Westchester Dermatology Center

Philip Fried, M.D.
Jay Lerman, M.D.
Adult and Pediatric Dermatology
Cosmetic & Laser Surgery

20 Old Mamaroneck Road	2426 Eastchester Road	242 Naples Terrace	787 Lydig Avenue
White Plains, NY 10583	Bronx, New York 10469	Bronx, NY 10463	Bronx, NY 10462
P: 914-949-6070 F: 914-949-4560	P: 718-865-8733 F: 718-841-7119	P: (718) 432-8282	P: 718-863-7774

NEW PATIENT INFORMATION

LAST NAME_____FIRST NAME_____M.I._____

HOME # ( ) _____WORK # ( ) _____CELL # ( ) _____

EMAIL ADDRESS_____HOW DID YOU HEAR ABOUT US? _____

ADDRESS_____APT #_____

CITY_____STATE_____ZIP CODE_____

MAILING ADDRESS/BILLING ADDRESS (IF DIFFERENT FROM ABOVE)

_____

SSN_____DATE OF BIRTH_____AGE_____SEX_____

MEDICAL EMERGENCY CONTACT (COMPLETE FULL NAME AND TELEPHONE NUMBER)

1) NAME: _____ TELEPHONE #: _____

2) NAME: _____ TELEPHONE #: _____

REFERING PHYSICIAN: _____ TELEPHONE # :_____

ADDRESS OF REFERRING PHYSICIAN: _____

PHARMACY NAME: _____ TELEPHONE#:_____

REASON FOR TODAY'S VISIT _____

HAVE YOU EVER BEEN SEEN BEFORE BY ANY OF OUR DERMATOLOGISTS? YES OR NO

ANOTHER DERMATOLOGIST? YES/NO IF YES WHEN?_____

WE OFFER A COMPLETE BODY SKIN EXAM ON YOUR INITIAL VISIT WOULD YOU LIKE THIS PERFORMED? Y/N

MEDICAL INFORMATION

CURRENT OR PAST MEDICAL CONDITIONS: (CIRCLE ALL THAT APPLY)

LUNG DISEASE	BLEEDING PROBLEMS	HEART DISEASE	ASTHMA
HEPATITUS	HYPERTENSION	PACE MAKER	GLAUCOMA
HAY FEVER	DRUG OR ALCOHOL ABUSE	HIV/AIDS	CANCER
DIABETES	ANY OTHER DISEASES: _____		

OPERATIONS/SURGERIES EXPLAIN: _____

CURRENT ORAL MEDICATIONS: (INCLUDING BIRTH CONTROL PILLS) _____
_____

CURRENT TOPICAL & OVER THE COUNTER MEDICATIONS & CREAMS
_____

HAVE YOU HAD AN ALLERGIC REACTION TO ANY MEDICATIONS? YES/NO
ARE YOU ALLERGIC TO: PENICILLIN_____ LIDOCANE_____ OTHER: _____
PLEASE EXPLAIN THE ALLERGIC REACTION: _____

ANY KELOID OR ENLARGED SCARS? _____
ARE YOU PREGNANT? YES/NO DO YOU HAVE A PRESCRIPTION DRUG PLAN? _____
DO YOU SMOKE? YES/NO OR HAVE EVER SMOKED? YES/NO
PERSONAL HISTORY OF SKIN CANCER? YES/NO LOCATION:_____
ANY FAMILY HISTORY OF MELANOMA? _____ ECZEMA_____ PSORIASIS _____
BASAL CELL CARINOMA_____ SQUAMOS CELL CARINOMA_____
OTHER SKIN CONDITIONS _____ PLEASE EXPLAIN: _____
OTHER PERTINENT INFORMATION: _____

PLEASE READ THIS STATEMENT AND SIGN BELOW:
ALL INFORMATION PROVIDED ON BOTH PAGES ARE TRUE AND COMPLETE. THIS SIGNATURE WILL ALSO BE USED
AS A "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. (IF YOU DO NOT CONSENT TO THE PERMISSION OF THE PHOTOGRAPH'S PLEASE ADVISE)
I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO: PHLIP FRIED M.D. PLLC I AM FINANCIALLY RESPONSIBLE FOR ALL NON-COVERED SERVICES.

PATIENT'S SIGNATURE

_____ DATE _____
SIGNATURE OF PARENT OR GUARDIAN
_____

Philip Fried, M.D. PLLC

Westchester Dermatology Center

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Philip Fried, M.D. PLLC and associates, may use and disclose Protected Health Information about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Philip Fried, M.D. PLLC Notice of Privacy Practices for a more complete description of uses and disclosures

I have the right to review the Notice of Privacy Practices prior to signing this consent Philip Fried, M.D. PLLC 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 Philip Fried, M.D. PLLC Privacy Officer.

With my consent, Philip Fried, M.D. PLLC may call my home or other designated locations 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, insurance items and return calls requesting a call back.

With my consent, Philip Fried, M.D. PLLC may mail my home or other designated locations any items that assist the practice in carrying TPO, such appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Philip Fried, M.D. PLLC may e-mail to my home or other designated locations any times that assist the practice with carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Philip Fried, M.D. PLLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requests restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Philip Fried, M.D. PLLC use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Philip Fried, M.D. PLLC may decline to provide treatment to me.

_____ _____

Print Patient's Name Patient's Signature

_____ _____

Print Name of Legal Guardian Legal Guardian Name

_____

Today's Date

Philip Fried, M.D. PLLC

Westchester Dermatology Center

FINANCIAL POLICY

Thank you for selecting Westchester Dermatology Center for your dermatological cares. In order to prevent any misunderstanding concerning the responsibility regarding payment for medical/surgical care and/or laboratory, the following information is provided.

HMO/PPO Insurance Coverage

If you have Insurance through a company we 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

I'm a participating Medicare provider and accept Medicare assignment, which is the ALLOWABLE charge approved by Medicare. Medicare will pay 80% of the allowable charges after you pay your annual deductible and the 20% co-insurance. If you have a secondary insurance, we will submit to your 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 upon 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)

Patients without insurance, the Guarantor is responsible in full for the bill at the time of service.

Cosmetic Patients

Deposits are required prior to the date of the procedure. The balance of the payment is required prior to the procedure being performed.

Returned Checks and Collections

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

_____ _____

Signature Date

_____ _____

Print Last Name, First Name Social Security #