

PLEASE TELL US ABOUT YOURSELF

Patient Demographic Form

Please PRINT

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Nickname/AKA					
Date of Birth	Social Security Number		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female					
Marital Status	<input type="checkbox"/> Married	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<input type="checkbox"/> Life Partner	<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed	<input type="checkbox"/> Other	Preferred Language
Home Address	Apt #	City	State	Zip Code				
Home Phone	Work Phone	Cell Phone						
Please circle where we can leave a message if necessary.								
Email Address								

PHYSICIAN REFERRAL INFORMATION

Referring Physician/PCP	Phone #		
Address	City	State	Zip Code

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient	<input type="checkbox"/> Self (If self, skip to Emergency/Next of Kin)	<input type="checkbox"/> Spouse	<input type="checkbox"/> Parent	<input type="checkbox"/> Other
Last Name	First Name	Middle Initial		
Date of Birth	Social Security Number			
Home Address	Apt #	City	State	Zip Code
Home Phone	Work Phone	Other Phone		

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name	First Name	Relationship to Patient		
Address	Apt #	City	State	Zip Code
Home Phone	Work Phone	Other Phone <input type="checkbox"/> Cell <input type="checkbox"/> Pager <input type="checkbox"/> Fax		

Insurance Information (if used)  
Please PRINT

PATIENT INFORMATION			
Insurance Company	Policy Number	Group	Co-Pay Amount:
<hr/>			
Authorization Number (if required)	HMO/PPO (circle)	Name/DOB of person who 'owns' the policy	
<hr/>			
Secondary Insurance	Policy Number	Group	

Pharmacy Information				
Address	City	State	Zip Code	Phone Number
<hr/>				

Medicare Patients

I hereby authorize payment of medical benefits to Heights Dermatology and Laser Group MD PC.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

ALL PATIENTS

I hereby give permission to bill insurance company. I realize I am financially responsible for any unpaid balances, deductibles, co-pays, and/or co-insurance. I understand my insurance company will not pay for cosmetic procedures; therefore I am responsible for payment in full.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Would you like information on any of the following?

- Hair Transplantation

Cool Sculpting for Fat Removal

Laser for Hair

Fillers and Botox
- PRP for Hair Loss

Laser for Wrinkles

Removal Laser for Redness

Other: \_\_\_\_\_

Reason for your Visit

Medications: (Please enter all current medications)

Allergies: (Please enter all allergies)

Past Medical History: (please check all that apply)

- ☐ Anxiety

☐ Depression

☐ Lung Cancer
- ☐ Arthritis

☐ Diabetes

☐ Lymphoma
- ☐ Atrial Fibrillation

☐ End Stage Renal Disease

☐ Prostate Cancer
- ☐ Asthma

☐ GERD

☐ Radiation Treatment
- ☐ Bone Marrow

☐ Hearing Loss

☐ Seizures
- ☐ Bleeding Disorder

☐ Hepatitis

☐ Stroke
- ☐ Breast Cancer

☐ High Blood Pressure

☐ Thyroid Problems
- ☐ Colon Cancer

☐ HIV/AIDS

☐ Transplantation
- ☐ COPD

☐ High Cholesterol

☐ Do you need prophylaxis?
- ☐ Coronary Artery Disease

☐ Leukemia

☐ NONE

Other: \_\_\_\_\_

Past Surgical History: (please check all that apply)

- ☐ Appendix Removed
- ☐ Gallbladder Removed
- ☐ Ovaries Removed: Endometriosis
- ☐ Bladder Removed
- ☐ Biological Valve Replacement
- ☐ Ovaries Removed: Cyst
- ☐ Mastectomy (Right, Left, Bilateral)
- ☐ Heart Transplant
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Lumpectomy (Right, Left, Bilateral)
- ☐ Joint Replacement Knee (Right, Left, Bilateral) Date: \_\_\_\_\_
- ☐ Prostate Removed: Prostate Cancer
- ☐ Breast Biopsy (Right, Left, Bilateral)
- ☐ Joint Replacement Hip (Right, Left, Bilateral) Date: \_\_\_\_\_
- ☐ Prostate Biopsy
- ☐ Breast Reduction
- ☐ Other Joint Replacement
- ☐ TURP ( Prostate Removal)
- ☐ Colectomy: Colon Cancer Resection)
- ☐ Kidney Biopsy (Nephrectomy)
- ☐ Spleen Removed
- ☐ Colectomy: Diverticulitis
- ☐ Kidney Removed
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ Colectomy: IBD
- ☐ Kidney Stone Removal
- ☐ Hysterectomy( Fibroids or Uterine Cancer)
- ☐ Coronary Artery Bypass
- ☐ Kidney Transplant
- ☐ NONE

Other: \_\_\_\_\_

Skin Disease History: (please check all that apply)

- ☐ Melanoma
- ☐ Pre-Cancerous Moles
- ☐ Squamous Cell Skin Cancer
- ☐ Basal Cell Skin Cancer

Other: \_\_\_\_\_

\_\_\_\_\_

Do you have any 1<sup>st</sup> degree relatives who have had Melanoma or any other skin cancers? If yes please list below

\_\_\_\_\_

\_\_\_\_\_

1. Is it possible you are pregnant?

Yes or No
2. Are you breast feeding?

Yes or No

**FOR INSURANCE PURPOSES**

Your insurance company requires the following intake form to be completed in order to provide you with the best care possible.

Please answer the following questions so we can comply with insurance guidelines at our practice.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date \_\_\_\_\_

1. Do you have any of the following conditions ( please check all that apply)

- ☐ Heart Failure
- ☐ Coronary Artery Disease
- ☐ Chronic Obstructive Pulmonary Disease ( COPD)
- ☐ Diabetes

2. Did you receive the Flu vaccine before this past Flu season?

- ☐ Yes
- ☐ No

3. Have you ever received the pneumonia vaccine?

- ☐ Yes
- ☐ No

4. Do you have a history of Melanoma?

- ☐ Yes
- ☐ No

5. Do you smoke?

- ☐ Yes
- ☐ No

6. Number of Alcoholic beverages consumed per day?

- ☐ None
- ☐ Less than 1 per day
- ☐ 1-2 per day
- ☐ 3 or more per day

7. Primary Care Physician Name: \_\_\_\_\_

Date of last physical exam (mm/yy): \_\_\_\_\_

## CONSENT FOR USE/DISCLOSURE OF HEALTH INFORMATION

Patient's Name:

Patient's Date of Birth:

Patient's SSN:

### Notice to Patient:

By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of treatment, various activities associated with payment and health care operations. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the notice accompanying this consent form, please ask for one. We encourage you to read it since it provides the details on how information about you may be used and/or disclosed, and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have a right to revoke your consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this consent. You should also understand that if you revoke this consent, we may decline to treat you.

You are entitled to a copy of this consent form after you have signed it.

(To be completed by patient or patient's representative)

I, \_\_\_\_\_, have read the contents of this consent form and the **Notice of Privacy Practices**. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

\_\_\_\_\_  
Patient's signature or signature of patient's representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient's representative

\_\_\_\_\_  
Relationship to patient

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: Kim Blackburn  
Practice Address: 115 ½ Remsen St, Brooklyn, NY 11201  
Phone: (718) 852-4646  
Fax: (718) 624-5972

### HIPPA Consent for Use/Disclose of Health Information

*This form does not constitute legal advice and covers only federal, not state, laws.*

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES**

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. A patient copy of the notice is available in the waiting area. If you would like a copy please notify the front desk. Please sign this form to acknowledge that you understand the location of this Notice. You may refuse to sign this acknowledgement, if you wish.

\_\_\_\_\_  
Please print your name here

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain acknowledgement.

☐ We weren't able to communicate with the patient.

☐ Other (Please provide specific details.) \_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**Heights Dermatology and Laser PQRS and MIPS**  
**intake form**

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_

Please answer the following questions so we can comply with insurance guidelines at our practice. Please return the completed sheet to the front desk. Thank you.

1. Do you have any of the following? Please circle Yes or No.

- Heart Failure                      Yes      No
- Coronary Artery Disease      Yes      No
- Chronic Obstructive Pulmonary Disease (COPD)    Yes    No
- Diabetes    Yes      No

2. Did you receive the flu vaccine before this past flu season?    Yes    No

3. Have you ever received the pneumonia vaccine?                      Yes    No

4. Do you have a history of Melanoma?    Yes    No

5. Do you smoke?    Yes    No

6. Number of Alcoholic drinks per day:    **Please Circle One**

**None**

**Less than 1 per day**

**1-2 per day**

**3 or more per day**

7. **Who is your Primary Care Physician:** \_\_\_\_\_

Month and Year of your last visit/physical: \_\_\_\_\_

**Heights Dermatology and Laser Group** has implemented a credit card policy. Recent changes in healthcare markets and payment processes have altered insurance coverages to shift more of the cost of care to our patients. The credit card on file policy is a convenient method to pay for the portion of services that are deemed patient's responsibility, such as copay, deductible and co-insurance.

Co-pays are still due at the time of visit. At your appointment, the credit card information will be obtained and kept confidential and secure until the insurance(s) have paid their portion and notifies Heights Dermatology of the balance due, if any. At that time, the billing department will send a statement via mail in which the patient will have 30 days to pay or make other forms of payment arrangements. After 30 days, the debit/credit card on file will be automatically charged for any outstanding balance.

Please read below and sign.

**In Network and Medicare Patients:**

If we participate in your insurance plan, you will be responsible for paying your copay, deductibles and/or co-insurance at the time of service. You may also be responsible for payment of services related to conditions that are not covered by your plan. If you have not met your deductible, you will be responsible for the amount of the deductible and whatever amounts the insurance company does not pay. If your insurance company denies payment or will only pay a portion of your medical bill, you, the patient, will be responsible for payment of services rendered and will be billed accordingly. Please be aware that your insurance carrier does not guarantee accuracy of its confirmation of coverage and benefits. In order to expedite this responsibility, we require that you leave a credit card on file with the office.

**Other Bills:**

If you should undergo a biopsy in our office, your insurance carrier will be billed separately by the Lab. You will receive a separate bill from the Lab for any uncovered charges or co-payment due.

**Payment Methods:**

For your convenience, we accept the following forms of payment: Cash, Check, Visa, Mastercard, Discover, and American Express.

- It is office policy that a credit card is left on file as most insurance policies have deductible, co-insurance, and surgical co-insurance in addition to copays. Your insurance company determines the exact amount after we have submitted your claim for payment. We will charge your card for the amount which is your responsibility, and your insurance company will also send you a copy of the explanation of benefits.

- Your signature below provides authorization for our office to process payment(s) to this card for reasons as outlined above.

It is our utmost concern that patients' transactions are processed according to the highest security standards. To that end, **Heights Dermatology and Laser Group** will safely and securely store your credit card information on Authorize.net, the industry leader in gateway security. This method meets all PCI requirements. All card information will be stored in an Authorize.net "lock box" and truncated during the process to prevent unauthorized access to full card information.

Failure to pay:

Any unpaid balance that exceeds 120 days will be sent to a collection attorney and will incur any attorney fees and collection costs. The patient/or guarantor will be responsible for all associated costs including interest from the date of service.

I, \_\_\_\_\_ have read the above disclaimer and fully understand my financial responsibilities to Heights Dermatology and Laser Group.

Patient/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_