Downtown Dermatology

291 Broadway, Suite 1803 New York, NY 10007 Ph. (212) 233-2995 Fax. (212) 227-6577

DATE: ___/______/_____

LAST NAME: ________________________________ **FIRST NAME:** ________________________________

SEX: _____ **DATE OF BIRTH:** ____/____/_____ **SS#:** _______________ **EMAIL:** ____________________

ADDRESS: ________________________________ **CITY:** ______ **STATE:** ______ **ZIP:** ___________

HOME PHONE: ______________________ **CELL:** ______________________ **MARITALSTATUS** ___________

REFERRED BY: ________________________________ **If a doctor referred you, please provide:**

ADDRESS: ________________________________ **PHONE:** ______________________

PHARMACY: ________________________________ **PHONE:** ______________________

PATIENT'S BUSINESS DATA

EMPLOYER: ________________________________ **OCCUPATION:** ______________________

ADDRESS: ________________________________ **CITY/STATE** ________________ **ZIP:** __________

EMERGENCY CONTACT (Spouse/Parent/Nearest Relative/Friend)

NAME: ________________________________ **Relationship to Patient:** ______________________

ADDRESS: ________________________________ **CITY/STATE:** ______________ **ZIP:** ________

HOME/CELL: ___________________ **WORK PHONE:** ________________ **EMAIL:** ______________________

PRIMARY INSURED'S NAME: ________________________________ **DATE OF BIRTH:** ________________

HOW DID YOU HEAR ABOUT OUR OFFICE? CHECK ALL THAT APPLY:

- ☐ YELP
- ☐ CITY SEARCH
- ☐ YELLOW PAGES.COM
- ☐ INSURANCE
- ☐ PATIENT/PHYSICIAN REFERRAL
- ☐ GOOGLE
- ☐ RATE MD
- ☐ VITALS
- ☐ ZOCDOC

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Patient Name: ______________________________

Date: ___/___/___ **Last Total Skin Exam:** ___/_____/_____

Reason for Consultation: ______________________________

Duration: _____ **Days** _____ **Wks** ______ **Mths** ______ **Yrs** **Location:** ____________________

CHECK ALL THAT APPLY:

☐ Persistent ☐ Episodic ☐ Recurrent ☐ Bleeding ☐ Scabbing/Crusting
☐ Burning ☐ Itching ☐ Flaking ☐ Redness ☐ Blisters ☐ Spreading
☐ New Lesions ☐ Roughness ☐ Painful ☐ Change in Color/Shape

CHECK ALL THAT APPLY:

MEDICATIONS	SOCIAL HISTORY	FAMILY HISTORY	ALLERGIES
☐ NONE	☐ MARRIED	☐ NONE	☐ NONE
	☐ WIDOWED	☐ MELANOMA	☐ ASPIRIN
	☐ DIVORCED	☐ DYSPLASTIC NEVI	☐ PENICILLIN
	☐ SINGLE	☐ BASAL CELL	☐ LATEX
	☐ PARTNERED		☐ OTHER
	WEIGHT: ___(LBS HEIGHT:_____	PACEMAKER: Y ◯ N ◯ PRE MEDICATION: Y◯ N ◯	

MEDICAL HISTORY	☐ HIV	SURGERIES
☐ NONE	☐ ASTHMA	☐ NONE
☐ CANCER	☐ CHOLESTEROL	
☐ BLOOD TRANSFUSION	☐ THYROID DISEASE	**TANNING BED USE**: Y◯ N◯
☐ COLLAGEN VASUCLAR DISEASE	☐ CARDIAC DISEASE	**SMOKING**: CIG ◯ CIGAR◯ NO◯
☐ BLEEDING DIATHESES	☐ HEPATITIS A◯ B◯ C◯	**ALCOHOL**: SOCIALLY◯ DAILY◯ NO◯
☐ DIABETES	☐ HIGH BLOOD PRESSURE	

PAST COSMETIC PROCEDURES: ☐ LASER ☐ BOTOX ☐ FILLERS PEELS ☐ FACE LIFT ☐ TATTOO

IF FEMALE: MENSES: REGULAR ◯ IRREGULAR◯ **LAST MENTRUAL PERIOD:** ___________ **PREGNANT**: Y◯ N◯
BREASTFEEDING: Y◯ N◯

Downtown Dermatology L.L.C.

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New York, N.Y. 10007

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Fax: (212) 227-6577

Credit Card Authorization Form

Dear Patient,

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

As you know, there are charges for each of the medical services that we provide you. Co-payments, deductibles, co-insurance, and charges for medical services are determined by your specific health care coverage. Please be aware that your health plan does not guarantee the accuracy of its confirmation of coverage or benefits.

Since you are ultimately responsible for the medical services provided to you, **it is our policy to obtain your credit card number and authorization to process payment for charges not covered by your insurance carrier.** These health benefits are decided by your employer and selected health plan.

In providing your credit card information below, you authorize payment by credit card for services in the absence of coverage by your health plan including, but not limited to, co-payments, deductibles, co-insurance, and all uncovered medical services rendered by Downtown Dermatology L.L.C. and received by you.

Your credit card information will be kept on file. The staff of Downtown Dermatology will contact you by phone or email to inform you of outstanding balances and to provide you with a copy of the EOB as proof of non coverage prior to use of the credit card.

***Please note that Downtown Dermatology has the right to refuse medical services if credit card information is not provided.**

We thank you in advance for your cooperation,

Sincerely,
Downtown Dermatology

Credit Card Information

Patient's First Name:______________________ Last Name:______________________

Name on Card:____

Card Type: Visa ( ) Master Card ( ) American Express ( )

Card Number: ______________________________ Expiration Date: ___/___/___

Security Code: ______________

Signature______________________________ Today's Date: ___/___/___

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NO SHOW /CANCELLATION POLICY

Dear Patient/Parent,

In an effort to maximize the time your physician spends with you and minimize your wait time, we have made changes to our **No-Show Policy/Cancellation Policy** as follows:

Effective immediately, a No **Show /Cancellation Fee** will affect **ALL** patients that fail to keep their scheduled appointment or those that cancel an appointment with less than a 24-hour notice.

This fee will be charged to the credit card on file

- Patients will receive a $50.00 fee for Office Visit/Regular Visit Appointments
- Patients will receive a $150.00 fee for Surgical or Cosmetic Appointments

Thank You for your understanding.

Patient Name: ____

Patient Signature or Parent/Guardian Signature: ______________________________

Date: ______________________

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HIPPA CONSENT FORM

This consent form allows Gilberto **Alvarez del Manzano Dermatology PLLC** to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

Gilberto Alvarez del Manzano Dermatology PLLC has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. it provided this notice prior to my signing the form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may changes and that I may obtain revised notices by mail or by an update on our website.

I understand that I have the right to request, now and in the future, how protected health information is used or disclosed to carry out treatment, payment and health care operations. I understand that while Gilberto Alvarez del Manzano Dermatology PLLC is not required to agree to my restricted restrictions, if it does agree, it is bound by that agreement.

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that the service may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected information.

I understand that Gilberto Alvarez del Manzano Dermatology PLLC may refuse me further service if I revoke the consent.

I request that Gilberto Alvarez del Manzano Dermatology PLLC have access to my medical records, information on my condition, and any of my protected health information.

______________________________ ______________

PATIENT'S NAME (LEGAL GUARDIAN IF A MINOR) **DATE**

______________________________ ______________

PATIENT'S SIGNATURE (LEGAL GUARDIAN IF A MINOR) **DATE**

______________________________ ______________

PRIVACY OFFICE (FOR OFFICE USE) **DATE**

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INSURANCE ACCEPTANCE AGREEMENT

IN-NETWORK/OUT OF NETWORK AND/OR PRIVATE INDEMNITY INSURANCE ALLOWANCE AGREEMENT:

I fully understand that, even though I have a referral authorization from my primary care physician, if my carrier deems that the visit/or procedure is cosmetic or not medically necessary, I will accept full responsibility for payment to Dr. Gilberto Alvarez del Manzano.

In addition, should my carrier deny payment due to the fact that I have a pre-existing condition, I will accept full responsibility for payment. Accepting your insurance allowance means that you are responsible for the payment of all deductible and co-insurance(s), if applicable, which is the difference between the insurance carrier approved/allowed amount and the paid amount. Each individual may have an annual deductible amount that must be satisfied prior to the insurance benefits commencing. If my insurance carrier determines that the visit/procedure is deemed cosmetic or not medically necessary, I will accept full responsibility for payment. In conclusion, should my carrier deny payment due to the fact that I have a pre-existing condition, I will accept full responsibility for payment of the charges outstanding.

ALL PATIENTS PLEASE READ AND SIGN THE FOLLWING:

If I have unknowingly provided the incorrect information, such as the primary carrier, effective date of coverage or I have not provided your office with the necessary identification card and /or referral authorization at the time services are rendered, I agree to be fully responsible for the charges incurred. Furthermore, if it is later ascertained that I am insured by a carrier of which you are not a participating provider, I understand that I will only be reimbursed the insurance payment issued and not the charges I have incurred and paid.

I authorize the release of any information necessary to process my insurance claim. I request that payment be made directly to the physician for services rendered. A copy of this authorization may be used in place of the original. This is also an authorization for the doctor to take, or direct to be taken, any photograph(s) required for the completion or records. These photographs shall be the sole property of Dr. Alvarez del Manzano and may be used for educational or promotional purposes. It is also understood that these photographs may be used in medical or lay publications or shown at scientific meetings. The patient's identity will be concealed.

I am aware that the office policy states that I must notify the office at least 24hrs in advance, should I need to reschedule my appointment. In the event that I do not call or email the office within 24hrs of my scheduled appointment or I simply do not show, I understand that I will be billed $25* for an office visit and $50 for cosmetic/aesthetic or procedure appointments. I agree that I will accept full responsibility for this charges and payments for appointments not cancelled 24hrs in advance.

PATIENT'S NAME: ______________________________ **DATE:** ____________

PATIENT/GUARDIAN'S SIGNATURE: ______________________ **DATE:** ____________

NYULMC HIE,
CARE EVERYWHERE and HEALTHIX
CONSENT FORM

Downtown Dermatology

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)

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MEDICAL RECORDS RELEASE FORM/ PATIENT ACCESS OF MEDICAL INFORMATION

PATIENT NAME_________________________DATE OF BIRTH________________________S.S.#______________________

STREET, APT #____

CITY, STATE, ZIP CODE____TELEPHONE #_____________________________

I hereby authorize the Medical Records Department at Downtown Dermatology to release information from my medical record to (If self-please indicate below):

NAME____

ADDRESS____

CITY, STATE, ZIP CODE____

TELEPHONE: (   ) _________________________   FAX: (   ) _______________________

I limit the information to be released to the following items: (Please check specific items)

_____Consultation

_____Diagnostic test (e.g. Lab, X-ray, Radiology)

_____Pathology

_______ ALL medical Records

Covering records from on or about (Date)___________________________________to (Date)_________________________________

CONFIDENTIAL INFORMATION

________ I understand that if my record contains **information concerning mental health and/or drug and alcohol treatment**, such information will be released pursuant to this authorization.

________ I understand that if my record contains **confidential HIV related information**, such information will be released pursuant to this authorization form. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV. I know I do not have to allow release of HIV related information and that I can change my mind at any time before it is released.

This authorization will automatically expire within six months from the date of signature. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department at Downtown Dermatology. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I also understand that I have the right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form. You also have a right to receive a copy of this form after you have signed it.

I also understand Downtown Dermatology is not responsible for another provider/individual re-disclosure of your medical records. However, the potential for an unauthorized re-disclosure may not be protected by federal confidentiality rules.

I also understand that in order to process this request to reproduce medical record information on a timely basis Downtown Dermatology, in which I am requesting information from, may utilize a photocopy service and my signature authorizes the release of information to such photocopy service for the purpose of satisfying this request.

____   _______________________________________
(Signature of Patient/ Representative/ or Legal Guardian)   (Date)

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PERMISSION TO ACCOMPANY A MINOR

I, ___________________________, give permission to ____________________________
(Name of Parent/Guardian) (Name of adult to be accompanying child)
to accompany my child __________________________ and authorize treatment for my
(child's name and DOB)
child in accordance with the office policy of Downtown Dermatology. This includes bringing the child into the office of Downtown Dermatology, providing a history of present illness, disclosing protected health information, accompanying consented research study procedures, and witnessing any physical exam completed by the provider. This adult has the responsibility to relay any diagnosis, treatment plan or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all copays and coinsurance.

This authorization is effective from: ______________ to ______________.
(effective date) (end date)

Child's Health Information
Current prescribed or over-the-counter medications and dosages:
Medication: _____________________________ Dosage: ______________________
Medication: _____________________________ Dosage: ______________________
Allergies, illnesses or other comments: ____
____

Emergency Contact Information for Parents/Guardians:
Where/how can you be contacted in case of emergency? ___________________________
Phone: ______________________________
Comments: ____

Health Insurance Information ❒ No change since last visit *(skip to next section)*
Insurance Company: __________________________ Policy Holder: ___________________
ID Number: _________________________________ Group Number: _________________

Parent or Legal Guardian's Name: ____

Parent or Legal Guardian's Signature: _______________________________________

Date:_____________