



Laser & Skin Surgery Center of New York®

PATIENT REGISTRATION INFORMATION

TODAY'S DATE: ___/___/___

Last Name	First Name	MI
Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow
Patient Address		Apt.
City, State, Zip		Email:
Home Phone	Cell Phone	Work Phone
Employer	Address	Occupation
Person Responsible for Payment (if other than patient)	Name:	Relationship:
Address: (if different)	Date of Birth:	Phone #:

INSURANCE INFORMATION (COMPLETE ONLY IF POLICYHOLDER IS DIFFERENT THAN THE PATIENT)

Insurance Company Name:	Policy ID #:
Name Of Policy Holder:	DOB Of Policy Holder:

REFERRAL INFORMATION: If referred by a physician, please enter the following:

Name of Physician: _____ Phone #: _____

Address of Physician: _____

IF NOT REFERRED BY A PHYSICIAN, HOW DID YOU HEAR ABOUT OUR PRACTICE? (please specify)

Friend/Family: _____ Website: _____

Newsletter Other: _____

PRIMARY CARE PHYSICIAN INFORMATION:

Physician's Name: _____

Phone #: _____

Address: _____

WHO SHOULD WE CALL IN CASE OF AN EMERGENCY?

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please provide the name(s) of person(s) you would like your medical information released/provided to:

**LASER & SKIN SURGERY CENTER OF NEW YORK PHYSICIANS FINANCIAL POLICY
PHARMACY INFORMATION AND HIPAA PRIVACY & NOTIFICATION**

Thank you for choosing the physicians at the Laser & Skin Surgery Center of New York for your health-care needs.

The following is our payment policy which we require you to read and sign prior to your visit (s).

Patients have many different types of insurance and payment options for services rendered. Also, not all physicians in the practice accept the same type of insurance. To ensure that we have accurate information to process your claim, we will make a copy of your medical insurance and/or Medicare card at the time of your appointment.

You are required to inform us immediately of any changes in demographic information or medical insurance information. Patients without medical insurance are required to pay in full at the time of service.

PARTICIPATING PLANS

You must present your insurance card, and if applicable, your insurance referral form, at every visit. We will submit bills directly to your insurance company for payment on your behalf. Patients without insurance cards or proper referrals will be asked for full payment at the time of service. All co-pays, deductibles and non-covered services will be collected at the time of service. Some insurance plans may send payments directly to you. If you receive payments for the services received, you are responsible for forwarding the check to The Laser & Skin Surgery Center of New York.

NON-PARTICIPATING PLANS

If your provider does not participate in your insurance plan, you are responsible for payment of all charges at the time of service. We will provide you with a receipt that you can submit directly to your insurance carrier.

COSMETIC SERVICES / NON-MEDICALLY NECESSARY SERVICES

Payment in full is due at the time of service for the consultation and all non-medically necessary services and/or cosmetic services. The consultation fee is \$400/\$450 in addition to all bills for services rendered.

USUAL AND CUSTOMARY RATES

Your insurance policy is a contract between you and your insurance company. Our practice is committed to providing the best treatment and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

COLLECTION ACCOUNTS

For all accounts with balances that are submitted to our collection agency for collection, you will be responsible for all legal and court fees as well as an additional fee of \$25.00 for submission to our collection agency.

PAYMENT

For your convenience, the following payment methods are accepted: CASH, PERSONAL CHECK (for established patients only), VISA, MASTERCARD, AMERICAN EXPRESS, and DISCOVER

I have read the policy, I understand and agree to it.

(Signature of the Patient or Responsible Party) *(Date)*

(Please Print the Name of the Patient)

PHARMACY INFORMATION

NAME OF PHARMACY: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

My signature below acknowledges that I understand that all prescriptions are e-prescribed.

HIPAA PRIVACY NOTICE

My signature below signifies that I have read, reviewed and have been offered a copy of the HIPAA privacy notice.

NOTIFICATION

My signature below acknowledges that it is the office policy not to testify in court, depositions, arbitrations, etc. relating to Worker's Compensation and other personal injury action.

Patient Signature

Today's Date

Medical History Information (for patients who did not access the portal)

Patient Name: _____ A/C#: _____ Date: _____

Medical History: Please place an "x" in the box provided for conditions you currently have

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> End Stage Renal Disease	<input type="checkbox"/> Hypercholesterolemia (High Cholesterol)	<input type="checkbox"/> Prostate Cancer
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> GERD (Acid Reflux)	<input type="checkbox"/> Hyperthyroidism (Over Active)	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Asthma	<input type="checkbox"/> COPD	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Hypothyroidism (Under Active)	<input type="checkbox"/> Seizures
<input type="checkbox"/> Atrial Fibrillation (Irregular Heartbeat)	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bone Marrow Transplantation	<input type="checkbox"/> Depression	<input type="checkbox"/> Hypertension (High Blood Pressure)	<input type="checkbox"/> Lung Cancer	<input type="checkbox"/> Other
<input type="checkbox"/> BPH	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Lymphoma	<input type="checkbox"/> None

Past Surgeries: Please place an "X" in the box provided for any past surgeries you have had

<input type="checkbox"/> Appendix (Appendectomy)	<input type="checkbox"/> Gallbladder (Cholecystectomy)	<input type="checkbox"/> Kidney: Kidney Stone Removal	<input type="checkbox"/> Ovaries Tubal Ligation	<input type="checkbox"/> Skin: Skin Biopsy
<input type="checkbox"/> Bladder (Cystectomy)	<input type="checkbox"/> Heart: Biological Valve Replacement	<input type="checkbox"/> Kidney: Kidney Transplant	<input type="checkbox"/> Pancreas: Pancreatectomy	<input type="checkbox"/> Skin: Squamous Cell Carcinoma
<input type="checkbox"/> Breast Biopsy	<input type="checkbox"/> Heart: Coronary Artery Bypass Surgery	<input type="checkbox"/> Kidney: Nephrectomy	<input type="checkbox"/> Prostate (Prostatectomy) Prostate Biopsy	<input type="checkbox"/> Spleen Splenectomy
<input type="checkbox"/> Breast: Lumpectomy Right / Left / Both	<input type="checkbox"/> Heart: Heart Transplant	<input type="checkbox"/> Liver: Hepatectomy	<input type="checkbox"/> Prostate (Prostatectomy) Prostate Cancer	<input type="checkbox"/> Testicles: Orchiectomy
<input type="checkbox"/> Breast: Mastectomy Right / Left / Both	<input type="checkbox"/> Heart: Mechanical Valve Replacement	<input type="checkbox"/> Liver: Liver Transplant	<input type="checkbox"/> Prostate (Prostatectomy) TURP	<input type="checkbox"/> Uterus (Hysterectomy): Fibroids
<input type="checkbox"/> Colon (Colectomy) Colon Cancer Resection	<input type="checkbox"/> Heart: PTCA	<input type="checkbox"/> Liver: Shunt	<input type="checkbox"/> Rectum: APR	<input type="checkbox"/> Uterus (Hysterectomy): Uterine Cancer
<input type="checkbox"/> Colon (Colectomy) Diverticulitis	<input type="checkbox"/> Joint Replacement: Hip Right / Left / Both	<input type="checkbox"/> Ovaries (Oophorectomy): Endometriosis	<input type="checkbox"/> Rectum: Low Anterior Resection	<input type="checkbox"/> Uterus (Hysterectomy): Cervical Cancer
<input type="checkbox"/> Colon (colectomy) Inflammatory Bowel Disease	<input type="checkbox"/> Joint Replacement: Knee Right / Left / Both	<input type="checkbox"/> Ovaries (Oophorectomy): Ovarian Cancer	<input type="checkbox"/> Skin: Basal Cell Carcinoma	<input type="checkbox"/> None
<input type="checkbox"/> Colon Colostomy	<input type="checkbox"/> Kidney: Kidney Biopsy	<input type="checkbox"/> Ovaries (Oophorectomy): Ovarian Cyst	<input type="checkbox"/> Skin: Melanoma	

Skin Disease History: Please place an "X" in the box provided for any condition you may have

<input type="checkbox"/> Acne	<input type="checkbox"/> Basal Cell Skin Cancer	<input type="checkbox"/> Eczema	<input type="checkbox"/> Poison Ivy	<input type="checkbox"/> Squamous Cell cancer
<input type="checkbox"/> Actinic Keratosis	<input type="checkbox"/> Blistering Sunburns	<input type="checkbox"/> Hay Fever/Allergies	<input type="checkbox"/> Precancerous Lesion	<input type="checkbox"/> Other
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> None

Family History of Melanoma: Do you have a family history of Melanoma? NO **If yes, which relative?**

<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Grandson <input type="checkbox"/> Granddaughter	<input type="checkbox"/> Niece/Nephew
<input type="checkbox"/> Daughter <input type="checkbox"/> Son	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	<input type="checkbox"/> Other: Specify: _____		

Do you wear Sunscreen? If yes, What SPF _____

Do you tan in a tanning salon? Yes or No

SOCIAL HISTORY:

Tobacco Use Screening

<input type="checkbox"/> Never Smoker	<input type="checkbox"/> Current every day smoker	<input type="checkbox"/> Former Smoker
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Alcohol Use Screening

<input type="checkbox"/> None	<input type="checkbox"/> Less than 1 drink per day	<input type="checkbox"/> 1-2 drinks per day	<input type="checkbox"/> 3 or more drinks per day
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WOMEN ONLY: In the past year have you had more than 4 drinks in 1 day? If yes, how many? _____

MEN ONLY: In the past year have you had more than 5 drinks in 1 day? If yes, how many? _____

65 OR OLDER: In the past year have you had more than 5 drinks in 1 day? If yes, how many? _____

Are you pregnant? Yes or No **Are you trying to get pregnant?** Yes or No

Do you have a pacemaker/defibrillator? Yes or No

Height: _____ft _____inches **Weight:** _____lbs

HAVE YOU HAD A FLU VACCINE? Yes No

HAVE YOU HAD A PNEUMONIA VACCINE? Yes No

DO YOU TAKE MEDICATION? Yes No (If yes, please list, including over-the-counter medications)

<u>Name of Medication</u>	<u>Dosage/Strength</u>	<u>How often do you take medication?</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

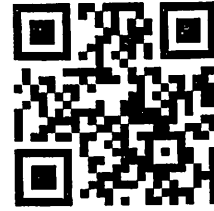
Do you have allergies? Yes (if yes, please list) **NO ALLERGIES**

to be completed by clinical personnel:

For Mohs Consults ONLY: BP: _____/_____

**NYULMC HIE,
CARE EVERYWHERE and HEALTHIX
CONSENT FORM**

Laser and Skin Surgery of New York



laserskinsurgery

Before signing the NYULMC HIE Consent Form below, please ensure that you have read the laminated NYULMC HIE Disclaimer Page

*For detailed information please request for an HIE Information Sheet or call 212-404-4101.
This form has to be signed only once per practice.*

PATIENT INFORMATION (PRINT CLEARLY)

First Name

Last Name

Date of Birth (MM/DD/YYYY)

Patient ID/MRN

/ /

Please check Box 1 or 2:



1. I GIVE CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access ALL of my electronic health information through the NYULMC HIE and I GIVE CONSENT to ALL employees, agents and members of the medical staff of NYU Hospitals Center to access ALL of my electronic health information through HEALTHIX in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.

2. I DENY CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access my electronic health information through the NYULMC HIE or HEALTHIX for any purpose, even in a medical emergency.

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the NYULMC HIE. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by New York State Law.

Signature of Patient or Patient's Legal Representative

Today's Date (MM/DD/YYYY)

/ /

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative (if applicable)

Scan on an approved scanner