DATE:_____

WE WOULD LIKE YOU TO HELP US LEARN MORE ABOUT OUR NEW PATIENTS. PLEASE COMPLETE THIS FORM AND RETURN IT TO THE RECEPTIONIST.

ALSO PLEASE PROVIDE US WITH AN ADDRESS OF WHO REFERRED YOU SO THAT WE MAY EXTEND OUR APPRECIATION.

Patients Name:_____

Address:_____

E-Mail Address:_____

Repeat E-Mail Address:_____

I called Dr. Haberman for an appointment because:

(PLEASE CHECK ALL THAT APPLY)

_____1. My friend _____

recommended the doctor.

His/Her address:_____

_____

_____2. My doctor_____referred me.

_____3. The office is convenient to my house/business. **(Circle one)**

_____4. I noticed the ad in the Yellow Pages, Shopper, □ other

_____

_____5. _____ Hospital recommended the doctor.

_____6. I've heard the doctor speak on _____

at _____

_____7. I've read the doctor's column in the _____

_____8. I saw the doctor on TV_____

_____9. Other **(Please specify)** _____

Patient Registration

Name: Soc. Sec. #

Street: Birthdate: Age:

City Home Phone: Cell phone:

Occupation (If minor, parent's occupation)

Employer:

Work address:

Insurance information

Do you have Medicare? Yes No (Please circle) Medicare number:

Do you have Medigap? Yes No (Please circle)

Primary insurance carrier:

Secondary Insurance Carrier

Do you have a prescription card? Yes No (Please Circle)

Name of family doctor: Phone number:

Name of pharmacy: Phone number:

Statement to authorize and release my medical record.

Last Name First Name Phone Number Signature

I hereby **give my permission for treatment** and I understand that payment **in full** is due at the time of service.

Patient's signature:

Parent/guardian's signature (If patient is minor):

May we use your medical records and/or photographs for the purpose of medical education? **Yes** **No**

I realize there will be no compensation. My signature below will authorize the above.

Signature:

Dermatology Medical History

Patient: _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? ☐ yes ☐ NO If Yes List:
1. _____ 2. _____

Have you ever had dental anesthesia (Novacaine0? ☐ YES ☐ NO Any bad reaction? ☐ YES ☐ NO

List all medications you are currently taking (including prescription, over-the-counter meds., vitamins, and herbals):
1. _____ 3. _____
2. _____ 4. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	**Yes**	**No**
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Morning Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐

Cardiovascular:	**Yes**	**No**
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
Inflammation of vein	☐	☐
Bloodclots	☐	☐
Pacemaker	☐	☐

Other Systemic:	**Yes**	**No**
Diabetes	☐	☐
Excessive thirst/hunger	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Bladder	☐	☐
Frequency/burning	☐	☐
Gastrointestinal	☐	☐
Stomach absorptive disorder	☐	☐
nausea, vomiting, diarrhea	☐	☐
when taking antibiotics	☐	☐
Yeast infection when	☐	☐
taking antibiotics	☐	☐
Arthritis/Joint Deformity	☐	☐
Arthralgia	☐	☐
Limited motion	☐	☐
Artificial joint	☐	☐
Convulsions, Epilepsy or Seizures	☐	☐
Fainting	☐	☐

Skin:

When you are exposed to sun do you: ☐ Tan only ☐ Tan & burn ☐ Burn
Have you ever had skin cancer? ☐ YES ☐ NO
Has anyone in your family had skin cancer? ☐ YES ☐ NO IF YES, Who? _____
Do you have a history of any specific skin diseases? ☐ YES ☐ NO
If yes, please list:

_____

Do you develop skin rashes in reaction to ☐ Medications ☐ Food ☐ Environment? _____

List any other diseases or conditions: _____
List surgical procedures you have in the last 6 months: _____

Social History:

Do you drink alcohol? ☐ YES ☐ NO If YES_____ drinks per day
Do you IV drugs? ☐ YES ☐ NO If YES, what? _____ How much? _____
Do you smoke ☐ YES ☐ NO If YES, How much? _____

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

Please answer the following questions:

A. Do you bleed easily? ☐ YES ☐ NO
B. (Woman) Are you Pregnant? ☐ YES ☐ NO Due Date: _____
C. What is your occupation? _____
D. What are your hobbies? _____

Completed by: ☐ Patient
☐ Medical Assistant _____ Initials

_____ Signed by Patient Date

_____ Reviewed by Date

AFFILIATED DERMATOLOGY AND PLASTIC SURGERY CENTER

Dr. Fredric Haberman, Director of Surgery
Board Certified, Diplomate American Board of Dermatology
Fellow, American Academy of Dermatology
Fellow, American Society for Mohs Surgery
Fellow, American Society for Dermatologic Surgery
Fellow, American Society for Laser Medicine and Surgery
Clinical Assistant Professor, Albert Einstein College of Medicine

75 North Maple Avenue
Ridgewood, NJ 07450
(201) 445-8181

871 Fifth Avenue
New York, NY 10021
(212) 362-1662

50 Market Street
Saddle Brook, NJ 07663
(201) 368-0011

CANCELLATIONS AND BROKEN APPOINTMENTS POLICY

If you are unable to keep your appointment, please kindly give us 48 hrs. notice. This courtesy will allow us to utilize the time for other patients.

If you cancel within 48 hours, or do not keep your appointment, we will have to charge you for a broken appointment.

The minimal charge is $75.00

If we reserved extra time for you, the charge is $150.00

If you have made an appointment for a cosmetic procedure which requires more than 1 hr, the broken appointment charge is $200-$400, depending on the amount of time reserved for you.

Please understand that this charge only partially covers our expenses associated with lost time. We are not able to make any exceptions to this policy.

I fully understand and agree with the above policy.

Patients signature _____ Date _____

INSURANCE INFORMATION AND PAYMENT AGREEMENT

Our payment policy is payment in full at the time of services rendered. We do accept Visa, Mastercard, American Express, Debit-Card, cash or checks. A copy of your driver's license will be requested at your initial visit.

We are participating with Medicare at this time. There is a coinsurance amount due when billing Medicare. Medicare coinsurance is billable to the patient. If the patient has a secondary carrier, we do as a courtesy submit to your secondary carrier. In the case your secondary does not cover, or only pays percentage of the billable amount you are responsible for balance not paid by secondary carrier. Also, Medicare patients are responsible for yearly deductible unless deductible, has been paid by your secondary Carrier.

It is your responsibility to bring your insurance card, a referral number or referral form if it is needed before seeing the doctor.

If no arrangements have been discussed, all balances will be paid at time of service. We have agreed between us that you do **willingly accept** the responsibility of **payment in full**, for all deductibles, co-pays and non-covered services.

If any payments do not clear up with your credit-card company or banking institution, fees and immediate action will be taken for balance due.

There is an insurance reimbursement variation that may be less than our charge depending on such factors as (if insurance submission arrangements have made).

*Your insurance contract: what is covered; specific exclusions; general exclusions; deductibles
*Availability of the procedure: (this relates to commonness but not necessarily to quality, the more common a procedure, the more insurers feel it is "generally recognized as safe and effective" or "generally accepted", a procedure not widely performed may even be termed "experimental" and excluded from coverage).
*Medical necessity" as determined by insurer.

When the claim is submitted to your insurer, it is possible that they will refuse reimbursement on the basis that the service was 'not medically necessary', we both know that our standards of necessity are different from your insurers. It is up to your insurance company to decide what is 'medically necessary' (in the bounds of your insurance contract).

In many instances, services here are deemed elective by insurance companies. We both agree, of course, that these services are necessary in light of our mutual goal of keeping you and your skin in the best possible healthy condition. In all instances, care is; of course, medically sound with the best possible risk-benefit ratio. Any payments not covered by insurance carrier are tax deductible.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to: Dr. Fredric Haberman for any services furnished to me by the physician/supplier.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to: Dr. Fredric Haberman for any services furnished to me by the physician/supplier.

SIGNATURE:_____ DATE_____

NOTICE OF PRIVACY PRACTICES

This practice adheres to any and all governmental regulations regarding patient privacy and accessibility of their records in accordance with HIPAA

In the course of treatment it may become necessary to share information with outside providers for treatment, payment and operations (TPO).

- Staff personnel will have the minimum necessary access to medical, demographic and billing information to accomplish the intended purpose of handling of your care and treatment.

- Dr. Haberman refers all biopsies to laboratories. Be advised that insurance information as well as diagnosis and request for a pathology opinion of any and all biopsies obtained in the office will be sent to this laboratory.

- All insurance claims will be forwarded with the information necessary to obtain payment from all appropriate insurance carriers either electronically or by "hard claim copy".

- Billing and insurance information will be electronically transmitted to our softward vendor for preparation and mailing of our monthly statements. This will include your demographic information as well as your account balance.

- Our staff may at some time in the course of your treatment telephone other physicians to discuss your treatment or to make an appointment on your behalf.

- It is our policy to telephone you the day prior to your visit to confirm your appointment. In the event you are unavailable we may leave the information with whoever answers the telephone or leave a message on your answering machine. If this is not agreeable, please notify our staff.

- It is also our policy to send routine reminders of appointments on a postcard. If you prefer that we do not do this, please notify our staff.

- We take every precaution to keep you medical records secure and out of sight. We utilize sign-in sheets and will call your name from our reception lobby.

- All examination room doors remain closed for your privacy.

- You have the right at any time to examine your medical records and to amend as you deem necessary.

Patient signature_____ Date_____