BigAppleSkin Dermatology
Judith Hellman, MD, PLLC
Board Certified Dermatologist

30 Central Park South, Suite 10A
New York, NY 10019
Tel: 212-751-0577 Fax: 212-751-0118

Name: **Age:**

Occupation: **Referred By:**

Date: **Insurance:**

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PLEASE CIRCLE THE APPROPRIATE ANSWER Have you ever been treated for any of the following?

Question		
Duodenal or peptic ulcer?	Yes	no
Tuberculosis or lung disease?	Yes	no
Heart murmur / disease?	Yes	no
High blood pressure?	Yes	no
Blood clot?	Yes	no
Kidney disease?	Yes	no
Hepatitis?	Yes	no
Emotional disorder?	Yes	no
Diabetes?	Yes	no
Bleeding disorder?	Yes	no
Joint replacement?	Yes	no
Immuno deficiency disorder? HIV?	Yes	no
Artificial heart valve?	Yes	no
Do you take antibiotics prior to surgery?	Yes	no
Have you been hospitalized? Why?	Yes	no
Are you now taking medicine? (if yes please list)	Yes	no
Are you allergic to any medicine? (if yes please list).	Yes	no
Do you take aspirin?	Yes	no
Do you take blood thinners?	Yes	no
Have you ever had difficulty with: healing of wounds?	Yes	no
Excessive bleeding when cut?	Yes	no
Overgrown scars or keloids?	Yes	no
X-ray treatment for acne or other skin conditions?	Yes	no
Do you have a PACEMAKER?	Yes	no
Has anyone in your family had a malignant melanoma or other skin cancer?	Yes	no
Do you and/or other family members have large or unusually numerous moles?	Yes	no
Do you have any pigmented spots that have changed in size, color, thickness, texture, etc?	Yes	no
Are there any areas on your skin which bleed or will not heal?	Yes	no

FOR FEMALES. Are you now pregnant, planning a pregnancy in the near future, or nursing a child? (if yes please specify). Yes no

Patients signature ____________________ **Date:** ____________

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Tel: 212-751-0577 Fax: 212-751-011

Last Name: First Name: M.I.:

Address:

City: State: Zip:

Age: DOB: Sex:

* Cell/Pager # ( ) *REQUIRED: Please provide for emergency notifications.

* E-Mail: *REQUIRED: Please provide for emergency notifications.

Home Tel # ( ) Work Tel # ( )

Soc. Sec. # Pharmacy # ( )

Name of Business: Occupation:

Address of Business:

Referred By (please list name): ( )Web Search Engine ____________ *If you visited our website, please tell us who referred you to it. ( )Patient ____________ * *Please provide a specific source of referral.*

We would like to thank your friend for their kind referral which is the highest form of compliment. ( ) Insurance ____________

( ) Internist/Primary M.D.____________ Or Other: ____________

Family Physician/Primary Care Physician:

Address: Tel: # ( )

INSURANCE INFORMATION

Primary Insurance: Secondary Insurance:

Address For Claims: Address For Claims:

Insured's Name: Insured's Name:

Insured's DOB: Insured's DOB:

Soc. Sec. # Soc. Sec. #

Policy # Policy #

Group # Group #

Relationship: Relationship:

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

I hereby consent to the Notice of Privacy Practices currently in force by BigAppleSkin Dermatology. I certify by my signature that I read and understand the information disclosed in the reverenced notices. I also understand that changes to this notice can be made at any time, and that it is the patient's responsibility to remain current on those changes. A copy of the current Notice of Privacy Practices will be available for inspection at the reception desk at all times, and copies of current notice can be obtained at no charge, upon request.

I confirm that the information provided above is truthful and accurate, and any discrepancy may result in further clarification.

PATIENT'S SIGNATURE: TODAY'S DATE:

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, complete items 9, 9a, and 9d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____________ DATE ____________

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____________

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

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CONTRACT OF AGREEMENT

Whether you are new to our practice or we have had the pleasure of serving you over the years, we would like you to be aware of our financial policies. Please read this information carefully—front and back sides—sign on the reverse, and turn in to the receptionist. We will be happy to give you another copy to keep for your reference.

Registration: At each visit our receptionist will verify and update your demographic information and insurance coverage and may periodically ask you to complete a new registration form to insure our information is accurate. Please be sure to have your insurance cards with you at every visit so we may properly bill your insurance company. If you do not have your card with you, you may be required to make full payment that day. Because of new federal laws designed to protect you from identity theft, we must also ask for photo I.D. such as Driver's License or other government-issued identification.

Insurance

We participate in most commercial insurance plans and Medicare but cannot know the details of the coverage and benefits for your particular policy. Therefore, you will need to be familiar with your policy and know what is required to access medical care. Please note that it is your responsibility to confirm prior to visiting the office that Dr. Hellman is in network with your insurance plan.

Your insurance may have one or more of the following requirements: (1) Referral from your primary care physician authorizing your visit with our doctor, done either by a specific form or by a tracking number assigned to your visit. (If your insurance card has a physician's name on it, it usually means that physician must authorize your care by a specialist.) (2) Co-pay that must be paid each visit. (3) Annual deductibles that apply. (4) Specific clinical laboratories and hospitals that must be utilized for specific services. Your insurance plan may also decline to pay for some procedures outright and may require you to get pre-authorization or pre-certification prior to your office visit. It is your responsibility to be aware of those uncovered procedures prior to your visit. If you are unsure of what you need, contact your insurance representative or primary care physician before your visit.

A further note about Referral Authorizations: If your insurance policy requires this referral, it is your responsibility to make sure we have authorization prior to being seen by the doctor. If we do not have a referral authorization for your visit and you are unable to obtain one, the visit will be rescheduled. While this may seem harsh, it is for your protection as much as ours, as some insurance plans will not pay for any tests or treatments that result from an unauthorized visit. If you have a second insurance company, please consider whether that insurance company may require prior referral authorization for the services; if so, and none has been obtained, they will deny payment and you will be responsible for the amounts they might have otherwise paid on your behalf.

Patient responsibility balances. You will be responsible for (1) Services not covered by your insurance. (2) Co-pays (will be collected at check-in) and (3) balances remaining after your insurance company has paid, including deductibles and co-insurance (percentage of the allowed amount that is your obligation). (4) Balances that remain unpaid 60 days after they have been filed with your insurance company but we have received no payment or response.

Payment in full is expected within 30 days from your first statement advising you of the patient balance due. A $5.00 rebilling fee will be added to your account balance for each subsequent statement and delinquent accounts may be turned over for pursuit by an external collection agency.

Self-Pay, Services not covered by insurance, and Large deductibles. If you do not have medical insurance or we are not contracted with your insurance plan, you will be expected to pay at the time of service, or, in some instances, prior to service. Similarly, if you have a large deductible on your insurance policy, we may require a prepayment towards the cost of certain procedures.

Cancellation Policy: I understand that I am expected to give 48 hours notice either by phone, email or text if I cannot keep my appointment, otherwise I will be charged a $75.00 cancellation fee.

Payment methods: For your convenience, in addition to cash, we also accept all major credit and debit cards, We do accept American Express and Discover cards. We do not accept personal or business checks. For your convenience, we also accept the six month option with Care Credit if you require a payment plan. If you are unfamiliar with Care Credit you can ask our office coordinator about this financing plan.

Third Party Billing: If presenting for services that are to be paid by someone other than myself, I understand that Hellman Dermatology Group does not bill third parties without written consent and a verbal confirmation. I understand that I am responsible for all services rendered and if any conflict arises regarding payment I agree to contact the payer to resolve the conflict upon notification. I understand that I am ultimately responsible for the payment of all services.

Assignment of benefits and release of medical information: I acknowledge that I have the insurance coverage presented and directly assign all medical benefits to Dr. Judith Hellman or other medical providers under her supervision. I understand that I am financially responsible for all medical charges and authorize the office of Dr. Judith Hellman to release all information necessary to obtain payment of insurance benefits. I authorize the use of the signature below on all insurance claims submitted on my behalf.

Acknowledgement and Authorization. I have read, understand, and agree to the above policies. Regardless of any insurance I may have, I am ultimately responsible for payment for any professional services rendered. I authorize the release of medical information necessary to process a claim for benefits under my policy and assign payment of my insurance benefits to Hellman Dermatology Group If my account should become delinquent, I agree to pay the costs of collection, including legal fees and court costs.

__________________________________ __________________ ________________

Signature of Patient/Parent or Guardian Date Witness

HELLMAN DERMATOLOGY GROUP
CREDIT CARD AUTHORIZATION FORM
(Mandatory for all new patients)

PATIENT NAME:________________________________**DATE OF BIRTH:**________________

The purpose of this form is to authorize the Hellman Dermatology Group to retain a valid credit card number on file for you as our patient. **All new patients are required to complete this form.** This form will be kept confidential and only authorized staff will have access to the information.

Your supplied credit card will be charged ONLY under the following circumstances:

1. Hellman Dermatology Group reserves the right to charge the credit card listed below for all current patient balances, including co-pays and deductibles. A receipt will be kept in your patient chart, unless directed to send the receipt directly to you. This notice serves as your consent to being charged for all current patient balances on your account.

2. If you, as the patient, miss a scheduled appointment without 48-hour notice to cancel or reschedule, Hellman Dermatology Group reserves the right to charge the credit card listed below $75.00 for our standard no-show fee and a receipt will be sent to the current address on file. This notice serves as your consent to being charged for any and all no-shows. *As is customary, a representative from Hellman Dermatology Group will contact the phone number on file to remind you of your scheduled appointment. This reminder is usually done 48 hours prior to your scheduled appointment. It is the patient's responsibility to ensure we have a correct, current telephone number on file.*

3. If we receive notice that a payment is returned to us for any reason, Hellman Dermatology Group reserves the right to charge the credit card listed below a $30 returned check fee. A receipt will be sent to the current address on file. This notice serves as your consent to being charged for any returned payments.

Other than the conditions mentioned above, under NO circumstance will Hellman Dermatology Group charge your credit card for anything not discussed personally with you. In conjunction with HIPPA regulations, all credit card information will be confidentially kept within your medical chart in our office. Only authorized staff will be able to access this information.

Acknowledged, Agreed & Accepted:
Having read this form and talked with the physician, and/or staff, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged accordingly for the conditions listed above.

X________________________ ________ X________________________ ________

Patient Signature Date Staff Signature Date

NAME AS IT APPEARS ON CREDIT CARD:____________________________

BILLING ADDRESS:____

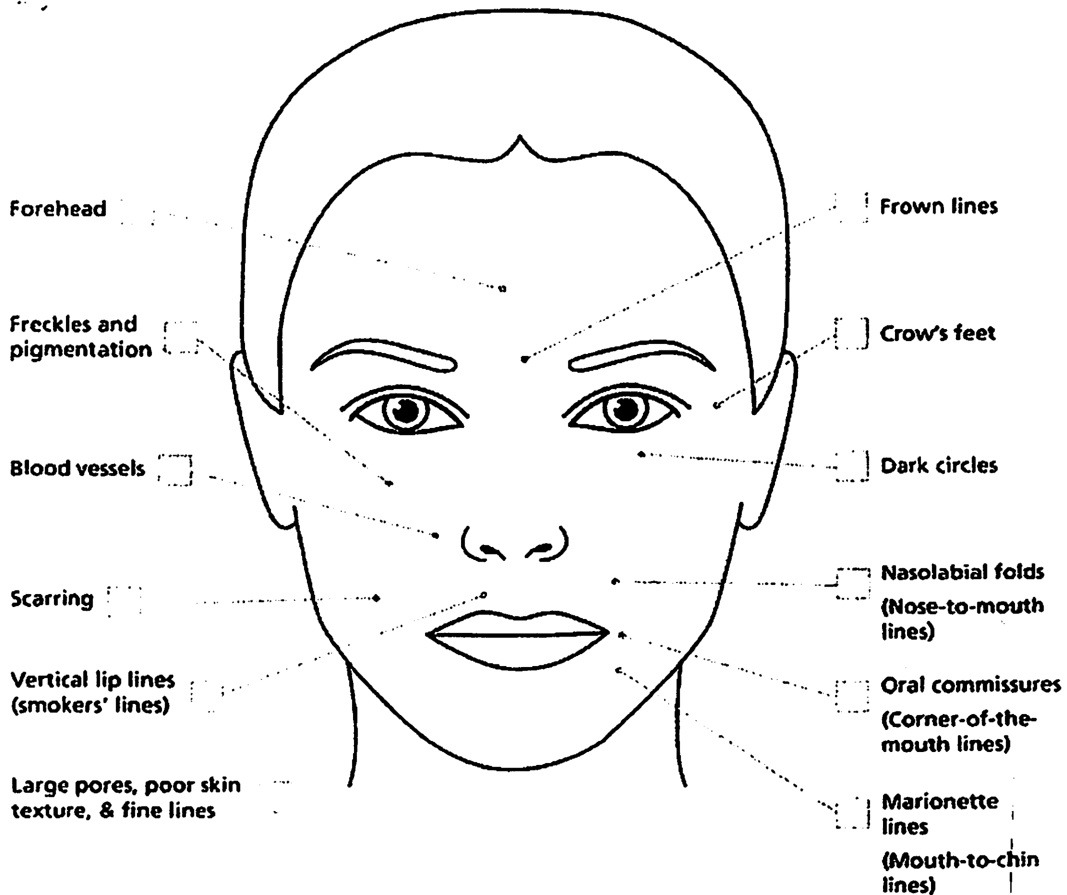
AMEX/DISC/MC/VISA CARD#: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

EXPIRATION DATE: ______/______

VERIFICATION CODE (3 or 4 DIGITS): __ __ __ __

<u>Optional</u> Cosmetic Interest Questionnaire

Please mark any areas that you are interested in treating (Check all that apply)



Would you be interested in any of the following? (Check all that apply)

[ ] Acne Treatment
[ ] Botox ®
[ ] Hair Removal
[ ] Tattoo Removal
[ ] Vein Removal
[ ] Acne Scars

[ ] Glycolic Peels/Laser Peels
[ ] Fillers (e.g. *Restylane*®)
[ ] Laser Resurfacing
[ ] Skin Rejuvenation
[ ] Skin Tightening
[ ] Lip Plumping

[ ] Birthmark/Mole Removal
[ ] Pigmentation (liver/sun spots)
[ ] Laser Treatments
[ ] Skin-care Products
[ ] Fat Reduction (Body/Neck)
[ ] Non-Surgical Lid Treatment

[ ] Other, please specify:______________________________

HELLMAN DERMATOLOGY GROUP

PATIENT AND PHARMACY INFORMATION

New York State has made e-prescribing mandatory as of March 27, 2016. This program electronically transmits your prescriptions directly to the pharmacy of your choice and improves accuracy, security and convenience in prescribing medications.

We need to obtain information on your preference of pharmacies. Please designate a primary pharmacy or pharmacy benefits manager (PBM). If you have a mail order or online benefit program, select the appropriate box below.

Date ________________ Social Security Number __-__-__ __-__ __-__-__-__

Patient Name ______________________________ DOB ______________

Street Address ____________________ City ______________ Zip Code ____________

Phone# ______________ ________ Email Address ______________________________

Name of Insurance ___________________________ Member ID ____________________

Phone# ____________________ Pharmacy Claims Phone # (if available) ______________ _

Pharmacy/PBM Information

Name ____________________ Address __________________________

City ____________________ State ____ Zip ______ Phone# ____________________

Mail Order/Online

□ CareMark □ Express Scripts, Inc. □ OptumRx

□ PharmaCare □ Other ____

Drug Allergies

Please list all of your drug allergies: ____________________________________ ________