Robin R. Blum, MD, FAAD
Medical & Cosmetic Dermatology

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www.CPSDerm.com
(212) 969-9655 | Fax (212) 969-9665

TODAY'S DATE: _____

NAME: _____

Date of Birth**:** _____ Gender: □ Male □ Female □ Other

ADDRESS: _____ APT/SUITE: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PRIMARY NUMBER: (_____) _____-_____ □ CELL □ HOME □ WORK
□ OK to leave message with detailed information
□ Leave message with call back number only

SECONDARY NUMBER: (_____) _____-_____ □ CELL □ HOME □ WORK
□ OK to leave message with detailed information
□ Leave message with call back number only

EMAIL: _____

PHARMACY NAME: _____PH. NUMBER: _____

STREET: _____ ZIP CODE: _____

PRIMARY CARE PROVIDER NAME: _____

PH.NUMBER:_____

□ OK to review and communicate results with primary care/referring physician

HOW WERE YOU REFERRED?

□ REFERRING PHYSICIAN: _____

□ FAMILY/FRIEND: (Please Provide Name) _____

□ Zocdoc.com □ Insurance Website □ Mt. Sinai Website □ Internet Search

□ Other: _____

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: (_____) _____-_____

Authorization to release medical information/Protected Health Information (PHI):

□Yes, I authorize Dr. Blum and her associates to share/release medical and billing information about myself with the following:

Name: _____ Relationship: _____

Phone number: _____

Check all that apply:

□ Scheduling/Appointment information

□ Medical information, including diagnosis, symptoms, medications, and treatment plan

□ Lab/test results

□ Billing and payment information

PatientSignature:_____

□ No, I do not authorize Dr. Blum and her associates to share/release medical and billing information about myself, with the exception of information releasable through HIPAA.

Consent for Communication via E-mail and Text

I hereby consent to have my physician, Dr. Robin Blum and/or members of her staff communicate with me via e-mail or text regarding all aspects of my medical care and treatment, including test results, prescriptions, appointments, billing, etc. I understand that e-mail and texting is not a confidential method of communication. I further understand that there is a risk that e-mail or text communications between my physician or members of her staff and me regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail or text communication between my physician and her staff may be printed out and made part of my medical record. I understand that in an urgent or emergent situation I should call my provider or go to the emergency room and not rely on e-mail or text.

Patient Signature:_____

PAST MEDICAL HISTORY:
Please Circle below if you have a history of: □ **N/A**

ANXIETY	DEPRESSION	HYPERTHYROIDISM
ARTHRITIS	DIABETES	HYPOTHYROIDISM
ASTHMA	END STAGE RENAL DISEASE	LEUKEMIA
ATRIAL FIBRILLATION	GERD	LUNG CANCER
BONE MARROW TRANSPLANT.	HEARING LOSS	LYMPHOMA
BREAST CANCER	HEPATITIS	RADIATION TREATMENT
COLON CANCER	HIGH BLOOD PRESSURE	SEIZURES
COPD	HIV/AIDS	STROKE
CORONARY ARTERY DISEASE	HIGH CHOLESTEROL	PACEMAKER

□ **OTHER:**

FOR WOMEN, are you currently: □Pregnant □ Trying to Get Pregnant □Breastfeeding □N/A

PAST SURGICAL HISTORY:

_____
_____
_____

MEDICATIONS: (please list all current meds including topicals) □**N/A**

_____ _____ _____
_____ _____ _____
_____ _____ _____

ALLERGIES TO MEDICATION: □ YES □ NO □ N/A

IF YES, Please Indicate: _____ _____

_____ _____ _____

SKIN DISEASE HISTORY: (please circle all that apply)

Acne	Eczema	Poison ivy
Actinic keratoses	Flaking or itchy scalp	Precancerous moles
Blistering Sunburns	Dry Skin	Psoriasis

NONE

Other _____

HAVE YOU EVER HAD A SKIN CANCER? □ YES □ NO

- If YES, which type?

  □ Melanoma When? _____ Body Site? _____

  □ Basal Cell Carcinoma When? _____ Body Site? _____

  □Squamous Cell Carcinoma When? _____ Body Site? _____

Melanoma Family History: Mother Father Sister Brother Daughter Son Other

SOCIAL HISTORY:

Cigarette Smoking/Tobacco Use:
□ Never □ Smokes/Uses Tobacco Less Than Daily
□ Quit: Former Smoker/User □ Smokes/Uses Tobacco Daily
Alcohol:
□ None □ 1-2 drinks per day
□ Less than 1 drink a day □ 3 or more drinks per day

What is the reason for your visit today?

_____
_____
_____

Would you like to discuss any of the following?
□Botox □ Fillers □Sculpsure/Laser body contouring □Photofacial Skin Rejuvenation
□Laser hair removal □Chemical peels □Uneven skin pigmentation □Skin tag removal
□Hand rejuvenation □Other

FINANCIAL POLICY

Central Park South Dermatology is dedicated to providing you with the best possible care and service, and as a commitment to you, we participate with a majority of health insurance plans. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees or your financial responsibility.

It is important for you to familiarize yourself with the specific requirements and policies of your insurance plan.

- If your insurance plan requires a referral from your Primary Care Physician in order for services to be covered, it is your responsibility to obtain the referral prior to your appointment. If a referral is not presented at your appointment, you will be responsible for the entire cost of the visit.
- Payments are expected at the time services are rendered.
- If your insurance requires you to meet an annual deductible before your visit is covered, you will be billed for all services rendered until you meet your deductible.
- If any services are denied as Out-Of-Network, not covered by the terms of the policy, policy not in force, not medically necessary, or have a deductible/co-insurance issue, you will be billed and are responsible for the balance.
- If a biopsy or lab specimen is collected at your visit, it is sent to an outside lab for processing. This is a separate service that may incur a bill if you have a lab fee or deductible fee and will be billed separately by the lab.
- If you fail to notify our practice of any insurance changes, you will be fully responsible for any fees not paid by your insurance company.
- Payments not received within 90 days of statement being sent will be sent to collections and subject to a $50 collections fee.

Cancellation Policy: As a courtesy, we make every effort to confirm appointments in advance. We will call and email or text. Please make sure to keep your contact information updated. If you are unable to keep an appointment, we ask that you give a 24 hour notice and if you need to cancel or reschedule an appointment, please speak to the receptionist directly. Messages left via phone, email, or text, are not considered as valid. ***In the event you are unable to give sufficient notice or have missed your appointment, a cancellation fee of $75 will automatically be billed to your account.***

Cancellation of a cosmetic appointment with less than 24 hours notice is subject to a $200 fee, or 50% of the cost of the procedure if the time slot allotted is over half an hour.

Returned checks will result in a $50 service charge.

Signature:_____ **Date**:_____

Patient Billing and Credit Card on File (CCOF) Policy

Central Park South Dermatology is committed to reducing waste and inefficiency and making our billing process as simple and easy as possible. Starting August 1, 2024, we are requiring that all patients provide a credit card on file with our office. We run our payments through our HIPAA-compliant, secure practice management software Modernizing Medicine. When you come in, we will scan your card with a card reader. Your payment information is stored on Modernizing Medicine's secure servers for future transactions. Office personnel will not have access to your card. For your protection, only the last 4 digits of your card will show in our system.

Credit Card on File (CCOF) will be used to pay account balances after insurance adjudication. Once your insurance has processed your claims, they will send an Explanation of Benefits (EOB) to both you and our office showing what you are responsible for your visit. If you disagree with the patient responsibility amount owed, it is your responsibility to contact your insurance carrier promptly.

Notes:

- Once your insurance company has processed your claim your credit card on file will be charged and we will then provide you with an emailed receipt. Please check your spam as our emails occasionally go to spam.
- If you would like us to use your Health Savings Account (HSA) or Flexible Savings Account (FSA), please provide us with the appropriate card information.
- During the time you leave a credit card on file, if it expires or becomes inactive, we will expect you to promptly provide a new means of payment.
- Ultimately, you are responsible for knowing what services are covered, how often, and how much of the cost is your responsibility As indicated in our financial policy, you will be responsible for any portion of services that your insurance does not cover.
- Charges processed will not compromise your ability to dispute a chare with your insurance company's determination of payment.
- **All patients will be required to have a credit card on file regardless of insurance or visit type.**

FAQs

When I booked my appointment, the receptionist told me I must keep a credit card on file with the office. Why do you do this?

Credit Card on File (CCOF) is the new standard in the healthcare industry nationwide. In the past few years we have seen an increase in patient copays and deductibles and a decline in physician reimbursement. This shift in patient responsibility puts increased administrative burden on medical offices to collect payment from patients. How efficiently our office collects your financial portion is essential for our practice to survive and thrive and offer you the best care.

How does CCOF work? *I'm nervous about giving up my sensitive financial information.*

Your card information is securely protected by the credit-card processing component of our HIPAA-compliant practice management system. This system stores the card information for future transactions using the same sort of technology that credit card company's use. We cannot access the entire card number – we can only see the last 4 digits. There is no way to export the card information out of our system. We can only use it to process a payment in our practice management system, which creates an indelible record (one that cannot be deleted).

I always pay my bills on time. Why do I have to do this?

The entire billing process is wasteful, and the many patients that we have to bill multiple times or even send to a collection's agency costs us a lot of time and expense. Reducing unnecessary costs is essential for us to continue to accept insurance and Medicare. This new process dramatically cuts down on the administrative costs associated with billing.

Nothing is changing about how much you pay.

When you come into our office and receive a service, you do so with the understanding that you are ultimately responsible for the cost of your care. We bill your insurance company for you, and we have contracts with most insurance companies that help to get you the best possible coverage for your care. CCOF will only cover your responsibility after your insurance pays its contracted share.

How does CCOF benefits patients ?

First and foremost, it is more convenient for you – you do not have to waste time calling the office, buying stamps, or worrying about getting around to paying the bill. It takes the hassle out of the process. If you get your statement and want to use a different card or pay by check, you may still do so as long as you do so promptly.

What if there is a problem with my bill and I don't notice it until after the payment is processed?

We hope that this does not happen. And although we love technology in this office, we routinely review the accuracy of claims processed by insurance and will contact you if we find a problem. But, if you find a problem, please call us and we will investigate it. If we owe you money, we will refund it promptly to the same card.

CREDIT CARD AUTHORIZATION

I, _____, authorize Central Park South Dermatology to charge any outstanding balances to the following credit card.

LAST 4 DIGITS of CARD NUMBER: _____

EXPIRATION DATE: _____

CREDIT CARD TYPE: _____

BILLING ZIP CODE: _____

NAME ON CARD: _____

SIGNATURE: _____

Date:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AS WELL AS HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY:

In general, The HIPAA (Health Insurance Portability and Accountability Act) privacy rule gives individuals the right to request restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to home or office, leaving messages on answering machines, and leaving lab or procedure results with a spouse.

I acknowledge that I have been provided a copy of Robin R. Blum, MD,PC/Central Park South Dermatology Notice of Privacy Practices and have been provided an opportunity to review it. I authorize release of medical information to my Primary Care Physician or Referring Physician, Consultants, if needed, and as necessary to process insurance claims, insurance applications, and Prescriptions. I also authorize payment of medical benefits to Robin R. Blum, MD, PC.

If you have any questions regarding this notice, please contact Dr. Robin Blum (privacy officer) at 212-969-9655.

Signature: _____ **Date:** _____