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 ◯

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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:** _____

Downtown Dermatology L.L.C.

291 Broadway Suite 1803
New York, N.Y. 10007

Tel: (212) 233-2995
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: ____/____/____

Downtown Dermatology

291 Broadway, Suite 1803
New York, NY 10007

Ph. (212) 233-2995
Fax. (646) 810-4939

Cancellation Policy/No Show Policy for Doctor Appointments

Our goal is to provide quality medical care in a timely manner. In order to do so we have had to implement an appointment/cancellation policy.

The policy enables us to do better utilize available appointments for our patients in need of medical care.

1. Cancellation/No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

A "no show" is someone who misses an appointment without canceling it with a 24-hour/s working day advance notice/without a 24-business hour/s notice from Monday to Friday.

No-shows inconvenience those individuals who need access to medical care in a timely manner.

2. How to Cancel Your Appointment?

If it is necessary to cancel your scheduled appointment, we require that you call one working day in advance / 24-business hour/s from Monday to Friday.

Please note that this constitutes Monday-Friday only.

Appointments are high in demand, and your early cancellation will give another person the possibility to have access to timely medical care.

To cancel an appointment, please call our office from 10:00 am through 5:00 pm at (212-233-2995) from Monday to Friday.
If you call after hours, you will be directed to our secure patient portal, KLARA.

Please leave a message and we will respond as soon as possible.

3. Scheduled Appointments

We understand that delays can happen, however, we must try to keep the other patients and doctors on time. If you are running late, please notify the office. If a patient is 15 minutes past their scheduled time, there may be a wait associated. If we are unable to accommodate a late appointment, we may have to reschedule your appointment.

The following are charges for services in the office:

Same Day Appointment Cancellation: $50.00

No Show Fee: $50

Procedure Appointment (30mins or more): $150.00

Thank you for understanding.

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Date: _____

Patient Name: _____

Patient Date of Birth: _____

1. Have you traveled outside the United States in the past 14 days (2 weeks)? If yes, please list countries: _____	□ YES □ NO
2. Has a close contact (household member) traveled outside the United States in the past 14 days? If yes, please list countries: _____	□ YES □ NO
3. Have you had close contact with a person with Coronavirus (COVID-19), Middle Eastern Respiratory Virus (MERS), Ebola/Lassa/Marburg, Measles, Mumps, Chickenpox, or any other known infectious disease?	□ YES □ NO
4. Do you have a fever (temperature of 100.4°F [38C]) or feel hot?	□ YES □ NO
5. Do you have a cough, shortness of breath, sore throat?	□ YES □ NO
6. Are you vomiting or have diarrhea?	□ YES □ NO
7. Do you have any rash?	□ YES □ NO

If you answer YES to any part of question 1, and YES to any other question, please notify the staff immediately for further instructions.

Healthix

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow Gilberto Alvarez del Manzano Dermatology PLLC DBA Downtown Dermatology to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically to improve the quality of healthcare and meets the privacy and security standards of HIPAA, the requirements of the federal confidentiality laws, 42 CFR Part2, and New York State Law. To learn more visit Healthix's website at www.healthix.org.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for Gilberto Alvarez del Manzano Dermatology PLLC DBA Downtown Dermatology to access ALL of my electronic health information through Healthix to provide health care.

☐ **2. I DENY CONSENT** for Gilberto Alvarez del Manzano Dermatology PLLC DBA Downtown Dermatology to access my electronic health information through Healthix for any purpose.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through Healthix and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.
2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization listed may access ALL of your electronic health information available through Healthix. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases
   - Medication and Dosages
   - Diagnostic Information
   - Allergies
   - Substance use history summaries
   - Clinical notes
   - Discharge summary
   - Employment Information
   - Living Situation
   - Social Supports
   - Claims Encounter Data
   - Lab Test
3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Healthix. You can obtain an updated list at any time by Healthix's website at www.healthix.org or by calling 877-695-4749.
4.
5. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.
6. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Healthix for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.
7. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Gilberto Alvarez del Manzano Dermatology PLLC DBA Downtown Dermatology at (212) 233-2995; or visit Healthix's website: www.healthix.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.
8. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.
9. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice, death or until such time as Healthix ceases operation. If Healthix merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.
10. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.
11. **Copy of Form**. You are entitled to get a copy of this Consent Form.