MANHATTAN DERMATOLOGY, PLLC

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NAME OF PATIENT: (LAST) _____ (FIRST) _____ (M.I.)_____

SOCIAL SECURITY NUMBER: _____ **DATE OF BIRTH**: _____ **AGE:** _____

SEX: M / F **MARITAL STATUS:** S / M / D / W / DP

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

PREFERRED PHONE # _____-_____-_____ **CELL/HOME #** _____-_____-_____ **WORK #**_____-_____-_____

EMAIL ADDRESS: _____@_____ **PHARMACY NUMBER:** _____-_____-_____

EMERGENCY CONTACT PHONE NUMBER: _____-_____-_____ **NAME:** _____

NAME OF EMPLOYER: _____**OCCUPATION:** _____

NAME OF PRIMARY INSURANCE COMPANY: _____

NAME OF INSURED: (LAST) _____ (FIRST) _____ (M.I.) _____

RELATIONSHIP TO INSURANCE HOLDER: SELF / SPOUSE / CHILD / OTHER **DATE OF BIRTH:** _____

INSURANCE HOLDER'S SOCIAL SECURITY NUMBER: _____

WERE YOU REFERRED BY A PHYSICIAN? (IF SO, PLEASE PROVIDE NAME) _____

ADDRESS OF REFERRING PHYSICIAN: _____

NAME OF PRIMARY CARE PHYSICIAN: _____**TELEPHONE:** _____-_____-_____

ADDRESS: _____ **ZIP CODE:** _____

IF NOT REFERRED BY A PHYSICIAN, HOW DID YOU HEAR ABOUT OUR OFFICE? _____

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOU:

ASTHMA	HEART DISEASE	MRSA	SEASONAL ALLERGIES
HIGH CHOLESTEROL	HIGH BLOOD PRESSURE	HEART ARRHYTHMIA	STOMACH ULCER/GERD
BLEEDING PROBLEMS	HEPATITIS A B C	ONYCHOMYCOSIS	THYROID DISEASE
PSORIASIS	HERPES	PARKINSON'S DISEASE	URTICARIA (HIVES)
CHICKEN POX/SHINGLES	HIV	TINEA VERSICOLOR	VITILIGO
DEPRESSION	HPV	RHEUMATOID ARTHRITIS / LUPUS	ACNE
DIABETES I OR II	KIDNEY/LIVER DISEASE	ROSACEA	
ECZEMA	LYME DISEASE	CANCER, PLEASE SPECIFY _____	
ARE YOU PREGNANT, NURSING, OR TRYING TO CONCEIVE? _____		OTHER MEDICAL PROBLEMS_____	

Do you currently smoke? Yes/No If yes, how many stick/pack_____ per day **Are you a former smoker?** Yes/No

Do you drink alcohol? Yes/No If yes, how much per week? _____

PERSONAL HISTORY OF SKIN CANCER:

_____

_____

FAMILY HISTORY OF SKIN CANCER/SKIN DISEASE:

_____

_____

LIST ALL ALLERGIES:

_____
_____
_____

LIST ALL MEDICATIONS, SUPPLEMENTS, VITAMINS:

_____
_____
_____

REASON FOR TODAY'S VISIT:

_____

WILL YOU FURNISH A PHONE NUMBER WHERE WE MAY LEAVE A MESSAGE WITH CONFIDENTIAL MEDICAL INFORMATION, SUCH AS LAB RESULTS? PLEASE SELECT EITHER _____ YES, OR _____ NO

IF YES PLEASE PROVIDE NUMBER _____-_____-_____

CANCELLATION POLICY:

IF YOU MUST CANCEL OR RESCHEDULE YOUR APPOINTMENT, WE REQUEST THAT YOU DO SO AT LEAST ONE BUSINESS DAY PRIOR TO YOUR APPOINTMENT. IF YOU MISS AN APPOINTMENT WITHOUT DOING SO, WE WILL PUT THROUGH A $50.00 CHARGE ON YOUR CREDIT CARD.

FOR SURGICAL PROCEDURES, ½ HOUR COSMETIC APPOINTMENTS, OR PATCH TESTING APPOINTMENTS, YOU MUST CANCEL 24 HOURS PRIOR TO YOUR APPOINTMENT OR YOU WILL BE CHARGED A $250 FEE.

FOR MOH'S MICROGRAPHIC SURGERY APPOINTMENTS, YOU MUST CANCEL ONE WEEK PRIOR TO YOUR APPOINTMENT, OR YOU WILL BE CHARGED A $250 FEE.

FOR SCITON AND FRAXEL LASER APPOINTMENTS, YOU MUST CANCEL ONE WEEK PRIOR TO YOUR APPOINTMENT, OR YOU WILL BE CHARGED A $500 FEE.

FINANCIAL POLICIES:

ALL COPAYS ARE EXPECTED AT THE TIME OF THE VISIT.
YOU MAY RECEIVE A SEPARATE BILL FOR LAB CHARGES.

IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR INSURANCE PLAN'S POLICIES AND TO GET REFERRALS FROM YOUR PRIMARY CARE PHYSICIAN IF REQUIRED BY THE PATIENT'S INSURANCE PLAN. EVEN IF WE ARE IN NETWORK WITH YOUR INSURANCE, DEDUCTIBLES OR COINSURANCE MAY APPLY, WHICH MEANS YOU MAY BE RESPONSIBLE FOR A PORTION OF THE CHARGES. ***PLEASE INITIAL HERE*** **_____**

THIS FORM AND MY SIGNATURE AFFIXED HERETO MAY SERVE AS A SIGNATURE-ON-FILE TO BE USED TO AUTHORIZE DISCLOSURE OF THE MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM, INCLUDING THE DIAGNOSIS AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME, AND TO FILE ALL FUTURE INSURANCE CLAIMS RELATED TO MY CARE.

I ALSO AUTHORIZE MY INSURANCE COMPANY TO PAY DIRECTLY TO DR. WILLIAM T. LONG, DR. WENDY S. LONG MITCHELL, DR. FORREST N. WHITE, DR. GEORGE G. KIHICZAK, AND/OR DR. TAYLOR M. DEFELICE THE AMOUNT DUE TO ME IN PENDING CLAIMS FOR MEDICAL OR SURGICAL TREATMENT OR SERVICES RENDERED TO ME.

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS PRACTICE'S NOTICE OF PRIVACY PRACTICES.

PATIENT'S OR RESPONSIBLE PARTY'S NAME: _____

PATIENT'S OR RESPONSIBLE PARTY'S SIGNATURE: _____DATE: _____

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Dear Patient:

We value you as a patient and appreciate that you have entrusted us with your health care needs.

Insurance companies and employers do not cover deductibles, coinsurances and copayments, as you know. It is our office policy to collect patients' credit card information to allow payment for these items and so avoid the need to bill you later. This saves expense for the billing and time for you and the office.

By signing below, you authorize payment by credit card for services for amounts listed as payment responsibility by your health benefit plan (including, but not limited to co-insurance, deductibles and/or uncovered services). We do not store your sensitive credit card information in our office. We store it in a secure site called a gateway. We access your information on this site only to process a payment.

We appreciate your cooperation in this matter and will guard your financial information under government HIPAA and HITECH guidelines.

Patient Name: _____

Signature: _____Today's Date: _____

HEALTH INFORMATION EXCHANGE,
CARE EVERYWHERE AND HEALTHIX
CONSENT FORM

Practices Please Fax signed consents to: **917-829-2096**

William T. Long, M.D.

Patient **MRN**/Patient ID in EMR:

In this Consent Form, you can choose whether to allow the health care providers listed on the NYU Langone Medical Center Health Information Exchange ("NYULMC HIE") website http://health-connect.med.nyu.edu/ ("HIE Participants") and non-NYU health care providers who may request access to your medical records for purposes of current treatment ("Care Everywhere Providers") to obtain access to your medical records through a computer network operated by the NYULMC HIE. In order for a Care Everywhere Provider to know that information may be available through the NYULMC HIE, you must tell them that you were/are a patient of an HIE Participant and that such information may be available upon request. This can help collect the medical records you have in different places where you get health care, and make them available electronically to the providers treating you.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of NYU Hospitals Center to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization (RHIO), a not-for-profit organization recognized by the state of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent also gives your permission for any NYU Langone Medical Center program in which you are a patient or member, to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling Healthix at 877-695-4749**.** Upon request, your provider will print this list for you from the Healthix website.

YOUR CHOICE WILL NOT AFFECT YOUR ABILITY TO GET MEDICAL CARE OR HEALTH INSURANCE COVERAGE. YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES.

The NYULMC HIE and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

PLEASE CAREFULLY READ THE INFORMATION ON THE FACT SHEET BEFORE MAKING YOUR DECISION.

Your Consent Choices. You can fill out this form now or in the future. You have the following choices:

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.

_____ _____

PRINT Name of Patient Patient Date of Birth

_____ _____

Signature of Patient or Patient's Legal Representative Date

_____ _____

Print Name of Legal Representative (if applicable) Relationship of Legal Representative to Patient (if applicable)