Manhasset Dermatology, P.C.
Patient Registration Form

Name: ____ ☐ Jr ☐ Sr
First *MI* *Last*

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. Gender: ☐ Male ☐ Female Date of Birth: ____/_____/__________

Race: ________________________(African American, Asian, Caucasian, Chinese, Hispanic, multiracial, etc.)

Ethnicity (please select one): ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Social Security #: ____________________________ Preferred Language: ____________________________

Address: ____
Street # *Street Name* *Apt #*

____
City *State* *Zip*

Home Phone: (   )__________________________ Alternate/Cell Phone #: (   )________________

Employer: ______________________________ Work Phone: (   )_________________________
Name

Referred By: ______________________________ Primary Care Physician: ______________________

Pharmacy Name: ___________________________ Pharmacy Telephone No.: _____________________

Please tell us how you learned about our office: ☐Insurance ☐Friend ☐Family Other: ______________

Spouse's Name: ____________________________ Spouse's Date of Birth:______/______/________
M D Y

If Student: ☐ Full Time ☐ Part Time Name of School: ____________________________

I authorize Manhasset Dermatology, P.C. to release medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I agree that Manhasset Dermatology may e-prescribe my prescriptions and may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. I authorize my doctor to act as my agent in helping me obtain payments from my insurance company. I also authorize payment of medical benefits to the physician. Should my insurance carrier require a referral from my primary care physician, I must obtain such referral and present it at the time of my visit. Should I fail to obtain the required referral form by the end of the date of service and/or should my insurance fail to make a payment for my visit, I am assuming responsibility for payment of these charges and can be billed directly. In order to establish optimal relations with our patients and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event that your check is returned for insufficient funds, an additional $40.00 fee will be added to your account. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services, or co-payments. In the event that your account must be turned over to collections, a $10.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy. I permit a copy of this authorization to be used in place of the original.

Patient or Responsible Party Signature: ____________________________ Date:______________________

Do we have your permission to:

- Leave a message on your answering machine at home? ☐ Yes ☐ No
- Leave a message at your place of employment? ☐ Yes ☐ No
- Discuss your medical condition with any member of your household? ☐ Yes ☐ No

If yes, with whom: ____________________________________ Relationship: ______________________

Revised 3-2014

INSURANCE INFORMATION

Primary Insurance Name: ______________________ Secondary Insurance Name: ______________________

Patient's ID #: ______________________ Patient's ID #: ______________________

Group #: ______________________ Group #: ______________________

Name of Policy Holder: ______________________ Name of Policy Holder: ______________________

Patient's Relationship to Policy Holder: __________ Patient's Relationship to Policy Holder: __________

POLICY HOLDER INFORMATION (IF DIFFERENT FROM PATIENT)

Name: ______________________ Relationship: ______________________

Address: ______________________ Home Phone: (______) ______________

Social Security #: ______________________ Date of Birth: ______/______/______

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

With my consent, Manhasset 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 Manhasset Dermatology, P.C.'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. Manhasset Dermatology, P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Manhasset Dermatology, P.C.'s O.C. Privacy Officer. With my consent, Manhasset Dermatology P.C. may call my home or other designated location and leave a message on voice mail of a person in reference to any items and any call pertaining to my clinical care, including laboratory results among others. With my consent, Manhasset 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. 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 Manhasset Dermatology P.C.'s use and disclosure of my PHI to carry out 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. If I do not sign this consent, Manhasset Dermatology P.C. may decline to provide treatment to me. I hereby acknowledge that I have received a copy of Manhasset Dermatology, P.C.'s notice of privacy.

______________________ ______________________ ______________

PRINT NAME SIGNATURE DATE

PATIENT CONSENT FOR RELEASE OF MEDICAL REPORTS

I authorize Manhasset Dermatology, P.C. to release Laboratory reports, Pathology reports, and Consultation reports to Myself, Parent/Guardian, Referring and/or Primary Care Physician and/or Plastic Surgeons and other health care providers involved in my care.

______________________ ______________________ ______________

PRINT NAME SIGNATURE DATE

We must be able to confirm your appointment. An automated message will be sent to you. Please indicate method of confirmation.

☐ Text message ☐ Automated message

Telephone number: (_____) ______________

Revised 3-2014