NEW PATIENT INFORMATION

Name _____ Today's Date _____
Street Address _____
City _____ State _____ Zip Code _____
Home Phone (_____) _____ Work (_____) _____
Cell Phone (_____) _____ SS# _____
Date of Birth _____ Age _____ Sex _____
Referred By _____
Pharmacy Name & Address: _____
Email Address: _____

PARENT / GUARDIAN / SPOUSE INFORMATION

Name _____ SS # _____
Street Address _____
Home Phone (_____) _____ Work Phone (_____) _____
Employer _____
Employer Address _____
Next of Kin _____
Address _____
Phone (_____) _____

PRIMARY INSURANCE TO FILE

Insured's Name _____ Relationship _____
Insured's SS # or ID # _____ Insured Date of Birth _____
Insurance Company Name _____
Insurance Company Address _____

PRIMARY PHYSICIAN INFORMATION

Primary Care Physician _____
Primary Address _____
Primary Care Phone Number (_____) _____

MEDICAL HISTORY

Circle "Yes" or "No"

1. DO YOU OR ANY MEMBER OF YOUR FAMILY HAVE? (SPECIFY WHO)

Asthma	YES	NO	Cold Sores, Fever Blisters	YES	NO
Hay Fever	YES	NO	Skin Cancer	YES	NO
Eczema	YES	NO	Diabetes	YES	NO
Hives	YES	NO	Bleeding Problems	YES	NO
Psoriasis	YES	NO	Other skin conditions (specify) ..	YES	NO
Hair or Nail Problem	YES	NO			

2. HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING?

Liver Disease (Hepatitis, etc)	YES	NO	Thrombophlebitis		
Lung Disease (Tuberculosis, etc.)	YES	NO	YES NO		
Duodenal or Peptic Ulcer	YES	NO	Venereal Disease		
Other Intestinal Disease (Colitis, etc.)...	YES	NO	YES NO		
Kidney Disease	YES	NO	Problems with sunburn	YES	NO
High Blood Pressure	YES	NO	Problems with hands in cold water		
Blood or Lymph Disorders	YES	NO	YES NO		
Eye Disease (Glaucoma, Cataracts, etc.)	YES	NO	Frequent infections (skin or other)		
Arthritis	YES	NO	YES NO		
Stroke	YES	NO	Excess bleeding when cut	YES	
Cancer	YES	NO	NO		
Heart Disease (Rheumatic Fever, Pacemaker)...			Poor wound healing; scars or keloids	YES	
YES NO			NO		

Skin x-ray or grenz ray treatments ..... YES NO

Any raised growth present since birth ... YES NO

A growth which changed color or size, bleeds, hurts, itches ..... YES NO

3. HAVE YOU EVER HAD A REACTION TO ANY OF THE FOLLOWING?

Novocain or other local anesthetics	YES	NO	Adhesive Tape	YES	NO
Penicillin or Sulfa Drugs	YES	NO	Food	YES	NO
"Mycin" or other antibiotics	YES	NO	Cosmetics	YES	NO
Topical Preparations (Neosporin, etc.) ...	YES	NO	Others (please specify)	YES	NO

4. TO BE COMPLETED BY ALL WOMEN.

Have you ever had vaginal yeast infections? ..... YES NO
Are you pregnant? ..... YES NO
Are you currently planning a pregnancy ..... YES NO
Please inform the doctor at any time if you do plan to or become pregnant during you treatment.

5. WHAT MEDICATIONS, DRUGS, OR OVER-THE-COUNTER PREPARATIONS ARE YOU NOW TAKING? (e.g. for constipation, sleep, headaches, birth control, anxiety) Please list all medications including vitamins and supplements:

_____

_____

6. PRIOR HOSPITALIZATIONS AND SURGERY (PLEASE GIVE APPROXIMATE DATES)

_____

_____

TO ALL PATIENTS – PLEASE READ AND ANSWER "YES" OR "NO"

It is strongly recommended that you have the doctor examine your entire skin surface. Even if you have just been to your family physician, it is recommended that you have your dermatologist examine your skin, thus extending but not replacing, a complete physical examination by your family physician. If you desire this examination, you will be given a disposable gown. Please completely disrobe to allow the doctor to view your entire skin surface for medically important benign or malignant lesions.

Do you wish to have this examination? ..... YES NO

Patient Acknowledgments of Brody Dermatology Office Policies

Insurance Information

Copayments and Deductibles

Payment is required for all services at the time they are rendered. All applicable copayments and deductibles will be collected at the time of service. An administrative billing fee of $15 will be applied if co-payments are not paid at the time of service. In the event that your account must be turned over for collections, interest and/or collection fee at the provider's current rate may be charged on all balances that are past due. Your signature below signifies your understanding and willingness to comply with this policy.

_____ _____

Patient Signature Date

Referral Information

If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my Primary Care Provider and assure it is available to be presented at the time of my visit. I further understand it is my responsibility to keep track of the number of visits I have used on my referral and the expiration date of my referrals and obtain new ones as needed. I understand that should I fail to have a valid referral for my visits; Brody Dermatology will reschedule my appointment.

_____ _____

Patient Signature Date

Insurance Cards

New patients or those patients with a change in their insurance information must provide a valid insurance card or temporary print out at the time of the visit. Should you be unable to produce this documentation, patients may pay in full at the time of service and submit the claim to your insurance carrier at your convenience for reimbursement. I understand by signing below that I am responsible for notifying the office of any changes to my insurance contact information.

_____ _____

Patient Signature Date

HIPAA Policy

Patients over the age of 18 are protected under Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Brody Dermatology from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments or obtain test results for you, please indicate their name(s) below. Only these individuals will be provided with information. Should you wish to update the names provided below, please ask the receptionist for a HIPAA Form.

Name of Individual (please print) **Relationship to Patient**

_____ _____

_____ _____

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

_____ _____

Patient Signature Date

Release of Information

I authorize the release of 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 also authorize payment of medical benefits to the physician. Should my insurance company send payment for these services to me rather than directly to Dr. Brody, I agree to forward that check or my equivalent personal check to the doctor immediately.

Patient or Responsible Party Signature _____ *Date___/___/___*

Payment Policy

Medicare: We are participating providers of the Medicare program. We will accept assignments on all claims. Patients are responsible for meeting their annual $100.00 deductible and paying for the 20% co-payment.

HMO, PPO or other Managed Care Patients: You will be responsible for paying your annual deductible, co-payment and charges for any non-covered, cosmetic services.

I also understand that I am personally responsible for payment for these services in the event that:

- There has been a lapse in my coverage or that it has been terminated.
- My insurance company refuses to pay because of a requirement that has not been met by either myself or my referring physician.
- My insurance company refuses to pay because it is not the primary carrier.
- If for any reason your insurance company does not pay us.

The rules that insurance companies use to determine payment on procedures and diagnoses changes on a daily basis. Since we are not informed of these changes, we can not be responsible for informing you in advance for each procedure. Therefore, when your insurance company does not cover a procedure we will consider it cosmetic and you will be billed by our office.

Patient or Responsible Party Signature _____ *Date___/___/___*

Brody Dermatology
1350 Northern Boulevard, 2nd Floor
Manhasset, NY 11030
T: 516-365-5652
F: 516-365-4550

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your dermatologic care to our board-certified physicians at Brody Dermatology. When you schedule an appointment with Brody Dermatology, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

1) Effective November 1, 2022, any established patient who fails to show or cancels/ reschedules an appointment and has not contacted our office with at least 24 hours notice will be considered a No Show and charged a $50.00 fee.
2) Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a second time will be charged a $75.00 fee.
3) If a third No Show or cancellation/reschedule with no 24 hour notice should occur the patient will be charged a $100.00 fee, and may face dismissal from the practice.
4) If you have a cosmetic appointment scheduled (i.e. pico laser, radio frequency micro needling, etc) and you fail to show or cancel/reschedule an appointment with no 24 hour hour notice, you will be charged a $250.00 fee and any subsequent cosmetic appointments will require a 50% non-refundable deposit to schedule.
4) The fee is charged to the patient's credit card on file 30 minutes after you fail to show for your scheduled appointment or, if no card is provided, a paper bill will mailed to the provided address.
5) As a courtesy, when time allows, we make reminder calls for appointments 4 days and 1 day prior to your scheduled appointment. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee.

You may contact us at 516-365-5652 and leave us a voicemail if you are unable to reach us during business hours.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

Signature (Parent/Legal Guardian) Date

Printed Name Relationship to Patient