PATIENT INFORMATION

NAME _____ AGE _____ SEX _____ MARITAL STATUS M___ S___ W___ D___

STREET _____ BIRTHDATE M____ D____ Y____ SS# _____

CITY, STATE, ZIP _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ REFERRING DOCTOR _____

INSURANCE INFORMATION

	INSURANCE COMPANY	ID NUMBER	GROUP PLAN	RELATIONSHIP TO INSURED
1.				
2.				
3.				

NAME OF INSURED PERSON	ADDRESS	PHONE	RELATIONSHIP TO PATIENT

PATIENT'S EMPLOYER	ADDRESS	PHONE	OCCUPATION

SPOUSE OR PARENT'S EMPLOYER	ADDRESS	PHONE	OCCUPATION

IN ORDER TO CONTROL COST OF BILLING, WE REQUEST THAT OUR CHARGES BE PAID AT THE CONCLUSION OF EACH VISIT. INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR AND IS NOT A SUBSTITUTE FOR PAYMENT.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE RELEASE OF INFORMATION NECESSARY TO SECURE THE REIMBURSEMENT.

SIGNED _____ **DATE** _____
(If minor, parent please sign)

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

1.	duodenal or peptic ulcer	yes	no
2.	other intestinal disease or colitis	yes	no
3.	liver disease or gallbladder disease	yes	no
4.	lung disease (tuberculosis, pleurisy, other)	yes	no
5.	heart disease (rheumatic fever, pacemaker, other)	yes	no
6.	high blood pressure	yes	no
7.	stroke	yes	no
8.	kidney disease	yes	no
9.	urinary or bladder problem or infection	yes	no
10.	venereal disease	yes	no
11.	blood disorder or lymph gland disorder	yes	no
12.	eye disease (glaucoma, cataract, cataract surgery, etc.)	yes	no
13.	arthritis, joint problem or bone disease	yes	no
14.	thrombophlebitis	yes	no
15.	cancer	yes	no
	frequent infections (skin or other)	yes	no
17.	neurological disorder	yes	no
18.	emotional or psychiatric problem	yes	no
19.	HIV infection or immune deficiency	yes	no

HAVE YOU OR ANY MEMBERS OF YOUR FAMILY HAD? (SPECIFY WHO)

1.	asthma	yes	no
2.	hay fever	yes	no
3.	eczema	yes	no
4.	hives	yes	no
5.	diabetes	yes	no
6.	psoriasis	yes	no
	skin cancer	yes	no
	glaucoma	yes	no
9.	other skin condition (specify)	yes	no

HAVE YOU EVER HAD?

1.	excessive bleeding when cut	yes	no
2.	difficulty with the healing of wounds	yes	no
3.	overgrown scars or keloids	yes	no
4.	allergy to local anesthetics	yes	no
5.	blood transfusion	yes	no

HAVE YOU PREVIOUSLY HAD A SKIN PROBLEM OR BEEN UNDER THE CARE OF A DERMATOLOGIST? IF YES, DESCRIBE:

SOCIAL HISTORY:

Do you drink alcohol? ____Yes ____No, If Yes_____drinks per week

Do you use IV drugs? ____Yes ____No, If Yes, what:_____How often? _____

Do you smoke? ____Yes ____No, If Yes, how much: _____

PLEASE TURN THE PAGE....

HAVE YOU EVER BEEN GIVEN X-RAY OR GRENZ TREATMENTS TO YOUR SKIN? yes no

DO YOU TAKE ANY MEDICATIONS, DRUGS, OR OVER-THE COUNTER PREPARATIONS OR REMEDIES? i.e. Medicines for sleep, constipation, headaches, birth control, "nerves" yes no

If yes, please list: _____

_____

ARE YOU ALLERGIC TO ANY MEDICINES, DRUGS, OR OVER-THE COUNTER PREPARATIONS OR REMEDIES? yes no

If yes, please list: _____

_____

_____

PRIOR HOSPITALIZATIONS AND SURGERY (Please give approximate dates)

_____

_____

_____

FOR WOMEN ONLY:

1. Have you had a vaginal yeast infection? yes no
2. Are you pregnant? yes no
3. Are you currently planning a pregnancy? yes no

PLEASE INFORM THE DOCTOR AT ANY TIME IF YOU DO PLAN TO OR BECOME PREGNANT DURING YOUR TREATMENT PERIOD.

FOR ALL PATIENTS - PLEASE NOTE:

The dermatological examination which you are about to receive is a total body exam. Although you may be here for a particular problem, the doctors feel that a COMPLETE skin exam is a necessary part of sound dermatological care. It is suggested that you have a complete physical examination by your family physician or internist.

DATE:_____ SIGNATURE: _____

DERMATOLOGY ASSOCIATES

SHARON A. GALVIN, M.D.
JONATHAN S. DOSIK, M.D.
348 SOUTH MAPLE AVENUE
GLEN ROCK, NJ 07452
201-652-6060 PHONE
201-652-1882 FAX

TO OUR MEDICARE PATIENTS: THE DOCTORS LISTED ABOVE ARE ***NON-PARTICIPATING*** PHYSICIANS IN THE MEDICARE PROGRAM. AFTER WE COLLECT THE MEDICARE LIMITING CHARGE FROM YOU, WE SUBMIT A CLAIM ON YOUR BEHALF TO MEDICARE IN ORDER FOR YOU TO BE REIMBURSED.

THIS OFFICE IS REQUIRED TO KEEP YOUR SIGNATURE ON FILE AUTHORIZING US TO FILE CLAIMS TO MEDICARE FOR YOU AND TO RELEASE INFORMATION TO THAT PAYOR IF THEY REQUIRE IT FOR THE PROPER CONSIDERATION OF A CLAIM. PLEASE READ AND SIGN THE FOLLOWING STATEMENT:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care 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 the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

Signature as it appears on Medicare Card Date

IF YOU HAVE A SUPPLEMENTAL POLICY AND IT IS A **MEDIGAP** POLICY TO WHICH YOUR MEDICARE CARRIER AUTOMATICALLY "CROSSES OVER", <u>WE ARE REQUIRED TO KEEP A SEPARATE SIGNATURE ON FILE:</u>

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 the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature as it appears on Medigap Card Date

Effective date April 14, 2003

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NOTICE OF PRIVACY PRACTICES

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment and healthcare operations (TPO). To that end, our practice and its physicians and staff will--

- Adhere to the standards set forth in the Notice of Privacy Practices.
- Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- Use and disclose PHI to remind patients of their appointments unless they instruct us not to.
- Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its physicians and staff will
  - Implement reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy. Our practice and its physicians and staff respect the patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will:

- Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.

- Not disclose PHI data unless the patient (or his or her authorized representative) has properly authorized the release or the release is otherwise authorized by law.

Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its physicians and staff will--

- Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.

- Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.

- All physicians and staff of our practice will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon request, so long as their requests are in writing.

- All physicians and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.

- All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.

Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

I, _____, have received a copy of DERMATOLOGY ASSOCIATES
Patients' Name

Notice of Privacy Practices.

_____ _____
Signature of Patient Date