Advanced Dermatology, Mohs and Laser Surgery Center, P.A.

240 East Grove Street
Westfield, NJ 07090-1687
Phone: (908) 232-6446
Fax: (908) 232-6447

Appointment Date: ____________________________

Time: ______________________________________

Doctor: ____________________________________

Physician Assistant: __________________________

Dear Patient:

Thank you for scheduling an appointment in our office. We are a computerized office and have found that the registration process can take some time. Please help us by completing the enclosed registration and medical history forms before you come to the office. Bring them with you to the office on the day of your appointment. **PLEASE DO NOT MAIL THEM BACK**.

For insurance plans in which we do not currently participate, your insurance policy is a contract between YOU and YOUR insurance company. We are not bound by their determination of what is "reasonable and customary". We feel our fees are fair and reflect the high quality of care offered to our patients. If we do not participate with your plan, you will be expected to pay for your visit before leaving our office.

Please be sure to bring your insurance cards to your appointment. If your insurance plan requires a referral, please be sure to bring it with you to your appointment. Knowing whether or not you need to bring a referral is YOUR responsibility.

In compliance with federal law, we require our patients to present a form of government issued photo ID. Please make sure you have this with you.

In order keep wait times to a minimum, we have a 15 minute lateness policy. If you are more than 15 minutes late for your appointment, you will be asked to reschedule your appointment. You are welcome to call prior to being late to request an exception. If the schedule permits, we will make exceptions with notice.

Be advised that we do require 24 hours notice for cancellation of your appointment.
Missed office visit charge $35.00.
Missed procedure visit charge $65.00

We look forward to seeing you.

Sabatino Ciatti, M.D.
Diplomate of American Board of Dermatology

Susan G. McFalls, M.D.
Diplomate of American Board of Dermatology

Mira Stotland, M.D.
Diplomate of American Board of Dermatology

Rachel Cittone, PA-C
Certified Physician Assistant

ADVANCED DERMATOLOGY, MOHS AND LASER SURGERY CENTER, PA.

(DENOTES REQUIRED INFORMATION)*

PLEASE PRESENT THE RECEPTIONIST WITH ALL OF YOUR INSURANCE CARDS ON THE DAY OF YOUR FIRST VISIT

***FIRST NAME:** ____________________ ***MI:** _____ ***LAST NAME:** ____________________

***ADDRESS:** ____

____

***CITY:** ______________________________ ***STATE:** _______ ***ZIP:** __________-________

AGE: _______ ***DATE OF BIRTH:** _______/_______/__________

***HOME #:** (____) ______-________ **WORK #:** (____) ______-________ **CELL #** (___) ________-__________

EMAIL ADDRESS: ____

***GENDER:** M / F ***MARITAL STATUS:** SINGLE / MARRIED / DIVORCED/ SEPARATED / WIDOW

***RESPONSIBLE PARTY:** ______________________________ ***PHONE:** (___) ______-__________

(I.E. PARENT/GUARDIAN)

***IF PRIMARY INSURED IS A PERSON OTHER THAN THE PATIENT (I.E. PATIENT IS SPOUSE OF POLICY HOLDER, OR A CHILD) PLEASE COMPLETE THE PRIMARY INSURED INFORMATION SECTION OF THIS FORM. THIS APPLIES FOR PRIMARY, SECONDARY AND TERTIARY INSURANCE.*

***PRIMARY INSURANCE CO:** ______________________________ ***ID#** ____________________

****PRIMARY INSURED (POLICYHOLDER):** ______________________________________

***SECONDARY INSURANCE CO:** ______________________________ ***ID#** ____________________

****PRIMARY INSURED (POLICYHOLDER):** ______________________________________

***TERTIARY INSURANCE CO:** ______________________________ ***ID#** ____________________

****PRIMARY INSURED (POLICYHOLDER):** ______________________________________

**PRIMARY INSURED

(COMPLETE THIS SECTION WHEN THE INSURANCE POLICY HOLDER IS A PERSON OTHER THAN THE PATIENT. EXAMPLES OF THIS IS WHEN THE INSURANCE POLICY HOLDER IS THE PARENT, LEGAL GUARDIAN, OR SPOUSE OF THE PATIENT)

PRIMARY INSURANCE

FIRST NAME: ____________________ MI: _____

LAST NAME: ______________________________

ADDRESS: ______________________________

____

____

HOME PHONE: (____) _______- __________

WORK PHONE: (____) _______-__________

DATE OF BIRTH (MM/DD/YYYY): ____/____/______

GENDER: *(CIRCLE ONE)* MALE / FEMALE

SECONDARY INSURANCE

FIRST NAME: ____________________ MI: _____

LAST NAME: ______________________________

ADDRESS: ______________________________

____

____

HOME PHONE: (____) _______- __________

WORK PHONE: (____) _______-__________

DATE OF BIRTH (MM/DD/YYYY): ____/____/______

GENDER: *(CIRCLE ONE)* MALE / FEMALE

*YOUR PHYSICIAN: ______________________________ *ADDRESS: ______________________________

*PHONE: ______________________________

*YOUR PHARMACY: ______________________________ *ADDRESS: ______________________________

*PHONE: ______________________________

I AUTHORIZE THE RELEASE TO ANY REFERRING PHYSICIAN OR APPROPRIATE INSURANCE COMPANY ANY MEDICAL INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

*SIGNATURE: ______________________________ *DATE: ____________________

UPDATED 03/18/2010

Advanced Dermatology, Mohs and Laser Surgery Center, P.A.

Health History Form

To expedite your care, please fill out the information on BOTH sides of this form, and bring it with you at your appointment time.

Patient Name: ______________________________ Date: ______________

Sex ___ Age: ___ Date of Birth: ___/___/____ M/S/W/D (Circle One)

Home # ( ) _____-____________ Cell# ( ) _____-____________

Occupation: ____________________ Pharmacy: ____________________

Reason(s) for visit: ____

Referred By: ____________________ Address:_____ ____________________

Current Medication (Include oral contraceptives/aspirin, if applicable): ______________

____

Drug Allergies? : ____

Do you require antibiotics before dental work? ____________________

Please check "YES" or "NO" for the following categories

I. PAST MEDICAL HISTORY: Have you ever had the following:

	YES	NO		YES	NO
Pacemaker	___	___	Mitral Valve Prolapse	___	___
AIDS/Risk Factors for AIDS	___	___	Hepatitis	___	___
Bleeding/Easy Bruising	___	___	Liver Disease	___	___
Transfusion	___	___	Ulcers/GI Disease	___	___
Diabetes	___	___	Kidney Disease	___	___
High Blood Pressure	___	___	Asthma/Lung Disease	___	___
Heart Disease	___	___	Tuberculosis	___	___
Cancer (non-skin)	___	___	Glaucoma	___	___
Arthritis/Bone/Joint Disease	___	___	Chicken Pox	___	___

Other: ________________

Previous Surgery (Please Specify):____

____

II. SKIN HISTORY: Have you ever had the following?

	YES	NO
Skin Cancer	___	___
Melanoma	___	___
Atypical Moles	___	___
Pre-Cancers	___	___
Keloid or unpleasant scars	___	___
Atopy (i.e. allergies, asthma, hay fever, eczema)	___	___

Skin Disease (Specify): ____

PLEASE TURN PAGE OVER

III. FAMILY HISTORY: Has anyone in your family ever had the following?

	YES	NO
Skin Cancer	___	___
Melanoma	___	___
Atypical Moles	___	___
Pre-Cancers	___	___
Keloid Scars	___	___
Atopy (i.e. allergies, asthma, hay fever, eczema)	___	___

Skin Disease (Specify): ______________________________

IV. SOCIAL HISTORY:

	YES	NO	
Drink Alcohol	___	___	How much? __________
Smoker	___	___	How much? __________
Drugs	___	___	Recreational? __________

V. REVIEW OF SYSTEMS:

	Normal	Abnormal (Explain)
General Health	_____	______________
Eyes	_____	______________
Ears/Nose/Throat	_____	______________
Heart	_____	______________
Lungs	_____	______________
Stomach/Bowel	_____	______________
Kidneys/Urination/Prostate	_____	______________
Arthritis/Muscles/Joints	_____	______________
Headaches/Seizures	_____	______________
Hormonal/Thyroid Problems	_____	______________

Psychological Problems: ______________________________

This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except who you have authorized us to do.

I authorize the release of any referring physician or appropriate insurance company any medical information acquired in the course of my examination or treatment.
To the best of my knowledge, the information on this form has been accurately answered. I understand providing inaccurate information can be dangerous to my (my child's) health. It is my responsibility to inform this office of any changes in my (my child's) medical status. I also authorize the medical staff to perform the necessary health care services that I (my child) may need.

Patient/Guardian
Signature: ______________________________

Physician Review
Signature: ______________________________

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Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that Advanced Dermatology, Mohs and Laser Surgery Center may disclose my health information to a family member, close personal friend, or other caregiver because such person is involved with my healthcare or payment relating to my healthcare. In that regard, Advanced Dermatology, Mohs and Laser Surgery Center will disclose only information that is directly relevant to the named person's involvement with my healthcare or payment relating to my healthcare.

I designate the following persons listed below as persons involved with my healthcare or payment relating to my healthcare. I understand that I am not required to list anyone. I also understand that I may change this list, in writing, at any time.

Print Name	Date of Birth	Telephone #
Print Name	Date of Birth	Telephone #
Print Name	Date of Birth	Telephone #

Patient Signature **Date**

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Dear Patient:

Knowing the insurance with which a doctor participates can be confusing. Your doctor is **not** participating directly with the plans listed below but is participating through a network such as Multiplan, Beech Street, or PHCS. We will file the claim on your behalf and adjust the charges according to the network's allowed amount. However, you will be responsible for a deductible and/or co-insurance in addition to the co-pay.

_____Healthnet

_____Oxford

_____United Healthcare

_____Other_______________

Patient's Signature________________________________ Date___________________

I understand that I am personally responsible for and, therefore, agree to pay any outstanding balance not covered or paid by my insurance carrier (unless prohibited by contract) including co-payment, co-insurance and/or deductible. I also agree to pay in full for procedures deemed by insurance carriers to be "cosmetic or medically unnecessary" which are not covered by medical insurance.

Patient's Signature________________________________ Date___________________

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HIPPA AND PRIVACY

I acknowledge having been offered a copy of the patient's Notice of Privacy Practices

________________________________ ____________________
Signature Date

____
Print Your Name

CREDIT CARD COLLECTION POLICY

To Our Patients:

In an effort to streamline patient billing and to avoid collection issues, we have initiated a policy, in which our office retains an imprint of your **Visa or Mastercard**.

After applying your co-pay and/or all insurance payments and adjustments, you will be billed for any balance owed. You will have 30 days to pay the balance of your bill via check or money order. If you have not paid your balance within 30 days of the statement date, we shall process payment via your credit card for the balance due.
The payment applied to your credit card will NOT be more than the total charge for services rendered.

Thank you for your cooperation in this matter. We value your business and will protect your privacy at all times. If you have any questions, please do not hesitate to ask Debra, our Billing Manager, at extension 114, or Robyn, our Office Manager, at extension 103.

Thank you.

PATIENT SIGNATURE: ____

DATE: ___________________________

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Your Health Information Rights

Although your health record is the physical property of the practice that compiled it, you have the right to:

Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. You must submit your request in writing. Usually, this includes medical and billing records, but does not include psychotherapy notes or information complied in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. Requests for access to and copies of your medical information must be submitted to Advanced Dermatology, Mohs and Laser Surgery Center, PA in writing. The fee is $35.00 under 15 pages, and $50.00 over 15 pages.

Please note that records are only available for 7 years. If more than 7 years elapse from the time of your last visit, your records are destroyed.

Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information by submitting a request in writing. You have the right to request an amendment for as long as we keep the information. We may deny your request for an amendment, and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures. You have the right to request an accounting of our disclosures of medical information about you except for certain circumstances, including disclosures for treatment, payment, health care operations, or where you specifically authorized a disclosure. Advanced Dermatology, Mohs and Laser Surgery Center, P.A. will provide the first accounting to you in any 12-month period without charge, upon your written request. The cost for subsequent requests for an accounting within the 12-month period will be $35.00.

Request Confidential Communications. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a procedure that you had. We ask that you submit these requests in writing.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you can ask that we use an alternative address for billing purposes. We ask that you submit these requests in writing.

A Paper Copy o f This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To exercise any of your rights, please obtain the required forms from the practice and submit your request in writing to the practice's privacy officer indicated below.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with us by calling (908) 232.6446 and asking for the Privacy Officer or by contacting the Secretary of the Federal Department of Health and Human Services by calling 800-368-1019, or by contacting the Office of Civil Rights regional office. All complaints must be also submitted in writing within 180 days of when you knew that the act or omission complained of occurred. You will not be penalized for filing a complaint.

Other Uses of Medical Information: Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your permission and we are required to retain our records of the care that we provided to you.

Privacy Officer is the Office Manager
Telephone Number (908) 232.6446

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Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Notice of Privacy Practices

Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact our Privacy Officer at the number listed at the end of this Notice.

Each time you visit a healthcare provider; a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This Notice applies to all of the records of your care generated by your health care provider.

Our Responsibilities:

Advanced Dermatology, Mohs & Laser Surgery Center, PA is required by law to maintain the privacy of your health information and to provide you with a description of our legal duties and privacy practices regarding your health information. The current Notice will be posted in the Reception area. The notice will include the effective date. IN addition, we will make our best effort to provide you with a copy of this notice that we request you acknowledge with your signature.

We are required by law to aide by the terms of this Notice and notify you if we make changes to this Notice, which may be at any time. Changes to the notice will apply to your medical information that we already maintain as well as new information received after the change occurs. If we change our Notice, it will be posted in the Reception area. You may also request that a revised Notice be sent to you in the mail or you may ask for one at your next appointment or appropriate visit. This Notice will also serve to advise you as to your rights with regard to your medical information.

How We May Use and Disclose Medical Information About You :

The following categories describe examples of the way we use and disclose medical information.

Treatment. We may use medical information about you to provide, coordinate, or manage your health care and any related services. We may disclose medical information about you to other doctors, nurses, technicians (e.g. clinical laboratories or imaging companies), medical students, or other personnel who are involved in your care. We may communicate your information either orally or in writing by mail or facsimile.

We may also provide a subsequent healthcare provider with copies of various reports that should assist him or her in treating you. For example, your medical information may be provided to a care provider to whom you have been referred so as to ensure that the doctor has appropriate information regarding your previous treatment and diagnosis.

Payment. We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information before it approves or pays for the health care services we recommend for you.

Health Care Operations. We may use and disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited to quality assessment activities, employee review activities, licensing, legal advice, accounting support, information systems support and conducting or arranging for other business activities. In addition, we may also call you by name in the waiting room when your care provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment by telephone or reminder card.

Business Associates. There are some services provided in our organization through contracts with business associates. Examples include transcription, software vendors and billing and collections. If these services are contracted, we may disclose your health information to our business associate so that they can perform the job that we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information through a written contract.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object.

We also may use and disclose your health information as set forth below. You have the opportunity to agree or object to the use of disclosure of all or part of your health information in these instances. If you are not present or able to agree or object to the use or disclosure of the health information (such as in an emergency situation), then your clinician, using professional judgment, determines whether the disclosure is in your best interest. In this case, only the information that is relevant to your health care will be disclosed.

Individuals Involved in Your Care or Payment for Your Care.: Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location

Future Communications: We may communicate to you via newsletters, mailings or other means regarding treatment options, information on health-related benefits or services; to remind you that you have an appointment for medical care; or other community based initiatives or activities in which our facility is participating. If you are not interested in receiving these materials, please contact our Privacy Officer.

As Required by Law: We may use and disclose health information to the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- Authority that receives reports on abuse and neglect

Law Enforcement/Legal Proceedings We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

State Specific Requirements. Many states have requirements for reporting which may include population-based activities relating to improving health or reducing health care costs, cancer registries, birth defect registries and other institution.