ASTHMA SKIN CANCER DIABETES SMOKING ALCOHOL DRUGS GLAUCOMA HIV/HEPATITIS HEART DISEASE LEAKY VALVES STROKE SEIZURES NERVE DAMAGE EXCESSIVE THIRST/URINATION DIZZINESS/FAINTING COLD/HEAT INTOLERANCE HEADACHE HYPERTENSION LUNG DISEASE RECENT OPERATION/HOSPITALIZATION SWOLLEN GLANDS CHANGING MOLES DRY SKIN HIVES SKIN RASH/LESIONS WEAKNESS NIGHT SWEATS SUDDEN WEIGHT LOSS/GAIN FEVER: **NONE** (Please explain circled items)

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____

<u>**ALLERGIES**</u>? ___________________________ **NONE** <u>WHAT HAPPENS</u>? ____

<u>**MEDICATIONS CURRENTLY TAKING**</u>? ____ **NONE**

<u>**FAMILY HISTORY OF**</u>: (PLEASE CIRCLE) ATYPICAL MOLES MELANOMA SQUAMOUS CELL CARCINOMA BASAL CELL CARCINOMA **NONE**

(Please identify relationship to self) ____

PLEASE READ THIS STATEMENT AND SIGN BELOW:
ALL INFORMATION I HAVE GIVEN IS TRUE AND COMPLETE. THIS 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. (PLEASE CROSS OUT THE PREVIOUS SENTENCE IF NOT DESIRED). I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO LONG ISLAND SKIN CANCER & DERMATOLOGIC SURGERY, P.C. I HAVE READ THE LONG ISLAND SKIN CANCER & DERMATOLOGIC SURGERY, PC. FINANCIAL POLICY AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR ALL NON-COVERED SERVICES.

XSIGNATURE____ DATE______________________

LONG ISLAND SKIN CANCER & DERMATOLOGIC SURGERY, P.C.
FINANCIAL POLICY

Thank you for selecting the Long Island Skin Cancer & Dermatologic surgery, P.C. for your dermatologic care. In order to prevent any misunderstanding concerning the responsibility regarding payment for medical/surgical care and/or any laboratory fees, the following information 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.**

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)

For patients with no insurance, the guarantor is responsible for the bill at the time of service.

Cosmetic Patients

Cosmetic procedures will not be submitted to your insurance company. Payment is due at the time of service.

Payments

Payments can be made by cash, check, VISA, or Mastercard. 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.

Returned Checks and Collections

A charge of $20 will be made for all returned checks. In the event that any action is brought to collection, I agree to pay any reasonable collection costs and/or attorney fees. My signature below indicates my understanding and full responsibility for the balance on my account for any professional services.

X____ ________________________
Signature Date

____ _______/______/___________
Print Last Name, First Name SS #

Benefits Assignment

I hereby authorize the assignment of benefits (payments) directly to Long Island Skin Cancer and Dermatologic Surgery, P.C. for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service.

X Signature of Responsible Party: ____________________________________ Date: ______________

Records Release

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

X Signature of Responsible Party: ____________________________________ Date: ______________

LONG ISLAND
SKIN CANCER &
DERMATOLOGIC SURGERY

DANIEL SIEGEL, MD **ANTHONY WONG, MD** **DARREN MOLLICK, MD**

MOHS MICROGRAPHIC SURGERY ■ DERMATOLOGIC SURGERY

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Long Island Skin Cancer & Dermatologic Surgery, PC may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Long Island Skin Cancer & Dermatologic Surgery, P.C. 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 prior to signing this consent. Long Island Skin Cancer & Dermatologic Surgery, P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Long Island Skin Cancer & Dermatologic Surgery, P.C.'s Privacy Officer.

With my consent, Long Island Skin Cancer & Dermatologic Surgery, P.C. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, and insurance items and return calls requesting a call back.

With my consent, Long Island Skin Cancer & Dermatologic Surgery, P.C. may mail to my home or other designated location any items that assists the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Long Island Skin Cancer & Dermatologic Surgery, P.C. may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Long Island Skin Cancer & Dermatologic Surgery, P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Long Island Skin Cancer & Dermatologic Surgery, P.C.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Long Island Skin Cancer & Dermatologic Surgery, P.C. may decline to provide treatment to me.

I wish to be contacted in the following manner (check all that apply):

Home Telephone: ( ) OK to leave message with detailed information
Work Telephone: ( ) OK to leave message with detailed information

List any family member we may release medical information to:

Name: ____________________________________ Relationship: ___________ Phone: ___________

Name: ____________________________________ Relationship: ___________ Phone: ___________

X__________________________________ __________________________________ ____________________
Patient's Signature Print patient's name Date

__________________________________ __________________________________ ____________________
Legal Guardian's Signature Print name of Legal Guardian Date

Phone: 631-864-MOHS (6647) ■ Fax: 631-864-6001
994 West Jericho Turnpike, Suite 103 - Smithtown, New York 11787
13405 Main Road - Mattituck, New York 11952

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PATIENT FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our practice manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- Your insurance policy is a contract between you and your insurance company only. If you fail to notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company.

- If you have insurance coverage with a plan that we do not have a prior agreement with, we will prepare and send the claim for you. Therefore, our charges for your care and treatment are due at the time of service.

- Unless either you or your health coverage carrier have made other arrangements in advance, payment is due at the time of service. For your convenience we will accept cash, check, MasterCard or VISA. If you have a financial hardship, arrangements for a financial plan can be made.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be “not covered”, you will be responsible for the complete charge.

- For all services rendered to minor patients, we will hold the parent or guardian accompanying the minor responsible for expenses incurred.

- In order to provide the best possible service and availability to all of our patients, please call us as early as possible if you know you need to reschedule your appointment.

- Patient balances are due within 30 days of receipt of statement. There will be a 2% additional charge on any outstanding balance or a $3.00 minimum additional charge on any outstanding balance if payment is not received in thirty (30) days unless previous arrangements have been made in advance with our Billing Office.

GUARANTEE OF PAYMENT FORM

Many insurance companies, including managed care organizations, require prior written authorization for treatment and follow up visits. It is your responsibility as a patient to obtain all necessary authorizations from your insurance company prior to receiving medical services. If you have not received prior approval for the service or authorization has been denied, you are fully responsible for all charges if your insurance company does not agree to pay. In addition, you will be responsible for all deductibles, co-insurance, co-payments, any service that is not covered by your insurance plan and any service that your insurance company has determined not to be “medically necessary”.

Provider Name: Long Island Skin Cancer and Dermatologic Surgery, PC

I have read and understand the information above. I understand that my insurance company may deny coverage and request that Long Island Skin Cancer and Dermatologic Surgery, P.C. perform this medical service anyway. I agree to be personally and fully responsible for all charges. I understand that the provider named above is relying on this promise and is rendering services without requiring payment at the time of service based on such reliance.

X______________________________	______________________________	__________
Patient or Guarantor	Print Name	Date
______________________________	______________________________	__________
Witness	Print Name	Date

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NOTICE TO OUR PATIENTS:

Each health plan varies regarding deductibles, co-pays and coinsurance. Terms are contracted between the insurance company and patient at the time you accept the insurance. It is your responsibility to be aware of your deductibles, co-pays and coinsurance and it will be your obligation to remit all appropriate payments as outlined in your insurance policy. These policy requirements no longer allow us to absorb any co-pays, coinsurance or deductibles.

Thank you for your cooperation.

Sincerely,

Drs. Daniel Siegel, Anthony Wong and Darren Mollick

XPatient Signature: ________________________________

Date: ____

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EMAIL ALERT

If you would like to receive office announcements, our newsletter or notification of upcoming studies offering payment to patients, please print your name below and we will be happy to put you on our contact list. All information will be kept confidential and only be used within this office for the purposes as specified below.

Thank you.

____________________________________ ____________________
Name Date

____
Email address

Yes, please send me information on the following topics:

General Office Announcements ( )

Bi-Annual Newsletter ( )

Patient Paid Research Studies ( )

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