Scott Sanders, MD
DERMATOLOGY

Scott Sanders, MD Dermatology
301 North Main Street, Suite 3
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Tel: (845)-499-2017
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info@scottsandersdermatology.com
www.scottsandersdermatology.com

Scott Sanders, MD - Shilesh Iyer, MD - Elena Maydan, MD

PATIENT REGISTRATION FORM

Patient Information

Name: ______________________ Social Security #: ______________

Address: ____

City, State, Zip: ____

Birthdate: ________ Age: ______ Sex: M____ F____ Marital Status: ______________

Race: __________ Ethnic Group__________ Preferred Language______________

Occupation: ______________ Employer: ______________________

Contact Information

Home phone: __________________ Cell Phone: __________________

Work phone: __________________ Email: __________________

Is it okay to leave information on a recorded message or with someone at home? Y N

Emergency Contact

Name: ________________ Relationship: ____________________

Phone number: ____________________

Pharmacy Name/Address/Phone #: ______________________________

How did you learn about our office? ______________________________

What is your primary care doctor's name? ______________________________

Insurance Information: Do you have medical insurance? Y N

Primary insurance company: ______________________________

Insurance ID number: ______________________________

Name of insured: __________________ Soc. Sec. No: __________________

Your relationship to the insured: ______________ Birthdate of Insured: ______________

Insured's Employer: __________________ Phone: __________________

Secondary insurance company: ______________________________

Insurance ID number: ______________________________

Name of insured: __________________ Soc. Sec. No: __________________

Your relationship to the insured: ______________ Birthdate of Insured: ______________

PATIENT SIGNATURE: ______________________________ ***DATE:*** ______________

(Relationship to patient (if signed by personal representative of patient): ______________

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease

Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood Pressure
High Cholesterol
HIV/AIDS

Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Thyroid Problems
NONE

Other ____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)

Joint Replacement within last 2 years
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

NONE

Other ____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns

Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma

Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

NONE

Other ____

Do you wear Sunscreen? Yes No
If yes, what SPF? ________
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? ____

Medications: (Please enter all current medications)

____

____

____

____

____

Allergies: (Please enter all allergies)

____

____

Social History: (Please circle all that apply)

Cigarette Smoking:
Currently Smokes
Never Smoked
Former Smoker
Date stopped: ______________

Alcohol Use:
EtOH – None
EtOH – less than 1 drink per day
EtOH – 1-2 drinks per day
EtOH – 3 or more drinks per day

Family History (Only first-degree relatives)

____

____

____

ALERTS: (please circle all that apply)

Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heartbeat with epinephrine
Are you pregnant or currently trying to get pregnant?

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Scott Sanders MD, PLLC may use and disclose protected health information (PHI) about me to carry out **treatment, payment, and healthcare operations (TPO)**. For a more complete description of these uses and disclosures, please refer to the trifold brochure available at the reception desk (Scott Sanders Dermatology, NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES). As a patient, you have the right to review this NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES prior to signing this consent. Scott Sanders MD, PLLC reserves the right to revise its NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES at any time. A revised NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES may be obtained by forwarding a written request to Scott Sanders MD, PLLC Privacy Officer at 301 North Main Street, New City, New York 10956.

I, ________________________________, hereby authorize Scott Sanders MD, PLLC and/or their representatives to release any and all information pertaining to my healthcare, results, and procedures and/or accounting information to the following person(s) or agencies:

_____ Myself

_____ Spouse/Partner, full name: ____

_____ Parent, full name: ____

_____ Other(s), full name: ____ (Relationship)

I further authorize Scott Sanders MD, PLLC and/or his representatives to release results of my medical exams in one or more of the following ways:
May call me (patient) – check all that apply:

______ At home/cell ______ At work ______ May leave a message

______ On answering machine at home/cell ______ On answering machine at work

With my consent, Scott Sanders MD, PLLC may send by e-mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, and healthcare operations. This includes but is not limited to appointment reminders and patient statements, as long as they are marked "Personal and Confidential.

My preferred email is: ____

I have the right to request that Scott Sanders MD, PLLC restrict how it uses or discloses my protected health information to carry out treatment, payment, and health care operations. The practice is not required to agree to my requested restrictions. However, if the practice does agree to those restrictions, it is then bound by this agreement.

By signing this form, I am consenting to Scott Sanders MD PLLC use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. I am aware that if I do not sign this consent, Scott Sanders MD, PLLC may decline to provide treatment to me.

____ ______________________________

Signature of Patient or Legal Guardian Date

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OFFICE POLICY REGARDING INSURANCES

From prior experience we have come to realize the necessity of this statement in order to anticipate some of your questions and concerns and to outline our billing policy. All patients have the opportunity to obtain a copy of this form upon request.

- ***Your Cooperation Is Necessary***: Without your cooperation, it is virtually impossible for our office to assure that we are informed of the current, specific requirements of your insurance coverage. This is because our office accepts many insurance plans. From time to time, these plans change their requirements for coverage and the scope of that coverage. A single plan may also differ among individuals. Moreover, deductibles, copays and coinsurances vary with each plan and its prior usage.
- ***Most of Life is Showing Up***: Your appointment time has been set aside for you and is unavailable to other patients. Therefore, we require at least 24 hours of advance notice for cancellation for medical appointments and 48 hours of notice for cancellation for cosmetic services. If you do miss an appointment or cancel with less than 24/48 hours' notice, you will be billed $100.00 (medical or cometic) or $150.00 (surgical) which must be paid prior to making any other appointments. Appointment reminder calls are a courtesy which we provide. However, if you do not receive such a call, it is still your responsibility to remember your appointment.
- ***Your Responsibilities***: At the time of appointment, it is the responsibility of the patient or guardian to provide our office with whatever documents are necessary for the insurance coverage to be effective. (This is typically just the insurance card and a referral). **It is the responsibility of the patient or their guardian to understand how their insurance plan works. The patient or their guardian should understand that liability for full payment remains with the policy holder.**
- ***When Coverage Is Denied***: Initial denial of coverage for a procedure by an insurance company is not uncommon. In that case, we will be happy to assist with an explanation of our services for resubmission of claims. If a denial of coverage presents a financial hardship, please discuss this with our Office Manager. The Office Manager is authorized to work with you to implement a payment strategy.
- ***Typical Limits of Insurance:*** Most insurance, including Medicare, cover 80% of total charges. This only takes effect after the deductible has been met. **This practice is NOT expected to absorb your deductible, copay, coinsurance or any other balance of your bill. These are the responsibility of the policy holder. This practice reserves the right to charge finance charges on any unpaid balances**. I understand and agree that in the event that I fail to make payment for services rendered to me, my name and account may be turned over to an attorney or collection agency and agree to pay said agency's fees for collection, court costs, and/or reasonable attorney's fees that may be incurred in the collection of any outstanding balance.
- ***If You Do Not Have Insurance***: For our patients without insurance, we will charge a flat fee for an initial appointment and for any follow up appointments. These charges are only for the visits. Additional procedures (e.g. biopsies) will have additional fees that will be discussed at the time of the visit and should be paid at that time. For your convenience we accept all major credit cards.
- ***Biopsies:*** If you have a biopsy or excision, the specimen is sent to an outside laboratory for tissue processing and sometimes for microscopic examination. We use Bio-Reference and Weill Cornell. We will send them your insurance information. Please be aware that you might receive a separate statement from either laboratory since they are a separate entity. If you receive a bill from either laboratory and have questions regarding the charges, please bring it to the attention of our Office Manager.

I HAVE READ THE INSURANCE OFFICE POLICY STATED ABOVE AND UNDERSTAND THAT ANY AMOUNT NOT COVERED BY INSURANCE IS MY RESPONSIBILITY.

Signature of Patient/Guarantor:____________________ **Date:**____________

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ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE INFORMATION TO THE ABOVE INSURANCE COMPANIES

I hereby authorize all medical and/or surgical benefits to Scott Sanders MD PLLC. This includes all major medical benefits, Medicare /Medigap, HMO and Government sponsored programs, or any other third-party payor for services rendered to me. I understand that I am responsible for all applicable DEDUCTIBLES, COPAYMENTS, COINSURANCE AND NON-COVERED SERVICES as required by my insurance policy.

I hereby authorize Scott Sanders M.D. PLLC to release all information necessary, including medical records to secure the payment of insurance benefits.

PATIENT/GUARDIAN SIGNATURE: ______________________________ DATE: __________________

MEDICARE ONLY

By signing below, I provide authorization for Medicare to assign benefits to my physician, Scott Sanders MD PLLC.

SIGNATURE: ______________________________ DATE: ______________________

OFFICE STAFF (WITNESS SIGNATURE): ____

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Consent for Electronically Accessing Pharmaceutical Information

I, ______________________________ give Sanders Dermatology permission to access and download my medication information from my current pharmacy and enter this information into my medical record at Sanders Dermatology.

The information will be used to evaluate any role that the medications that I am taking may play in my skin and overall health, as well as any possible interactions with medications that maybe prescribed to me by Sanders Dermatology.

The information obtained will be kept completely confidential in accordance with current HIPPA laws and is intended to help my provider maintain the most up-to-date information and provide the safest and most comprehensive care.

Signature: ____________________________

Date: ______________________________