BENJAMIN COHEN, MD • ADELE HAIMOVIC, MD

DERMATOLOGY & LASER CENTER, PA

DERMATOLOGY & DERMATOLOGIC SURGERY

145 WYCKOFF ROAD, SUITE 200, EATONTOWN, NJ 07724 • (732) 222-8323

LATE/MISSED APPOINTMENT POLICY and CREDIT CARD FORM

PRINT NAME:____

If you need to cancel an appointment, please do so **AT LEAST 24 HOURS IN ADVANCE.** The Answering Service is available 24/7 so that you can contact us at any time through our main office phone number; 732-222-8323.

Unless there is an **EMERGENCY,** appointments canceled last minute, or No Call/No Shows, you will be charged a **$125 fee**.

Please call the office if you are going to miss your appointment or are RUNNING LATE.

CREDIT CARD AUTHORIZATION

By signing this form, you give us permission to debit your account for the amount indicated for No-Show Fees and any and all other outstanding balances over 60 days.

Account Type: ☐ **Visa** ☐ **Mastercard** ☐ **AMEX** ☐**Discover**

Cardholder Name:____

Account Number:____

Expiration Date:____________________

Security Code:_____________________

Please complete the information below:

____

SIGNATUREDATE

I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. I certify that I am the authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the term indicated in this form.

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ACKNOWLEDGMENT OF HIPAA/NOTICE OF PRIVACY PRACTICES

PATIENT NAME

I have been given the opportunity to review the NOTICE OF PRIVACY PRACTICES (HIPAA). If at any time I would like to review my Personal Health Information rights, I understand I will be provided with a copy of the Notice of Privacy Practices by office personnel.

PRINT DATE

SIGNATURE

If not signed by the patient, please verify:

___ Parent or Guardian Signature
___ Guardian or Conservator Signature
___ Beneficiary or Personal Representative Signature

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PATIENT INFORMATION *(PLEASE PRINT)* TODAY'S DATE : ______________

Name ________________________ __________________________________ _______________________
Last *First* *Middle*

Address ____
Street *City* *State, Zip*

Home Phone ____________________ Work ___________________ Cell _____________________

Marital Status S☐ M☐ W☐ D ☐ Date of Birth ____________ SS# _________________ Sex _____ Age _____

Referred by ___________________________ Primary Care Physician ____________________________________

Employer ____

RESPONSIBLE PARTY or LEGAL GUARDIAN *(if different from patient)*

Name ____ Relationship __________________
Last *First*

Home Phone _____________________ Work ____________________ Cell _____________________

INSURANCE INFORMATION

Primary Insurance Name ____________________________ PPO/HMO/POS Insured's ID#____________________

Name of Insured _________________________________ Insured's Employer _____________________________

Relationship to Patient ___________________________ Insured's DOB __________ Group# ________________

Secondary Insurance Name ____________________________ PPO/HMO/POS Insured's ID#_________________

Name of Insured _________________________________ Insured's Employer _____________________________

Relationship to Patient ___________________________ Insured's DOB __________ Group# ________________

ADDITIONAL INFORMATION

May we leave personal information on your answering machine at home? ☐ YES ☐ NO

Do you give our office permission to discuss your medical information with family members? ☐ YES ☐ NO
If yes, please provide their names, relationship to the patient, date of birth and last 4 digits of their SSN below:

Name/Relationship: _____________________________________ DOB: ___________ Last 4-digits of SSN: _____

Name/Relationship: _____________________________________ DOB: ___________ Last 4-digits of SSN: _____

Other family members who are patients? ____

In case of emergency, who should we notify?____

Relationship to Patient: ____________________________ Phone: ____________________________

Pharmacy: _____________________________Phone: _________________ Date of Last Physical: ____________

Patient/Guardian Signature: ____

☐ Sent to Billing Service ___/___/________ ☐ Date Updated ___/___/________

GENERAL CONSENT AND FINANCIAL AGREEMENT

1. **CONSENT TO TREATMENT:** I, the undersigned, hereby consent to medical treatment. In addition, I give permission to have a biopsy(s), minor surgical procedure(s) and any subsequent treatment as deemed necessary as long as the risks and complications are discussed with me prior to the procedure. I understand that no guarantee has been made as to the result that may be obtained.
2. **RELEASE OF INFORMATION:** I authorize the release of any or all medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.
3. **FINANCIAL POLICY:** In order to establish optimal relations with our patients and avoid misunderstandings and confusion regarding our payment policies; our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments, co-insurance and deductibles will be collected.
4. **ASSIGNEMENT OF INSURANCE BENEFITS:** I hereby authorize payment of medical benefits to the treating physician/practice. I understand that I am responsible for any health insurance deductible, co-payments, co-insurance and non-covered services.
5. **ACKNOWLEDGEMENT:**<u>**my signature below**</u> acknowledges that I have read and understand each of the preceding sections, 1 through 4.

____Date: ___________________________________

(Patient or Person Authorized to Consent)

____ **____**

(Print Name if other than the Patient) **(Relationship to Patient)**

____ **Date:** ___________________________________

(Witness)

MEDICARE PATIENTS READ AND SIGN BELOW

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder o medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare 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 the party who accepts assignment. Regulations pertaining to Medicare assignments of benefits apply.

____ _______________

Signature as it appears on Medicare Card **Date**

If you have a supplemental policy and it is a MEDIGAP policy to which you Medicare Carrier automatically "crosses over," we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

____ _______________________

Signature as it appears on Medigap Card **Date**

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Patient History Form

Name: (PRINT) ________________________________ DOB: ___________ HEIGHT: _________ WEIGHT:__________

To help give you the best possible care, please carefully complete ALL QUESTIONS on this form.

1. Why are you consulting with us today? ____
   ____
2. Have you previously been to a dermatologist? ____
3. Please list any medications, supplements, or recreational drugs you take: ______________________________
   ____
   ____
4. Have you or any family members had: (Please specify who on the line below.)

Acne	yes	no
Alopecia (Hair Loss)	yes	no
Asthma	yes	no
Diabetes	yes	no
Eczema	yes	no
Glaucoma	yes	no
Hay Fever	yes	no
Hirsutism (Excess Hair)	yes	no
Hives	yes	no
Keloids	yes	no
Psoriasis	yes	no
Skin Cancer / Other Skin Conditions	yes	no

5. Are you allergic to any prescription, over-the-counter medications, or local anesthetic? yes no
   If yes, please explain____
6. Have you had radiation treatment to your skin other than X-Rays? yes no
   If yes, please explain____

FOR WOMEN ONLY

7. When was your last menstrual cycle?____
8. Are you pregnant? yes no
9. Have you had vaginal infections? yes no If yes, when?_______________________________________
10. Are you currently planning a pregnancy? yes no
11. Gynecological History: Menopause, Endometriosis, Hysterectomy, Removal of Ovaries, etc.?
    Procedure and Date:____
    Procedure and Date:____
    Procedure and Date:____

12. Have you ever been hospitalized or had surgery, including cosmetic surgery? yes no
    If yes, please describe: ____

13. Have you ever had or been *treated* for any of the following: (Please specify on the line below.)

Adrenal Disorder	yes	no
Arthritis, Joint or Bone Disease	yes	no
Bleeding Disorder	yes	no
Blood or Lymph Gland Disorder	yes	no
Diabetes	yes	no
Difficulty with Healing of Wounds	yes	no
Duodenal or Peptic Ulcer	yes	no
Emotional or Psychiatric Problems	yes	no
Eye Disease (Cataracts, Cataract Surgery, Other)	yes	no
Excessive/Easy Bruising	yes	no
Frequent Infections (Skin or Other)	yes	no
Heart Disease (Rheumatic Fever, Pacemaker, Other)	yes	no
Herpes Zoster or Simplex (Shingles)	yes	no
High Blood Pressure (Hypertension)	yes	no
Kidney Disease	yes	no
Liver or Gallbladder Disease (Hepatitis)	yes	no
Lung Disease (Tuberculosis, Pleurisy, Other)	yes	no
Other Intestinal of Colitis	yes	no
Other Hormone Disorder	yes	no
Overgrown Scars or Keloids	yes	no
Ovarian or Testicular Disorder	yes	no
Stroke	yes	no
Thrombophlebitis	yes	no
Thyroid Disorder	yes	no
Urinary or Bladder Infections or Other	yes	no
Venereal Disease of HIV	yes	no

14. If necessary, may we have permission to photograph your skin condition? yes no

15. I hereby confirm that everything on this form is true and correct to the best of my knowledge.

    Date: ____________________ Patient's Signature: ____
    (If guardian has completed this form, please sign and indicate.)

16. I hereby consent to allow The Dermatology & Laser Center P.A. to release information regarding my patient visits to my insurance company.

    Date: ____________________ Patient's Signature: ____

THE POLICY OF THE DERMATOLOGY & LASER CENTER IS FOR PAYMENT TO BE MADE AT THE TIME OF SERVICE. WE ACCEPT CASH, PERSONAL CHECKS, AND ALL MAJOR CREDIT CARDS. THANK YOU!

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Medicare Patient Information

Name: ____ SS#: ____________________

Home Address: ____

Street

___________________________________ ____________ ____________________

City State Zip Code

Date of Birth: _____________________ Age: _________ Sex: ☐ Male ☐ Female

Home Phone: _____ _______________Work Phone: _______________________

Please read each of the following and answer as they apply to you. If it does, please check "yes." If it does not apply to you, please check "no."

YES	NO	
☐	☐	Do you or a spouse work for a company that has more than 20 employees and have coverage through the insurance at that job?
☐	☐	Are you covered by an HMO/PPO which makes Medicare secondary?
☐	☐	Are you coming to this office for an illness or accident that has been covered or is authorized for coverage from the VA (Veteran's Administration)?
☐	☐	Are you eligible for any benefits through the Black Lung Program?
☐	☐	Are you coming to this office for an illness, accident or injury that is the result of a motor vehicle accident?
☐	☐	Are you coming to this office due to Medicare Disability Coverage?
☐	☐	Are you covered by the Federal End Stage Renal Disease Program?
☐	☐	Are you presently receiving Workman's Compensation?
☐	☐	Is the reason you are coming into this office today work-related?
☐	☐	Do you have medical assistance through Welfare or State-Aid?

If you answered YES to any of the above questions: ______________________________

Name of Company

Policy # ____________________________ Group # ____________________________

Referring Physician: ____

Name of Emergency Contact: ____
Emergency Contact Phone Number: ____

NAME AS IT APPEARS ON YOUR MEDICARE CARD

____
(Please Print)

Medicare Health Insurance Claim Number (As it Appears on Your Card)

____

(*Medicare NO LONGER USES Social Security Numbers as your Medicare ID. Please make sure you have the updated card as we CANNOT ACCEPT SSN for coverage. Thank you!)

Please Sign So We May Have Your Medicare Authorization on File:

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare 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 the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature: ____ Date: ______________________

In the event of a major procedure or hospitalization, we request insurance information for our records (supplemental Medicare Insurance information). Please fill out below if you are covered by a plan which covers the 20% NOT covered by Medicare (Medigap Coverage.)

Supplemental Insurance: ____
Policy #: ____

Please Sign So We May Have Your Supplemental Authorization on File:

I request authorized MEDIGAP benefits to be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature: ____ Date: ______________________

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TODAY'S DATE:____________________

Due to new requirements from the United States Department of Health and Human Services, we are requesting that all patients complete our Supplemental Patient Intake Form. We realize that some of the questions may be redundant. We appreciate your patience and apologize for any inconvenience.

Patient's Name (PRINT):____

Date of Birth:__________________ Sex: M ☐ F ☐ Patient Phone Number:__________________

We are in the process of implementing a Patient Portal to provide a communication option for our patients in compliance with the Health and Human Services Requirements. Please provide a valid email address below:

(REQUIRED) ____

Ethnicity: ☐ Non-Hispanic ☐ Hispanic

Language Preference: ☐ English ☐ Spanish ☐ Other: __________________

Race: ☐ Caucasian or European American ☐ African or African American ☐ Asian or Asian American
☐ Native American or Native Alaskan ☐ Native Hawaiian or other Pacific Islander ☐ Other

Smoking Status: ☐ Not a current tobacco user
- ○ 0 Cigarettes per day (non-smoker or <100 in lifetime)
- ○ 0 Cigarettes per day (previous smoker)

☐ Current tobacco user
- ○ Few (1-3 cigarettes per day_
- ○ Up to 1 Pack per day
- ○ 1-2 Packs per day
- ○ 2 or more Packs per day

☐ Vapes or E-Cigarettes with Nicotine
Duration of use ______________

Do you take any prescriptions or non-prescription medications?

☐ No ☐ Yes (Please list):

Medication:______________________________Dosage:____________________

Medication:______________________________Dosage:____________________

Medication:______________________________Dosage:____________________

Allergies to Medication?

☐ No ☐ Yes (Please List): ____

Location of Reaction: ☐ Skin ☐ Local ☐ Abdominal ☐ Systematic/Anaphylactic

Reaction: ____

Severity: ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe

Onset: ☐ Childhood ☐ Adult ☐ Unknown

Please check if you have a history of the following:

☐ High Cholesterol ☐ Joint Replacement ☐ Cancer ☐ Depression
☐ High Blood Pressure ☐ Thyroid Condition ☐ Diabetes ☐ Skin Cancer
☐ Asthma ☐ Other______________________________

Signature:______________________________ Date:__________________

(Parent or Guardian Signature if Patient is a Minor)

Pharmacy Name:__________________________ Phone Number:__________________

(PLEASE ALLOW 8 HOURS FOR PRESCRIPTIONS TO BE FILLED. THANK YOU!)