

Ariel Ostad, MD PC
897 Lexington Avenue New York, N.Y. 10065 Phone: 212-517-7900

Patient Registration Information

LAST NAME: _____ FIRST NAME: _____ MI: _____
STREET: _____ APT #: _____ Male Female
CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ WORK PHONE : _____ CELL PHONE: _____
DATE OF BIRTH: ____/____/____ SOCIAL SECURITY #: ____-____-____ MARITAL STATUS: Married Single Other
IN CASE OF EMERGENCY, PLEASE CONTACT: _____
RELATIONSHIP TO YOU: _____ PHONE: _____
EMAIL **: _____ @ _____ ** May we send you educational information? YES NO
ARE YOU EMPLOYED? Yes No If yes, employer name: _____

Were You Referred By a Doctor? Yes No If Yes, please give us the contact information of your doctor below:

REFERRING MD NAME: _____ PHONE: _____

If no, how did you find out about us? Website Family/Friend Newsletter Insurance Resources Google Search

City Search Magazine If a magazine, please tell us which one? _____

PRIMARY INSURANCE NAME / CLAIMS ADDRESS: _____

PHONE: _____

ID#: _____ GROUP #: _____

ARE YOU THE POLICYHOLDER? Yes No If not, please complete the information below on the policy holder.

INSURED'S NAME: _____ DOB: ____/____/____ SOCIAL SECURITY #: ____-____-____

EMPLOYER NAME: _____ EMPLOYER PHONE: _____

SECONDARY INSURANCE NAME/CLAIMS ADDRESS: _____

PHONE: _____ ID#: _____ GROUP #: _____

INSURED'S NAME: _____ DOB: ____/____/____ SS # ____-____-____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Ariel Ostad, MD, PC, and its associate physicians and para-professionals, to bill the above referenced health insurance companies on my behalf for any/all services performed. I hereby assign all insurance payment benefits directly to this physician group should they accept assignment to my insurance carriers. I understand that any payments that I may receive directly, for services which were billed on my behalf by the physicians, must be turned over to the physician. I understand that I am financially responsible for any/all charges not payable by my insurance carriers. I hereby authorize the release of any information necessary to secure payment of benefits. I affirm that I have been offered a copy of the patient bill of rights and provider information and may ask for a personal copy to take with me.

PATIENT / LEGAL GUARDIAN SIGNATURE

____/____/____
DATE

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Medical History Assessment

Name: _____

Date: ___/___/___

Date of Birth: ___/___/___

Gender: Male Female

Reason for today's visit:

Total Body Skin Check

Other: _____

(Please describe)

History of problem that brings you in today:

Site (skin area (s) involved): _____

Duration (how long has problem been present?): ___ Day(s) ___ Week(s) ___ Month(s) ___ Year(s)

Timing (has this been treated previously?): Yes No If yes, when? ___/___/___ (approx. if unknown)

Context (was a Biopsy done)? Yes No If yes, by whom? _____

Please check all that apply regarding the problem you are coming in for today:

Quality (Change in):

Size

Color

Elevation

Hardness

Modifying Factors (History of):

X-ray treatment

Ultraviolet light treatment

Arsenic exposure

Chronic scar

Immunosuppression

Associated Symptom(s):

Bleeding

Tingling/Pain

Ulceration

Infection

Itching

Severity:

No symptoms Occasional symptoms Constant symptoms

Are you allergic to any medications? Yes No If yes, please list:

1. _____ 2. _____ 3. _____

List all medications you are currently taking:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Did you use indoor tanning during childhood or adolescence? _____

Check all that apply to your overall health and add important information not mentioned:

Please circle all that apply regarding your overall health and add other pertinent information:

Skin	Hematologic	Lymphatic	Constitutional Symptoms	Eyes/Ears/Nose/Throat	Cardiovascular	Respiratory
Normal	Normal		None	Normal	Normal	Normal
Keloids	Anemia		Weight loss	Glaucoma	Angina	Asthma
Poor healing	Bleeding problem		Fever	Hearing Aid	Artificial heart valve	Emphysema
Skin problems	Enlarged lymph nodes		Other _____	Plastic surgery	Pacemaker	Other _____
					Hypertension	
					Heart attack	When: ___/___/___

Name: _____

Gastro-intestinal	Musculoskeletal	Neurological	Psychiatric	Endocrine	Infections
Normal	Normal	Normal	Normal	Normal	None
Stomach ulcer	Arthritis	Stroke	Depression	Diabetes	Hepatitis
Colitis	Artificial joint	Seizures	Anxiety attacks	Thyroid problems	HIV/AIDS
Other GI problems	Other _____				T.B. (Tuberculosis)

Other important medical information:

Past Medical History:

Previous Skin Cancer? Yes No If yes, what type if known? _____

Any major illnesses not prior stated or Hospitalizations? Yes No

If yes, please list _____

Family History Skin Cancer: Melanoma Basal cell or squamous cell None

Social History:

Do you wear glasses? Yes No Dentures? Yes No Contact Lenses? Yes No

Do you smoke? Yes No If yes, how many packs/ day? ___ If you were a smoker, when stopped: ___/___

Do you consume alcohol? Yes Socially or Regularly (circle one) No Never

History of alcohol or drug abuse? Yes No Addictions? Yes No
If yes, please describe: _____



Fine Lines & Wrinkles	
Lines around the Lips & Mouth	
Rough Texture of Skin	
Tired-looking or Uneven Skin Tone	
Dark Circles/Puffiness	
Sagging Skin	
Brown Spots/Freckles	
Excess Skin Eyelids/Neck	
Skin Hyperpigmentation	
Eyelashes: Fuller, darker, longer	
Unwanted Hair	
Acne Scars	
Unwanted Skin Veins	
Blood Vessels around Nose or Face	
Other:	

Are you interested in receiving "skin celebration" gift certificates?

Yes No

Please verify delivery preference:

Email (address): _____@_____

Regular Mail

Patient Signature: x _____

(Office use only) Reviewed by: _____ (Personnel)

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Patient Financial Obligation

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

In Network and Medicare Patients :

If we participate with your insurance plan you will be responsible to pay for your co-pay, deductibles and/or co-insurance at time of service. You may also be responsible for payment of services related to conditions that are not covered by your Plan. If you have not met your deductible, you will be responsible for the amount of the deductible and whatever amounts the insurance company does not pay. If your insurance company denies payment or will only pay a portion of your medical bill, you, the patient is responsible for payment of services rendered and will be billed accordingly. Please be aware that your insurance carrier does not guarantee accuracy of its confirmation of coverage and benefits. In order to expedite this responsibility we request that you leave a credit card on file.

If you should undergo a biopsy in our office, your insurance carrier will be billed separately by the Lab. You will receive a separate bill from the Lab for any uncovered charges.

Out of Network and Self Pay Patients:

Payment is due at time of service. As a courtesy to our patients, we will submit your paid claim to your insurance carrier; it is your responsibility to follow up with your carrier regarding your reimbursement. Patients should contact their insurance companies directly for any coverage questions they may have.

If you should undergo a biopsy in our office, your insurance carrier will be billed separately by the Lab. You will receive a separate bill from the Lab for any uncovered charges.

Payment Methods:

For your convenience, we accept the following forms of payment: Cash, Check, Visa, MasterCard, Discover or American Express.

- It is office policy that a credit card is left on file as most insurance policies have deductible, co-insurance, and surgical co-insurance in addition to co-pays. Your ins company determines the exact amount after we have submitted your claim for payment. We will only charge your card for the amount which is your responsibility and your ins co will also send you a copy of the explanation of benefits.
- Your signature below provides authorization for our office to process payment (s) to this card for reasons as outlined above.

Please be advised that billing statements are sent out bi-monthly for your convenience. Any unpaid balance that exceeds 30 days will be sent to a collection attorney and will incur interest charges of 2% compounded monthly, as well as 20% collection cost. The patient/or guarantor will be held responsible for all associated costs including interest from the date of service.

I, _____ **have read the above disclaimer and fully understand my financial responsibilities to Dr. Ariel Ostad:**

Patient/Guardian Signature: x _____ Date: ____/____/____

Credit Card# _____ Expiration Date: ____/____

<p>AUTHORIZATION TO RELEASE INFORMATION:</p> <p>I hereby authorize Dr. Ariel Ostad to release to the insurance company named above any information acquired in the course of my examination or treatment</p> <p>SIGNED _____</p> <p>(if patient is a minor, signed by parent or guardian)</p>	<p>ASSIGNMENT OF INSURANCE BENEFITS:</p> <p>I hereby agree to full responsibility for all expenses incurred by or on account of this patient and hereby assign to Dr. Ariel Ostad any and all insurance benefits due me to the fullest extent of my financial obligation to said office.</p> <p>SIGNED _____</p> <p>(if patient is a minor, signed by parent or guardian)</p>
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DERMATOLOGIC SURGERY OF LEXINGTON AVE, PC

Dear Patient:

Our surgical suite is certified by the Joint Commission on Accreditation of Healthcare Organizations (**JCAHO**). This is an official seal that is only awarded to select offices that meet the highest standards of quality and safety through rigorous monitoring year over year.

This translates into our commitment to upholding guaranteed quality control standards in our private facility.

Please be aware that we will be submitting facility charges to your insurance carrier in the event you undergo surgery with Dr. Ariel Ostad. It is possible that the remittance may be sent to you directly. In this case, kindly sign the check over to Dermatologic Surgery of Lexington Ave, PC including the explanation of benefits (EOB) so your account is credited correctly.

Patient/Guardian Signature

Date



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Notice of Privacy Practices

This notice describes how information about you as a patient of our practice may be used and disclosed as well as how you can access your health information. This is stipulated by the Privacy Regulation created by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We are committed to maintaining the privacy of your health information and we are required by law to ensure the confidentiality of your health information. These laws are complex therefore we have provided below the important information we are required to provide for your understanding. The following circumstances may require us to use or disclose your health information:

To Provide Treatment:

We will use your PHI (private health information) within our office to impart the highest quality healthcare possible. This may include administrative & clinical office procedures to schedule & coordinate care between physician, technician, nurse, medical assistant and business office staff. This also includes pathology laboratories, pharmacies or other healthcare personnel involved in your treatment and care. It may be necessary to release your test results to authorize healthcare providers treating patients even when the provider requesting results did not originally order the tests.

To Obtain Payment:

We may include your health information with an invoice in order to collect payment for treatment you received in our office. This may include insurance forms filed for you by mail or electronically. Our office makes a concerted effort to work only with companies that maintain similar standards to protect and maintain the security of your health information.

To Conduct Healthcare Operations:

Your health information may be used during staff performance evaluations, during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews i.e. JCAHO. Your PHI may be reviewed during the routine processes of certification, licensing or credentialing activities.

Communications:

As regular follow-up is essential to your health, we customarily remind patients of scheduled appointments as well as make contact to communicate to you that it is time for you to contact us to schedule an appointment. Methods of communication consist of postcards, letters, emails and phone. We may share your PHI with those individuals you inform us will be assisting you with your home needs, medications or financial responsibilities. You are welcome to request specific limitations and or restrictions with regard to the manner in which this information is shared and with whom it can be shared i.e. contact to be made at home rather than at work etc. We will make every attempt to comply with and honor your wishes.

____ (Initial) **RELEASE OF MEDICAL INFORMATION I do / do not** (circle one) authorize Dr. Ariel Ostad and its designated representatives to release medical information to (print name) _____ Relationship _____

Required by Law:

We may disclose your PHI to public health authorities and health oversight agencies that are authorized by law to collect information when required to do so by law enforcement officials, lawsuits and similar proceedings in response to a court or administrative order. This oftentimes occurs when it becomes necessary to reduce or prevent a serious threat to your health & safety, that of another individual, the public or for Worker's Compensation and similar programs.

Our patient medical records are kept confidential, secure and out of reach by unauthorized persons. All reports, consultations and correspondence are reviewed by Dr. Ariel Ostad prior to being filed in the medical record. A written release signed and dated by the patient/guardian must be obtained prior to the release of medical record information to comply with Privacy Regulations.

I have read and understand the content of this Notice of Privacy Practices. My signature below serves as my consent for your office to use and disclose my PHI as outlined above to facilitate and orchestrate my treatment and care at the highest standard.

Patient/Guardian Signature: x _____ Date: ____/____/____

**Specific Restrictions: _____

Interpreted by: _____

Signature: _____

Printed Name

E-Prescribing Consent Form

Patient's Name _____

Patients Account# _____

Ariel Ostad, M.D., P.C. is in the process of implementing ePrescribing:

- ★ ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011
- ★ ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.
- ★ ePrescribing software also lets your doctor see important information - like drug interactions and your prescription history.

Patient benefits:

- Less confusion over handwritten prescriptions or unclear phone calls
- Reduced possibility of medical errors
- Less chance of adverse drug reactions
- Fewer trips to drop off at the pharmacy
- A safer, faster, easier way to get your prescription filled

Patient Consent:

I agree that Ariel Ostad, M.D. P.C. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. This consent form will be updated on an annual basis.

Please provide our office with your **pharmacy name (s)**, address, phone number/ fax number.

Pharmacy Name: _____
Address: _____

Pharmacy Name: _____
Address: _____

x _____

(Patient Signature)

_____/_____/_____

Date