LOUCAS DERMATOLOGY

Emmanuel R. Loucas, M.D.,P.C.,
Director
Tatyana Groysman, D.O.,F.A.A.D

69 East 76th Street, New York, NY 10021
P.212.988.4357 F. 212.988.4374

Date: _____

Name: _____

Address_____

City: _____ State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Marital Status: M _____ S _____ D _____

Date of Birth _____ Age: ___ SSN # _____

Sex: M _____ F _____ Occupation _____

Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Spouse/Parent/Guardian Name _____
(Circle One)

Employer Name: _____

Employer Phone: _____

Medical Emergency Contacts: (list name & phone #'s)

Name: _____

Relationship: _____ Phone #: _____

HEALTH INSURANCE INFORMATION

Primary Insurance Co: _____

Name of Insured: _____

Relationship to Patient: (circle one)

Parent Spouse Self Other

Date of Birth of Insured: _____

Insurance ID#: _____

Group #: _____

SS # Of Insured: _____

Employer: _____

Insured/Group Name: _____

Co Pay Amount: _____

Name Of Insured: _____

Secondary Insurance Co: _____

Relationship to Patient: (circle one)
Parent Spouse Self Other

Date Of Birth of Insured: _____

SS# of Insured: _____

Insurance ID#: _____

Employer/ Group Name: _____

I understand that I am receiving medical service from this office under the provisions of my insurance plan. I will be financially responsible for all deductibles, copays and co-insurances under the terms of my insurance contract. If my insurance plan requires a valid referral to receive medical care, I understand that it is my responsibility to provide such a referral. If my referral is determined to be invalid by my insurance carrier, I understand that I will be financially responsible for balance on my account. If my insurance plan is not accepted by this office or the "indemnity" type, I understand that I am financially responsible for all balances remaining after payment of insurance benefits. I hereby authorize and assign directly to Loucas Dermatology, P.C. all medical benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Print Name: _____ Date: _____

Signature: _____

LOUCAS DERMATOLOGY

Emmanuel R. Loucas, M.D.,P.C.,
Director
Tatyana Groysman, D.O.,F.A.A.D

69 East 76th Street, New York, NY 10021
P.212.988.4357 F. 212.988.4374

Print Name: _____

Reason of Today's Visit: _____

We strongly recommend a complete body skin exam for skin cancer screening on your initial visit. Would you like one? Yes No

Seen by any other Dermatologist: YES NO If yes, whom: _____

When: _____ For what Problems: _____

PERSONAL HISTORY/GENERAL INFORMATION

Height: _____ Weight: _____

Drug Allergies	Yes	No
If so to what _____		
Food/Environment Allergies	Yes	No
Basal/Squamous Cell Carcinoma	Yes	No
Melanoma	Yes	No
Other Cancer	Yes	No
What type /when _____		
Hay Fever	Yes	No
Psoriasis	Yes	No
Eczema	Yes	No
Asthma	Yes	No
Bleeding Problems	Yes	No
Diabetes	Yes	No
Drug or Alcohol Abuse History	Yes	No
Hepatitis	Yes	No
If yes, which one Hepatitis	A B	C
HIV/AIDS	Yes	No
Hypertension	Yes	No
Aspirin Use	Yes	No
Use of Blood Thinners	Yes	No

List other operations, surgeries or diseases

_____
_____
_____
_____

Current oral medications, herbs, health foods, birth control other

_____
_____

Current topical & over the counter medications

_____

FAMILY HISTORY

Skin Cancer	Yes	No
If so, which type _____?		
other types of Cancer	Yes	No
If so, which type _____?		
Keloid/Enlarged scars	Yes	No
Heart Disease	Yes	No
Other skin conditions	Yes	No
please explain: _____		
Drug Allergies	Yes	No
Please explain: _____		
Other Allergies	Yes	No
Please explain: _____		

SOCIAL HISTORY

Are you pregnant	Yes	No
Do you smoke	Yes	No
Cigarettes/day _____ x year's _____		
Do you drink Alcohol	Yes	No
Drinks/ Week _____		

PRIMARY/ REFERRING DOCTOR

Name _____
Address _____
Phone: _____ Fax: _____

REFERRING FRIEND:

Friend: _____
Yellow Pages: _____
Internet: _____

PHARMACY NAME: _____

Address: _____

Phone: _____

Fax _____

LOUCAS DERMATOLOGY

Emmanuel R. Loucas, M.D.,P.C.,
Director
Tatyana Groysman, D.O.,F.A.A.D

69 East 76th Street, New York, NY 10021
P.212.988.4357 F. 212.988.4374

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION HIPAA CONSENT

With my consent Loucas Dermatology, P.C. may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Loucas Dermatologist Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Loucas Dermatology 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 Loucas Dermatology, P.C.

With my consent, Loucas Dermatology, P.C. may all my home or other designated location and leaves a message on voice mail or in person in reference to any item that assists the practice in carrying out TPO, such as appointment reminders, and insurance items and return calls requesting a call back.

With my consent Loucas Dermatology, P.C. may mail to my home or other designated location, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent Loucas Dermatology, P.C. may e-mail to my home or other designated location, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Loucas Dermatology, P.C. restrict how it uses or discloses my PHI to carry out TPO. However the practice is not 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 loucas Dermatology, P.C. use and disclose of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made discloses in reliance upon my prior consent. If I do not sign this consent Loucas Dermatology, P.C. may decline to provide treatment to me.

Print Patient Name _____ Patient's Signature _____

Date _____

Print Name of Legal Guardian _____ Legal Guardian's Signature _____

EXAM ROOM INSTRUCTIONS
*Please turn off all cell phones and pagers while in the office * If getting undressed please put clothing on chair and not on counter
*Please remove chewing gum, hard candies, or mints prior to exam * Please keep on only underpants and bra (optional) when undergoing complete body exam
Please take facial make-up off prior to exam * If any hand problems we usually like to examine the feet, so please remove socks & shoe

LOUCAS DERMATOLOGY

Emmanuel R. Loucas, M.D.,P.C.,
Director
Tatyana Groysman, D.O.,F.A.A.D

69 East 76th Street, New York, NY 10021
P.212.988.4357 F. 212.988.4374

FINANCIAL POLICY

Thank you for selecting Loucas Dermatology, P .C. for your dermatological care. In order to prevent any misunderstanding concerning the responsibility regarding payment for Medical/surgical care and /or any laboratory fees, the following information is provided.

HMO /PPO /OTHER INSURANCE COMPANIES

If you have insurance through a company we have contracted with, we will require a Copy of your insurance card and a d rive r's license. All co -payment are due prior to seeing the physician. If your insurance carrier required 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

Our physicians are participating Medicare providers and accept Medicare assignment which is the ALLOWABLE charge approved by Medicare. Medicare will pay 80% of the allowance charge after you pay for your annual deductible. You are responsible for any amounts applied to your deductible and the 20% co-insurance. If you have a secondary insurance, as a courtesy we will submit to that particular carrier any remaining balance. You will also be responsible for any service denied by your insurance carrier as not medically necessary and/or not covered.

LABORATORY

Depending on your insurance carrier's policy, you may be required to pay a separate co-payment for any specimen taken during your visit.

SELF-PAY AND COSMETIC PATIENTS

Patients with no insurance or cosmetics, the guarantor are responsible for the bill at the time of service.

RETURNED CHECKS AND COLECTIONS

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

CANCELATION POLICY: Please note any appointments that are not cancelled within 24 hours will be subject to a fee of $50

_____ _____

Signature Date

_____

Print Name

LOUCAS DERMATOLOGY

Emmanuel R. Loucas, M.D.,P.C.,
Director
Tatyana Groysman, D.O.,F.A.A.D

69 East 76th Street, New York, NY 10021
P.212.988.4357 F. 212.988.4374

An Important Message about your Insurance Coverage
Protect Your Insurance Benefits

In the past few years the number of different health insurance programs has increased at an amazing rate. Even within one company there may be several programs with varying benefits and requirements. There is no way that we can possibly know or keep up to date with each programs provision.

. Some programs require a specific facility to be used to be eligible for benefits

. Some programs require a patient to satisfy a deductible, co-insurance or other Out-of-pocket expense before paying for claims.

. Some programs require pre-authorization while others do not.

. Some programs require a signed referral from your primary care physician for any consultations or treatments with a specialist physician.

. Some programs may require a second opinion.

It must be your responsibility to know and advise us of your program's requirements in advance, each and every time we provide a service. We will do our best to comply with any requirements that your program may have. Please understand that if we provide a service that is outside of your program, you will be responsible for the appropriate fees.

These are not our regulations, they are your insurance company's regulations, and unless you follow them carefully the insurance company may decline all or part of your claim. Your insurance carrier should have provided you with a phone number to be used if you have any questions about your coverage.

In an insurance policy, the **deductible** is the amount of expenses that must be paid out of pocket before an insurer will pay any expenses. It is normally quoted as a fixed quantity and is a part of most policies covering losses to the policy holder. The deductible must be paid by the insured, before the benefits of the policy can apply. Typically, a general rule is: the higher the deductible, the lower the premium, and vice versa. Depending on the policy, the deductible may apply per covered incident, or per year. For policies where incidences are not easy to delimit (for example health insurance), the deductible is typically applied per year.

In health insurance, **coinsurance** is sometimes used synonymously with copayment, but is defined differently – a copay is typically fixed while the coinsurance is a percentage that the insured pays after the insurance policy's deductible is exceeded.

I acknowledge receipt of this information.

X_____ DATE_____

LOUCAS DERMATOLOGY

Emmanuel R. Loucas, M.D.,P.C.,
Director
Tatyana Groysman, D.O.,F.A.A.D

69 East 76th Street, New York, NY 10021
P.212.988.4357 F. 212.988.4374

Office Policy on Insurances and Payments

As a courtesy service to you, our office employs a billing service and participates with several insurance carriers. Please familiarize yourself with your insurance practices and policies.

1. If your insurance carrier requires you to pay a portion of your healthcare visits (i.e. Co-payment, Deductible, and Co-insurance), we are legally required to collect these and no exceptions will be made. You are required to pay your Co-payment at the time of your visit.

2. If your insurance carrier requires you to have a referral to be seen in our office, you must provide a referral or you will not be seen.

3. If your insurance requires you to meet an annual deductible or co-insurance before your healthcare is covered, you will be billed for the services rendered if you have not met your deductible.

4. You will be asked to leave a credit card number at the time of check-in. This information will be held securely until your insurances have paid their portion and notified us of your share. At that time, any remaining balance owed by you will be charged to your credit card from a secure site provided by chase bank and a copy of the charge will be mailed to you. Please note we only have access to last four digits of your card number. Security of your credit card information is very important to us.

Please note that this will not compromise your ability to dispute a charge or your insurance company's determination of payment. Unless otherwise specified, we will contact you via email regarding your balance. Please check here ___ if you do not wish to be contacted via email and prefer correspondence via regular postal mail.

I _____ (print name) authorize Loucas Dermatology to charge outstanding balances to my credit card on file.

Card Type: VS __ MC __ AMEX __ Card Number: _____ Exp Date: __/__ CVC Code _____

IS THE CARD PROVIDED AN HRA OR FLEX SPENDING ACCOUNT? YES __ NO ___

Select One:

___ Credit card billing address is the **same** as current address.

___ Credit card billing address is **different** from current address.
The correct address associated with the card provided is:

Street Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

I have read the above carefully and acknowledge these terms. I hereby assume all responsibility for any outstanding balances and (if selected) understand that these charges will be applied to the credit card I have provided.

Sign_____ Date _____