

Upper Hudson Valley Dermatology, PC and Schenectady Dermatology, PC

Welcome to. Upper Hudson Valley Dermatology, PC and Schenectady Dermatology, PC. We look forward to providing you with quality dermatological care.

Prior to your initial visit to our office, please take a few minutes to complete the following documents and remember to bring them with you to make your check-in a smooth one.

Please complete the following:

- *Patient Information*
- *Health History (front and back)*
- *General and Financial Consent*
- *HIPAA Authorization (Health Insurance Portability and Accountability Act)*

Additional documents that may apply to you:

- *Minor Consent Form* (If you are a minor, please have your parent or guardian review and sign this document). **Important:** A minor must be accompanied by a parent or guardian for the initial office visit.
- *Medicare Authorization Form*
- *Referrals* If your plan requires a referral, contact your primary care physician first, and then please contact us prior to your visit to confirm that the referral was received, or you may simply bring the referral with you. Patients who have not obtained a referral in time for their appointment will be asked to pay in full at the time of service.)
- ***Be sure to bring your health insurance card(s).***

If your insurance plan requires a co-payment, this amount will be due when services are rendered.

Should you have any questions or need to change your appointment time, please feel free to contact the appropriate office below, thank you.

Schodack Office

1547 Columbia Turnpike
Castleton, NY 12033
Phone: (518) 479-4156

Chatham Office

113 Hudson Avenue
Chatham, NY 12037
Phone: (518) 392-6742

Schenectady Office

650 Franklin Street Suite 100
Schenectady, NY 12035
Phone: (518) 374-7222

Upper Hudson Valley Dermatology, PC and Schenectady Dermatology, PC

GENERAL CONSENT, FINANCIAL, and CANCELLATION POLICY

Welcome to the dermatology practice of A. Neal Gregory, MD, MPH.

This financial statement and agreement is valid between any patient and Upper Hudson Valley Dermatology, PC and Schenectady Dermatology, PC. Please take a moment to review the terms and explanations below:

Medical Insurance: Our office participates in most medical insurance plans. When making your first appointment please be prepared to provide your insurance ID number and the name of your primary care physician. At the time of your initial visit, please bring your insurance ID card, and referral (if required).

If you have any questions about your medical insurance, we encourage you to contact your insurance company directly.

Participating Provider: This is a medical practice, such as this dermatology practice, that is part of an insurance company's network of health care providers. As a participating provider, we agree to accept the insurance company's terms of payment and collect any co-payment assigned by the insurance company to the patient for a particular visit to our practice.

We reserve the right to charge a \$10.00 service fee in addition to your co-payment if the co-payment is not paid at the time services are rendered. For your convenience, payment may be made by cash, personal check, Visa or Master Card.

Non-Participating Provider: This is a medical practice, such as this dermatology practice, that is *not* part of an insurance company's network of health care providers. As a non-participating provider, payment is the patient's responsibility and is due in full at the time services are rendered. You may submit your bill to your insurance company for possible reimbursement

Referrals: Certain insurance plans require patients to obtain referrals from their primary care physicians. Patients whose plans require referrals are responsible for obtaining the referral prior to being seen at Upper Hudson Valley Dermatology, PC or Schenectady Dermatology, PC. If the referral is not received prior to your appointment, you will be required to sign a patient waiver accepting financial liability, or you may choose to reschedule your appointment for a later date.

Cancellation Policy: If you are unable to keep your appointment, please notify us at least 48 hours in advance or you may be subject to a \$50.00 cancellation fee.

Covered Medical Procedure: This is a medical procedure that is the financial responsibility of the insurance company. It is the patient's responsibility to know which medical procedure(s) their insurance plan covers. Upon request, we will (if available) supply you with the CPT codes (a number assigned to identify each medical procedure) and the ICD-9 codes (a number assigned to identify a working diagnosis).

If you have any questions about your service coverage or insurance plan, we encourage you to contact your insurance company directly.

Non-Covered Medical Procedure: This is a medical procedure that an insurance company decides not to cover. We encourage patients to contact their insurance company prior to service in order to become familiar with the financial responsibility associated with having the services performed. Payment is the patient's responsibility and is due in full at the time services are rendered.

Cosmetic Procedure: Insurance providers consider these types of procedures medically unnecessary, or elective. Fees related to a cosmetic procedure are discussed with patients prior to the service(s) being performed. Payment is the patient's responsibility and is due in full prior to services rendered.

Thank you for choosing us as your health care provider.

I certify that I have read the general consent, financial and cancellation policy of Upper Hudson Valley, PC and Schenectady Dermatology, PC, and agree to abide by these terms.

Patient's Signature

Date

Parent or Legal Guardian

Date

Practice Authorized Signature

Date

Patient Information

Please answer all questions fully

Account Number:

A. Neal Gregory, MD

Patient					
Name (Last, First, MI)	Social Security	Age	Birth date	Sex	Home Phone
Mailing Address	City	State	Zip code	Marital Status	
Employer	City	State	Zip code	Work Phone	

Responsible Party					
Name (Last, First, MI)	Social Security	Age	Birth date	Sex	Home Phone
Mailing Address	City	State	Zip code	Marital Status	
Employer	City	State	Zip code	Work Phone	

Primary Provider	Referring Provider	Referring Address	Phone	Fax

Insurance Information				
Primary Insurance	Subscriber's Name, Birth date, SSN	Relationship	Policy/Group #'s	Copay
Second Insurance	Subscriber's Name, Birth date, SSN	Relationship	Policy/Group #'s	Copay
Third Insurance	Subscriber's Name, Birth date, SSN	Relationship	Policy/Group #'s	Copay

Emergency Contact Information			
Contact Name	Relationship	Primary Phone #	Secondary Phone #

Please List Additional Medical Information

Patient Release:

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due. I permit a copy of this release to be used in place of the original.

Signature: _____

Date: ____/____/____

(Insured or authorized person, patient or parent if minor)

Dermatology Medical History

Today's Date: _____

Patient: _____

Date of Birth: _____

Primary MD: _____

MD's Phone Number: _____

Chief Complaint: _____

Please check the appropriate answers below.

Are you allergic to any medications? YES _____ NO _____

If yes, please list: _____

Have you ever had anesthesia? YES _____ NO _____

Any negative reaction? YES _____ NO _____

List all medications you are currently taking, (including prescriptions, over-the-counter meds, vitamins and herbals)

Do you have or have you ever had any of the following diseases or conditions?

(Please check all that apply)

_____ Bronchitis
_____ Emphysema
_____ Asthma
_____ Excessive Thirst/Hunger
_____ Amputation
_____ Chronic Cough
_____ Thyroid
_____ Morning Cough
_____ Kidney
_____ Shortness of Breath
_____ Wheezing
_____ Bladder (frequency, bleeding)
_____ High Blood Pressure
_____ Stomach Absorptive Disorder
_____ Chest Pain

_____ Diabetes
_____ Nausea, Vomiting, Diarrhea
_____ Heart Attack
_____ Yeast Infection
_____ Heart Murmur
_____ Arthritis/Joint Deformity
_____ Irregular Heartbeat
_____ Arthralgia
_____ Phlebitis
_____ Limited Motion
_____ Inflammation of Veins
_____ Artificial Joints
_____ Blood Clots
_____ Convulsions, Epilepsy, Seizures

List any other diseases or conditions: _____

List all surgical procedures you have had in the past 6 months: _____

Please answer the following:

Skin-Related History

Have you ever had skin cancer? YES NO

Has anyone in your family had skin cancer? YES NO

Do you have a history of any specific skin diseases? YES NO

Do you have problems with healing? YES NO

Do you develop keloids (scars) after surgery? YES NO

Do you bleed easily? YES NO

Do you develop skin rashes in reaction to:

- Medications
- Food
- Environment
- Bandages
- Topical Medications
- Other _____

Social History

Do you drink alcohol? YES NO If YES, # of drinks per day _____

Do you smoke? YES NO If YES, how many per day? _____

Have you had or have you been exposed to HIV (AIDS)? YES NO

Have you had or have you been exposed to hepatitis B or C? YES NO

(For women only) Are you pregnant? YES NO Due date _____

What is your occupation?

Patient (please sign)

Parent/Guardian (please sign)

Medical Assistant (please initial)

Date

Additional information: _____

Reviewed by: _____

ASSIGNMENT OF BENEFITS
MEDICARE AND MEDIGAP CONSENT

ALL INSURANCE (EXCEPT MEDICARE)

I authorize my insurance company to pay benefits directly to Upper Hudson Valley Dermatology, PC and Schenectady Dermatology, PC. I also authorize Upper Hudson Valley Dermatology, PC and Schenectady Dermatology, PC to provide my insurance company with any information necessary to process claims for services rendered to me.

Signature (as it appears on your insurance card)

Date

MEDICARE

I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignments. Regulations pertaining to Medicare assignment of benefits apply.

Signature (as it appears on your Medicare card)

Date

MEDIGAP

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over," we are required to keep a separate signature on file.

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to my MEDIGAP carrier any information needed to determine these benefits or the benefits payable to related services.

Signature (as it appears on your Medigap card)

Date

Please answer:

Do you or your spouse work in a company that has more than 20 employees and have insurance coverage through that job? YES NO

Are you covered by any other insurance that makes Medicare secondary? YES NO

**UPPER HUDSON VALLEY DERMATOLOGY, PC
SCHENECTADY DERMATOLOGY, PC**

PRIVACY NOTICE

I acknowledge that I was provided with the Privacy Practice notice of Upper Hudson Valley Dermatology, PC and Schenectady Dermatology, PC.

Name of Patient: _____

Patient Signature: _____

Date: _____ Patient's Date of Birth: _____

Personal Representative (if applicable)

Name of Personal Representative: _____

Signature of Personal Representative: _____

Relationship to Patient: _____ Date: _____

I AUTHORIZE THE PERSON/PERSONS LISTED BELOW TO OBTAIN MEDICAL INFORMATION ON ME:

Name: _____ Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

Date of Birth: _____ Date of Birth: _____

COMMENTS: _____

Practice Authorized Signature

Date

Any questions regarding our privacy notice can be directed to our privacy official, Brian Brill at Upper Hudson Valley Dermatology, 1547 Columbia Turnpike, Castleton, NY 12033
Phone: (518) 479-4156