

# 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 / INTERNET/ 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:**

PRIMARY INSURANCE NAME: \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ POLICY# \_\_\_\_\_ SS# OF INSURED: \_\_\_\_\_

GROUP # \_\_\_\_\_ POLICY HOLDER'S EMPLOYER/GROUP NAME: \_\_\_\_\_

## **SECONDARY INSURANCE NAME (IF APPLICABLE):**

PRIMARY INSURANCE NAME: \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ POLICY# \_\_\_\_\_ SS# OF INSURED: \_\_\_\_\_

GROUP # \_\_\_\_\_ POLICY HOLDER'S EMPLOYER/GROUP NAME: \_\_\_\_\_

**REASON FOR VISIT:** \_\_\_\_\_ **LESION GROWING:** SLOW FAST

**WHERE ON THE BODY:** \_\_\_\_\_ **HOW LONG HAVE YOU HAD IT:** \_\_\_\_\_ (ie. days, months, years, don't know)

**MEDICAL HISTORY:** (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)

**HISTORY OF MELANOMA?** YES \_\_\_\_\_ DATE \_\_\_\_\_ NO \_\_\_\_\_

**ALLERGIES?** \_\_\_\_\_ **NONE** WHAT HAPPENS? \_\_\_\_\_

**MEDICATIONS CURRENTLY TAKING?** \_\_\_\_\_ **NONE**

**FAMILY HISTORY OF:** (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. I HAVE READ THE DERMATOLOGY AND AESTHETIC ASSOCIATES OF LONG ISLAND FINANCIAL POLICY AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR ALL NON-COVERED SERVICES.

**X** SIGNATURE \_\_\_\_\_

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: \_\_\_\_\_



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 Number: ( ) OK to leave message with detailed information
Work Number: ( ) OK to leave message with detailed information
Cell Number: ( ) 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



**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 \$25 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.
- Laboratory Fees – Depending on your insurance carrier's policy, you may be required to pay a separate co-payment for any specimen taken during your visit.

**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 I agree to be personally and fully responsible for all charges.

**X** \_\_\_\_\_  
Patient or Guarantor

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date



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

MOHS MICROGRAPHIC SURGERY ■ DERMATOLOGIC SURGERY

## 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

**X**Patient Signature: \_\_\_\_\_

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  
40 Crossways Park Drive, Suite 102 – Woodbury, New York 11797



## 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

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Yes, please send me information on the following topics:

General Office Announcements ( )

Bi-Annual Newsletter ( )

Patient Paid Research Studies ( )