CONFIDENTIAL DATA

BODIAN DERMATOLOGY GROUP, PC
11 GRACE AVENUE, SUITE 100
GREAT NECK, NY 11021

T: 516-482-2882
F: 516-482-6039

Date _____ **Patient's Date of Birth** _____ **Social Security Number** _____

Patient Name _____
Last First Middle

Home Address _____
Street City State Zip Code

Home Phone # _____ Cell Phone # _____ Other Phone # _____

E-mail address _____ May we contact you by e-mail? □ Yes □ No

Patient Sex □ Male □ Female **Relationship Status**: □ Married □ Single □ Widowed □ Divorced □ Partnered □ Other

Referred by: □ Friend_____ □ Family_____ □ Online_____ □ Other_____

Referring Physician _____
(First) (Last)

Address _____

Phone # _____

Family Physician _____
(First) (Last)

Address _____

Phone # _____

Name of Spouse/Partner _____ Spouse/Partner Work #_____ Spouse/Partner Cell# _____

Name & phone number of nearest relative not living with you: Name_____ Phone#_____

Pharmacy Name _____ Phone# _____

Address _____
Street City State Zip Code

IN ORDER FOR US TO FILE WITH YOUR INSURANCE COMPANY, ALL INFORMATION IN THIS SECTION MUST BE COMPLETE & ACCURATE. YOU MUST FILL THIS OUT EVEN THOUGH YOUR INSURANCE CARD HAS BEEN COPIED.

INSURANCE INFORMATION

Primary Insurance _____

Policy ID # _____

Group # _____

Policy Holder _____
□ Male □ Female

Relationship _____

DOB _____

Secondary Insurance _____

Policy ID # _____

Group # _____

Policy Holder _____
□ Male □ Female

Relationship _____

DOB _____

Please note: This information is requested for your protection, incorrect information supplied could result in your insurance not paying for services, leaving you responsible for the balance. If you are unsure of any information, we can make a telephone available for you to retrieve information. If you have any questions, please feel free to ask the receptionist.

RELEASE OF INFORMATION

I hereby authorize insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services or items processed as patient responsibility per the insurance. I also authorize the physician to release information required to process claims and agree that a photocopy of this authorization is as valid as the original. If for any reason you request your medical records to be sent to anyone, I.E. (yourself, physician, attorney, etc.) you **will** be charged a fee, unless **we** refer you to another physician.

Signature **Date**

BODIAN DERMATOLOGY GROUP AND MEDICAL SPA, P.C.

PATIENT HIPAA

With my permission, Dr. Adam Bodian &/or his associates may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare options (TPO). Please refer to the Bodian Dermatology Group's 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. Dr. Adam Bodian &/or their associates reserve the right to revise their Notice of Privacy practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Dr. Adam Bodian &/or his associates may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Dr. Adam Bodian &/or his associates 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 permission, the office of Dr. Adam Bodian &/or his associates 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 they restrict how they use or disclose 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, I am allowing Dr. Adam Bodian &/or his associates to use and disclose my PHI for TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

I hereby allow release of my medical information to the following individual (s):

_____

Print Name-Relationship

_____ _____

Signature of Patient or Legal Guardian Print Patients Name

Date: _____

BODIAN DERMATOLOGY GROUP, PC

Financial Policy
Effective 09/01/2015

Patient Name:_____

Thank you for choosing BODIAN DERMATOLOGY as your health care provider. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies with you.

1. _____I understand that if I do not have my insurance card, referral, and / or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments.
2. _____I understand that BODIAN DERMATOLOGY will collect all copayments and fees for any cosmetic procedures at the time of visit.
3. _____I understand that I am responsible for all deductibles and co-insurance balance. Deductibles and coinsurance are determined by billing code(s), details of your insurance policy, and agreement between your insurance company and BODIAN DERMATOLOGY. Any overpayment to your account will be refunded to you at your request after payment and/or remittance has been received from your insurance company.
4. _____I agree that if a co-payment or co-insurance comes directly to me I will send this balance to BODIAN DERMATOLOGY.
5. _____I understand that if I am unable to make a scheduled appointment I need to contact BODIAN DERMATOLOGY at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen. A $25 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS & $75 FOR MISSED PROCEDURES NOT CANCELLED WITH AT LEAST 24-HOUR ADVANCE NOTICE.
6. _____ I understand that if my account is not paid in full within 90 days of a statement date, a 35% collection agency processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.
7. _____BODIAN DERMATOLOGY will allow 60 days from the date of filing for my insurance company to process or pay a claim. State law allows insurance companies operating in the state no more than 60 days to process claims. It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify BODIAN DERMATOLOGY if there is any change in my insurance coverage, residence, or phone number. ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by BODIAN DERMATOLOGY.

Signature of Responsible Party:_____ **Date:**_____

ASSIGNMENT OF BENEFITS

We require insured patients to complete assignment of benefits authorizing insurance to remit payment to physician's office. I

hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: BODIAN DERMATOLOGY. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Signature of Responsible Party:_____**Date:**_____

DERMATOLOGY
LASER CENTER
MEDICAL DAY SPA
COSMETIC SURGERY
bodian dermatology

11 Grace Avenue, Suite 100
Great Neck, New York 11021
Tel: 516-482-2882 / Fax: 516-482-6039

Patient's Name: _____ **Date:**_____

Drug Allergies: _____

Past and Current Medical Conditions	Yes	No
Bleeding Tendency	☐	☐
Problem with Healing	☐	☐
Tendency to form Hypertrophic Scars/ Keloids	☐	☐
Artificial Heart Valve/ Mitral Valve Prolapse	☐	☐
Lung Disease/ Emphysema/ COPD	☐	☐
Pacemaker/ Defibrillator	☐	☐
Pregnant/ Planning Pregnancy/ Breastfeeding	☐	☐
Prosthetic Replacement: specify_	☐	☐
Blood Disorder: specify	☐	☐
Hypo/Hyperthyroidism	☐	☐
Diabetes	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
HIV/AIDS	☐	☐
Hepatitis/ Liver Disease		
Ulcers/ GI Disease		☐
Kidney Disease		☐
Arthritis/ Muscles/ Joint Disease		☐
Anxiety/ Depression/ Psychiatric Problems		
Cancer Type (other than Skin) _____		

Skin History	Yes	No
Skin Cancer	☐	☐
Melanoma: Year diagnosed_____	☐	☐
Family History of Melanoma:	☐	☐
Relation to self: _____		
Atypical Moles	☐	☐
Pre-Cancers/ Actinic Keratosis	☐	☐
Psoriasis	☐	☐
Atopy (ie. Allergies, Asthma, Hay Fever, Eczema)	☐	☐
Skin Disease (please specify) _____		
Previous Surgery (please specify)_____		
* If over 65 years old, have you previously received pneumococcal (pneumonia) vaccination? Yes ☐ No ☐		

Social History

Curren Yes ☐ No ☐ How much_____
Former Yes ☐ No ☐ How long _____
Drink A Yes ☐ No ☐ How much_____

****PLEASE INFORM THE DOCTOR AT ANY TIME IF YOU BECOME PREGNANT DURING YOUR TREATMENT**

TO ALL PATIENTS- FULL BODY EXAM IS RECOMMENDED ANUALLY. If you desire this examination, please tell the receptionist to schedule a full body exam for your next appointment. Please note: No other procedures are performed during this type of appointment.

Patient or Parent/Guardian Signature_____Date_____

DERMATOLOGY
LASER CENTER
MEDICAL DAY SPA
COSMETIC SURGERY

bodian dermatology

11 Grace Avenue, Suite 100
Great Neck, New York 11021
Tel: 516-482-2882 / Fax: 516-482-6039

Patient Name: _____Date of Birth: _____/_____/_____Today's Date: _____/____/____

Do you have any Allergies to Medication? Yes ☐ or No ☐ If yes, list allergies and reactions to medication(s) below

_____

Do you currently take any Medications? Yes ☐ or No ☐ If yes, please list all medications that you are currently taking. Include eye drops, inhalers, contraceptives, patches that contain medication, over-the counter medications (e.g; aspirin, antacids) and dietary/ herbal supplements (e.g; vitamins, gingko biloba). Also include medications taken as needed (e.g; nitroglycerin)

Date	Name of Medication & Dose (e.g; mg, drops)	Directions (e.g; am, pm)	Reason for taking/ Prescribing MD name	Prescribed or started recently? (Y/N)

To Our Patients:

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays due at the time of the visit will, of course, still be due at the time of the visit.

If you have any questions about this payment method, do not hesitate to ask.

Sincerely yours,

Adam B. Bodian, M.D.

I authorize Bodian Dermatology Group, PC to charge outstanding balances on my account to the following credit card:

Visa MasterCard American Express Discover

Credit Card Number_____

Expiration Date _____ Security Code _____

Print Name_____

Signature _____