ADVA ED DERMATOLOGY SURGERY & LA R CENTER
GLENN KOLANSKY, M.D.
PATIENT INFORMATION SHEET

Name:_____ Date of Birth:_____ SS#_____

Age:_____ Sex: M F Marital Status: S M W D Sep DP Spouse_____

Address:_____

City:_____ State:_____ Zip Code:_____

PRIMARY Phone:_____ (C / H) SECONDAY Phone:_____ (C / H)

WORK:_____

REFERRED BY:_____ Email:_____

Family Physician:_____ PHARMACY: Name:_____ Phone:_____

Emergency Contact (other than spouse):_____ Phone:_____

Employer:_____ Drivers License:_____

PRIMARY COVERAGE

INSURANCE COMPANY:_____ Policy #_____

Group #_____ Copayment:_____

Subscriber:_____ DOB: _____ Relationship to Subscriber:_____

Subscriber Address:_____ City:_____ State:_____ Zip code:_____

Subscriber's Employer:_____ City: _____

SECONDARY COVERAGE: **We will bill secondary coverage for Medicare patients only**

INSURANCE COMPANY:_____ Policy #_____

Group #_____ Copayment:_____

Subscriber:_____ DOB: _____ Relationship to Subscriber:_____

Subscriber Address:_____ City:_____ State:_____ Zip code:_____

Subscriber's Employer:_____ City: _____

We will bill your insurance company if we participate with that company. You are responsible for any and all charges that your insurance company does not cover. You are responsible for notifying us of any changes to your insurance. Medications dispensed by the Doctor are to be paid at the time of visit. Payments are payable at time of service. Parents are responsible for payments on minor's account. Subscribers will be billed for deductibles and any additional charges as indicated by EOB. I authorize the insurance payments to go directly to physician and for release of necessary medical records to the insurance company. I understand that all tissue removed will be sent for pathologic examination at additional cost.

Managed care participants: Although we will try to assist you as best we can, it is your responsibility to obtain referrals from your primary care physicians for each visit to our office. Even if a return visit is made for you by our office, your referral may have expired. If you are uncertain if one is current, please call our office to check at least 48 hours before your visit

I certify that understand the above and that the information I have given is correct to the best of my knowledge.

X_____ _____

PATIENT SIGNATURE (IF MINOR THEN PARENT.GUARDIAN MUST SIGN) **DATE**

ADVANCED
DERMATOLOGY
SURGERY &
LASER CENTER

GLENN KOLANSKY, M.D.

Director
4 Hartford Drive
Tinton Falls, New Jersey 07701
(732) 933-8500 Fax (732) 933-4177

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Diplomate National Board of Medical Examiners
Fellow American Academy of Dermatology

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RE: COPAYMENTS

Please be aware that copayments are collected at the time of your visit.
You can pay by cash, check, debit (as long as it's Visa or Mastercard) and credit card.

RE: CELL PHONE USE

As a courtesy to other patients and staff members, please refrain from cell phone use inside the office. If you must use your phone, please step outside. Thank you.

RE: INSURANCE & REFERRALS

-Please be advised that it is YOUR responsibility to know your insurance and whether you require referrals to see specialists. Our office cannot keep track of every patient's referral. If your insurance requires a referral, it is YOUR responsibility to make sure your referral is valid (including # of visits & the expiration date) BEFORE coming in to see the doctor.

-If our office schedules a follow-up appointment for you, please call our office at least 3 days prior to your appointment and we will gladly check the status of your referral.

-In the event that you do not have a referral or it is expired, you have the option of rescheduling your appointment or leave a deposit for the visit, which we hold for 2 weeks. Once you provide us with a properly dated referral, we will return your deposit (minus any copay).

-Again, it is your responsibility to know your insurance and whether or not you need referrals. We will not be held responsible if you come in for a visit without a valid or properly dated referral. If you have any questions regarding what your insurance company requires, please call your insurance company's member services number.
I have read and understand the above office policies.

X_____

Patient's Signature or Guardian's Signature (if patient is under age 18)

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OUR FINANCIAL POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. If you have any questions about our fees, financial policy or your financial responsibility, please ask the receptionist.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR.
WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- **COPAYMENTS** – By law we MUST collect your carrier designated copay at the time of service. Please be prepared to pay that copay at each visit upon check in.

- **NON CO-PAY PLANS** – If your plan does not require a copay and we participate, we will accept the designated fee. You are responsible for any deductible and balance your plan indicates on their explanation of benefits.

- **REFERRALS** – If your plan requires a referral from your primary care physician it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit If you do not have your referral, YOU WILL BE REQUIRED TO LEAVE A DEPOSIT FOR THE VISIT. It is then your responsibility to provide us with a properly dated referral as soon as possible.

- **NON-PLAN PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Your itemized receipt should be attached to your insurance form and sent to your carrier, who will reimburse you directly.

- **MEDICARE** – We will submit to Medicare for the Medicare allowed amount. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to secondary insurance if you have one.

- **We <u>DO NOT</u> participate with Medicaid and therefore <u>DO NOT</u> submit to them. You will be responsible for any balance after Medicare.**

You are responsible for the timely payment of your account.

WE ACCEPT CASH, CHECKS AND CREDIT CARDS.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

RESPONSIBLE PARTY SIGNATURE X_____ DATE _____

History and Intake Form

Name: _____ **DOB:** _____

Pharmacy: _____ **City:** _____ **Pharmacy Phone:** _____

What is the primary problem/reason that brings you to this office today? _____

How long have you had this problem? _____

Have you been treated by another doctor for this problem:	NO	YES
HAVE YOU EVER TESTED POSITIVE FOR THE AIDS/HIV VIRUS?	**NO**	**YES**
HAVE YOU EVER TESTED POSITIVE FOR THE HEPATITIS A, B OR C VIRUS?	**NO**	**YES**
DO YOU CURRENTLY HAVE ANY ARTIFICIAL VALVES OR JOINTS?	**NO**	**YES**
DO YOU TAKE ANTIBIOTICS BEFORE DENTAL OR OTHER PROCEDURES?	**NO**	**YES**

Past Medical History: Please circle all that apply

Anxiety
Arthritis
Asthma
Atrial Fibrillation
BPH (prostate enlargement)
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD (emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Reflux)
Hearing Loss
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation
Seizures
Stroke
Valve Replacement
Pacemaker
Other: _____
NONE

Past Surgical History: Please circle all that apply

Appendix Removed
Bladder Removed
Mastectomy (Right or Left)
Lumpectomy (Right or Left)
Breast: (Biopsy/ Reduction/Implants)
Colectomy: (Cancer/IBD/ Diverticulitis)
Gallbladder Removed
Coronary Artery Bypass
PTCA (angioplasty)
TURP
Joint Replacement: Knee/Hip (Right/ Left/ Both)
Kidney Biopsy
Kidney Removed (Right or Left)
Kidney Stone Removal
Organ Transplant: _____
Ovaries Removed: (Cancer/Cyst/Endometriosis)
Prostate: (Biopsy/Cancer/Removed)
Skin Biopsy
Skin Cancer Surgery: (BCC/SCC/Melanoma)
Spleen Removed
Testicles Removed: (Right/Left/Both)
Hysterectomy: (Fibroids/Cancer)
Valve Replacement
Pacemaker
Other: _____
NONE

Skin Disease History: Please circle all that apply

Acne
Actinic Keratosis
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Cancer
Other _____
NONE

Do you wear Sunscreen? NO YES If yes, what SPF? _____

Do you tan in a tanning salon? NO YES

Do you have a family history of Melanoma? NO YES If yes, which relative(s)? _____

Name: _____

Medications: (**Write NONE if NONE**) (Please list ALL CURRENT medications) ***Use back if needed***

Medication	Dose	Frequency

Allergies to Medications: **YES** **NO** If yes: _____

Social History: (please circle)
Currently smokes everyday
Currently smokes- not daily
Former smoker
Never smoked

Alcohol Use: **None**
less than 1 drink per day
1-2 drinks per day
3 or more drinks per day
Social

(Please check **YES** or **NO** for the following)

SYMPTOM	YES	NO
Joint Aches		
Thyroid Problems		
Pacemaker		
Defibrillator		
Artificial Joints w/in last 2yr		
Artificial Heart Valve		
Premedication Prior to Procedures		
Allergy to Adhesive		
Allergy to Topical Antibiotic Ointments		
Allergy to Latex		
Blood Thinners		
Pregnancy or Planning a Pregnancy		
Allergy to Lidocaine		
Rapid Heart Beat with Epinephrine		
Problems with Bleeding		
Problems with Scarring (Hypertrophic or Keloid)		
Immunosuppression		

Glenn Kolansky, MD
Advanced Dermatology Surgery & Laser Center, PC
4 Hartford Drive Suite 3
Tinton Falls, NJ 07701

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Advanced Dermatology Surgery & Laser Center, P.C. (ADSLC, PC) may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment, and healthcare operations.

_____
Pt Initials

I have the right to review the Notice of Private Practices prior to signing this consent. ADSLC, PC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the ADSLC, PC Compliance Officer.

_____
Pt Initials

PLEASE INITIAL EACH ITEM THAT YOU WOULD ALLOW US TO DO
(If any one item within the sentence is a NO, the whole number is no).
With this consent Advanced Dermatology Surgery & Laser Center, PC may:

_____ 1. Call my home or cell phone at _____/_____ respectively and leave a message on voicemail or speak to any such person that may answer the phone in reference to any items that assist its healthcare providers or employees in carrying out TPO (Treatment Payment Options) such as appointment reminders, insurance items, and requests for a call back.

____ 2. At the following alternative phone number(s) (_____) ADSLC, PC employees will only leave a message in reference to items that assist the practice in carrying out TPO, such as appointment reminders and any calls pertaining to my clinical care schedule. However, at these numbers ADSLC, PC will not leave a message about my medical condition or lab results with any other person.

____ 3. ADSLC, PC also has my permission to send and request faxes from other Providers, items that assist ADSLC, PC in carrying out TPO.

____ 4. Mail to my home (or other location designated in writing by me) information containing any items that may assist ADSLC, PC in carrying out TPO, such as appointment reminder cards and Patient statements.

____ 5. Answer questions about my healthcare and billing with the following family members:
_____

I have the right to request that ADSLC, PC restrict how it uses or discloses my PHI to carry out TPO. However, under certain circumstances, ADSLC, PC would not be 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 ADSLC, PC's use and disclosure of my PHI to carry out TPO.

I _____ (patient name) acknowledge that I have read and understand the above.

_____ _____
Patient's Signature **Date**

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, ADSLC, PC may decline to provide treatment to me. If you have any questions about our Notice of Privacy Practice, please contact the office at (732) 933-8500.

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We are requesting your email to keep you informed on "What's New in Dermatology" and our special promotions.

This is for in office use only.

I, _____ give my permission for Advanced Dermatology

and Surgery Center to send me e-mails.

Email Address: _____

_____ _____

Patient Signature Date

_____

Office Representative