INFINITY DERMATOLOGY NYC

FOREST HILLS | JAMAICA | WOODSIDE | MANHATTAN | BROOKLYN | RIVERDALE

WEBSITE: WWW.INFINITYDERMATOLOGY.COM

PATIENT INTAKE FORM

please print

PATIENT INFORMATION

First name_____ Last_____ Date of birth___/___/___ Sex: M F
Address:_____ Apt/Suite_____ City_____ State_____ Zip_____
Home #_____ Cell #_____ Email_____
SSN_____ Race:_____ Ethnicity_____ Language:_____
Primary care physician name and Tel #_____
Pharmacy name and Tel #_____
Referred by and Tel# _____
Referred from Jamaica Hospital? Yes____ No_____

INSURED/RESPONSIBLE PARTY

Insurance company_____ policy/ID # _____
Subscriber name_____ Date of birth__/___/___ Tel# _____

MEDICAL INFORMATION

Medication allergies:_____ Type of reaction_____

Medical problems:_____
_____

Medications:_____
_____

Please list any surgeries you had_____

Have you had any skin cancers in the past YES NO If YES please detail (type, year diagnose and method of treatment) _____

Do you have any family history of melanoma YES NO who?_____
Do you wear sunscreen regularly? YES NO Did you have sunburns as a child? YES NO
Do you smoke ? YES NO Do you drink alcohol regularly? YES NO Occupation?_____
What is the reason you are seeing us?_____ How long has it been present_____
What are the symptoms?_____
Has it been biopsied YES NO Result of biopsy_____
In the last 3 months have you experienced any of the following? (please circle all that apply)
Nausea/ Vomiting/ Fevers/Chills/Headaches/Shortness of breath/Changes in Vision/ Unintentional weight loss/ Lumps or bumps/ Abdominal pain/ Joint pain
When was your last total body skin check? _____

Patient Signature_____ Date_____

Health Insurance Portability and Accountability Act 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 (HIPPA).

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 Practices
- 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 anytime and all future disclosures will cease
- The Practice may condition receipt of treatment upon the execution of this Consent
- **The patient is aware that a Physician Assistant may be administering treatment in the event that a Doctor is not available.**

Privacy Practices Update
1. Patients may obtain copies of their health information in an electronic format within 30 days of requesting it, with one 30-day extension permitted.
2. A patient may instruct his or her doctor not to share information about a test or treatment for which the patient has paid out-of-pocket with his or her insurance company.

X Sign_____Date_____

Guarantee of Payment

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. 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.”
By signing this document, I acknowledge that I have read and understand this information. I understand that my insurance company may deny coverage and request that Forest Hills Dermatology Group 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. **All visits are billed under the main provider. All co pays are due in full at the time of the visit with either a Doctor or a Physician Assistant.**

X Sign_____Date_____

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UNDERSTANDING YOUR INSURANCE

What is Co-payment? Typically, **a co-payment** or **co-pay** is a specific flat fee you pay for each medical service, such as $30 for an office visit, after which the insurance company often pays the remainder of the covered medical charges.

EXAMPLE: Let's say you are not feeling well and went to see your doctor who charges $200 for the office visit. If your insurance plan has an office visit **co-payment** of $30, then you will only be responsible for the $30 and the insurance company will cover the remaining $170.

What is a Deductible? Typically, a deductible is the amount of money you must pay each year before your health insurance plan starts to pay for covered medical expenses.

EXAMPLE: So with a $100,000 heart surgery bill, you are responsible for paying the first $1,000. After this $1,000 **deductible** is met, the insurance company will pay a percentage of the bill in what is called the **coinsurance**.

What is Coinsurance? Typically, coinsurance is a cost-sharing requirement where you are responsible for paying a certain percentage and the insurance company will pay the remaining percentage of the covered medical expenses after your deductible is met.

EXAMPLE: For a health insurance plan with 20% **coinsurance**, once the deductible is met, the insurance company will pay 80% of the covered expenses while you pay the remaining 20% until your **out-of-pocket limit** is reached for the year.

What is Out-of-Pocket Limit? Typically, the out-of-pocket limit is the maximum amount you will pay out of your own pocket for covered medical expenses in a given year.

EXAMPLE: For a plan with a $2,000 **out-of-pocket limit**, you will pay a $1,000 deductible and $1,000 coinsurance while the insurance company covers the remaining $98,000 of the heart surgery bill. Even if you are hospitalized again in the same year, the insurance company will pay 100% of your covered expenses.

I, _____ understand the terms and conditions of my insurance policy and understand that if any of the above terms apply to my plan I am responsible for those charges.

Signed: _____ Date:_____

Forest Hills Dermatology Group, PLLC
COVID-19
Informed Consent

I understand I am giving this informed consent to Forest Hills Dermatology Group, PLLC (the "Practice") evidencing my educated decision to receive services at the Practice prior to any vaccine or known effective treatment to the CoronaVirus-COVID-19. I have been advised that the Practice has adopted recommended protocols for the prevention of COVID-19 at its facility. I have been advised I can request additional information prior to signing this consent, and at any time thereafter, as to the specific protocols in place regarding the Practice response to COVID-19.

By signing below, I acknowledge my understanding that the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and may still be highly contagious. I understand the Practice will be treating patients other than myself at its facility, as well as employing personnel who may be asymptomatic or qualified as "recovered" in accordance with CDC guidelines. I understand that it is impossible to determine who has it and who does not, at any given time, even as testing becomes readily available. I understand it is my responsibility to notify the Practice if I am medically "high risk" for any reason.

By signing below, I hereby agree to release the Practice, and its owners, members, officers, employees, contractors, agents, and representatives ("Practice Representatives"), and covenant not to commence or maintain any action or proceeding against any Practice Representatives, for or from any and all claims, causes of action, liabilities, damages, fees (including attorney's fees and costs of defense) and demands whatsoever, in law or equity ("Claims"), which I (and my heirs, executors, administrators and assigns) shall or may have, or from any person or entity other than myself, for, upon, or by reason of my contracting COVID- 19, including any claim resulting from my transmission of COVID-19 to any other person or thing. I hereby agree to indemnify and hold the Practice Representatives harmless from and against any and all Claims from or against any person or entity other than myself relating to my having or transmitting COVID-19.

By signing below, I acknowledge I have read this Informed Consent and I hereby agree to its terms and I assume the risk of potential Covid-19 exposure by receiving treatment at the Practice.

Patient Name: _____

Patient Signature: _____ Dated: _____

This consent will expire 6 month from the date patient sign it.