PLEASE BE ADVISED THAT WE DO NOT ACCEPT CHECKS.

Rose Dermatology P.C.

30-16 30th Drive, Mezzanine, Astoria NY 11102 718-728-3376

PATIENT INFORMATION-PLEASE PRINT LEGIBLY Today's Date____/____/____

Name_____
Last First M.I.

Mailing Address_____
Street Name/Building # Apt# City State Zip

Home Phone _____Work Phone _____Cell Phone_____
Area Code Area Code Area Code.

Date of Birth ____/____/____ Age ____ Sex ____ Marital Status ____Occupation_____ SS#-_____-___-_____

Email Address: _____ How would you like to receive appointment confirmations:
☐ Email ☐ Telephone

Race:*_____ Ethnicity:*_____ Languages: _____ Preferred Language:_____

Referred By: __Family/Friend __ Superpages.com __Yellowpages __Insurance Co. __ZOCDOC __Physician

Primary Care Physician	**Referring Physician**
Name: _____ Address: _____ *Street Name/Building # City State Zip* Phone: _____	Name: _____ Address: _____ *Street Name/Building # City State Zip* Phone: _____

Primary Insurance Holder Information
DO NOT COMPLETE THIS PORTION IF THE PATIENT IS THE PRIMARY INSURANCE HOLDER

Name_____ _____
Last First

Mailing Address_____
Street Name/Building # Apt# City State Zip

Home Phone_____ Work Phone _____Cell Phone_____
Area Code Area Code Area Code

What is the relationship of the patient to the Insured: ☐Child ☐Parent ☐Spouse

Date of Birth ____/____/____ Sex_____ SS#: _____-___-_____

Insurance Information	**Preferred Pharmacy**
Primary Insurance Name:_____ Insurance ID: _____ Group#: _____ Employer Name: _____ Employer Phone Number: _____	Name:_____ Phone Number: ( )_____ *Area Code* Address: _____

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We value you as a patient and are happy to provide medical services to you. It is our responsibility to inform you of our office policy.

1. For Medicare Patients Only: (Please do not sign if you do not have Medicare)

By signing, I request that payment of authorized Medicare benefits be made to ROSE DERMATOLOGY, P.C. for any services provided to me by the physician or physician's assistant. I authorize the release of my medical information to the Health Care Financing Administration and its agents to determine the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of HCFA 1500 claim form is completed, my signature authorizes releasing of the information to the insurers or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and **THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, COINSURANCE AND NON COVERED SERVICES**. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Patient/Medicare Beneficiary Signature: X_____

2. FOR NON MEDICARE PATIENTS

Financial Payments: By signing, I understand that a co-payment, deductible and/or coinsurance may apply to EVERY visit according to the terms and conditions of my insurance plan. I understand that even though I have insurance coverage, I am responsible for payment for services that are not covered by my insurance plan. I understand that if my insurance information is incorrect, I will be responsible for payment of the visit and to submit charges to the correct plan for reimbursement.

Signature: X_____

Copay: I agree to take full financial responsibility for payment of my copay. I understand that my copay amount is determined by my insurance plan benefit and the amount I am charged will be for services rendered by a specialist. **I understand that payment of my copay will be required at the time services are rendered, before seeing the medical provider.**

Initial: _____

Deductible: I agree to take full financial responsibility for payment of my deductible. I understand that my deductible amount is determined by my insurance plan benefit. I understand that the amount I am charged will be for services rendered by a specialist according to the fee schedule of my insurance plan. **I understand that payment of my deductible will be required at the time services are rendered, before seeing the medical provider.**

Initial: _____

Coinsurance: In the event that a coinsurance applies, I understand that I will be billed for any amount that my insurance company determines to be my responsibility. I agree to take full financial responsibility for payment of my coinsurance.

Initial: _____

3. Overpayment/Remaining Balances

By signing, I understand that my insurance company will process my claim and the amount I was initially charged may be different from what my insurance company deems my responsibility. In the event of an overpayment, I understand that I will receive a refund from Rose Dermatology for the amount which was overcharged. In the event of an underpayment, I understand that I will be responsible for unpaid charges and will remit payment immediately. I understand that the aforementioned charges will be IN ADDITION to payment that I may have previously made at the time of my office visit.

Signature: X_____ _____

4. Referrals/Authorization

By signing, I understand that it is my responsibility to know if my insurance plan requires a referral to see a specialist or whether or not preauthorization is required and what services are covered. I understand that if my plan requires a referral to see a specialist, it is my responsibility to obtain a referral from my primary care physician. In the event my referral is invalid due to an expiration date, exceeded number of visits or terminated coverage, I understand that I will be responsible for full payment for the services rendered.

Signature: X_____ _____

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CANCELLATION/NO SHOW POLICY

At Rose Dermatology, we value you as a patient. When we book appointments we designate a specific time for you to receive the necessary care and treatment you deserve. We understand that situations arise at which time appointments may need to be cancelled. Each time a patient misses or "NO SHOWS" an appointment without providing sufficient notice, another patient is prevented from receiving care. Therefore, we request that you give us no less than 24 hour notice for cancellations.

Office appointments which are cancelled/rescheduled with less than 24 hour notice will be charged a $20 cancellation fee. Patients who do not show up for their appointment without a call to cancel will be considered as "NO SHOW" and will be charged a $20 "NO SHOW" fee.

Cancellation/NO SHOW fees are the responsibility of the patient and payment must be made at the time the appointment is cancelled and before any future appointments can be booked.

By signing, you acknowledge you have read and agree to the terms of the Rose Dermatology Cancellation/NO SHOW policy.

_____ _____ _____/_____/_____

Print Last Name Print First Name Date

Sign X_____

Patient Consent for Use and Disclosure of Protected Health Information

Rose Dermatology

I hereby give my consent for Rose Dermatology to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Rose Dermatology's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Rose Dermatology reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Rose Dermatology Privacy Officer at [30-16 30th Drive, Mezzanine, Astoria NY 11102].

With this consent, Rose Dermatology may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Rose Dermatology may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Rose Dermatology may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Rose Dermatology restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Rose Dermatology's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Rose Dermatology may decline to provide treatment to me.

_____ _____

Print Patient's Name Date

_____

Signature of Patient or Legal Guardian

_____

Print Name of Legal Guardian

In the event that we are unable to reach you, whom may we contact regarding your medical condition and/or test results:

Primary Contact

_____ _____

Name Relationship to Patient

(_____) _____ (_____) _____ (_____) _____

Mobile Number Home Number Work Number

Secondary Contact

_____ _____

Name Relationship to Patient

(_____) _____ (_____) _____ (_____) _____

Mobile Number Home Number Work Number

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Rose Dermatology

_____

Practice Name

I am a patient of Dr. Lilly Rose Paraskevas. I hereby acknowledge receipt of Rose Dermatology's Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of Rose Dermatology's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____