

## ***A note from the medical practice of A. Neal Gregory, MD, MPH...***

*Welcome to Upper Hudson Valley Dermatology, PC and Schenectady Dermatology, PC. We look forward to providing you with quality dermatological care. Please review the appointment card enclosed to ensure the correct date and time of your upcoming appointment.*

Prior to your initial office visit, please take a few minutes to complete the enclosed 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, your guardian must review and sign this document). **Important:** A minor must be accompanied by a guardian for the initial office visit.
- Medicare Authorization Form
- Referral (*If your plan requires a referral, please confirm that your referral has been received by us prior to your visit, or simply bring it with you.*)  
Patients who have not obtained their referral in time for their appointment will be asked to pay in full at time of service.

### **Be sure to bring your insurance card(s).**

If your insurance plan requires a co-payment, this amount is due at the time services are rendered.

Should you have any questions or need to change your appointment, please feel free to contact us.

***We look forward to serving you.***

Upper Hudson Valley Dermatology, PC  
Schenectady Dermatology, PC  
GENERAL CONSENT  
FINANCIAL CONSENT  
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 as follows:

**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 healthcare providers. As a participating provider, we agree to accept the insurance company's terms of payment and to 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 MasterCard.

**Non-Participating Provider:** This is a medical practice, such as this dermatology practice, that is *not* part of an insurance company's network of healthcare 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. If the referral is not received prior to your appointment, you will be required to sign a patient waiver accepting financial liability in the event your referral is not received, or you may choose to reschedule your appointment for a later date.

**Cancellations:** 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 your insurance plan, we encourage you to contact your insurance company directly.

**Non-Covered Medical Procedure:** This is a medical procedure that insurance companies decide 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 financial and cancellation policy of Upper Hudson Valley Dermatology, 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 or 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 a 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 sign)

\_\_\_\_\_  
Date

Additional information: \_\_\_\_\_

Pharmacy Name/Phone # \_\_\_\_\_

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. I also authorize Upper Hudson Valley 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 which 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: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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