NO ACCEPTAMOS CHEQUES

Rose Dermatology P.C.

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

INFORMACION DEL PACIENTE:

Fecha de hoy____/____/____

Nombre____

Apellido Primer

Dirección ____

Calle *Apartamento/ piso* *Cuidad* *Estado* *Codigo Postal*

Telefono de casa__________________ Telfono de trabajo ________________________ Telfono cellular ________________________

Fecha de nacimiento _____/_____/_____ Eda _____ Sexo _____ Marital Status ________ Ocupación ____________________

Mes *dia* *año*

Número de seguro social: _____-_____-_______ Dirección de correo electrónico: ______________________________

Como le gustaria recibir confirmacion de su cita: ☐ Correo electrónico ☐ Teléfono

Raza:*________________ Etnicidad:*__________________ Idiomas: ______________ Idioma preferida :______________

Referido por: __Familiar/Amigo __ Superpages.com __Paginas amarillas __Compania de seguro. __ZOCDOC __Doctor

Doctor Primario	Doctor de referido:
Nomber: ______________________________	Nomber: ______________________________
Direccion:	Direccion:
______________________________	______________________________
Calle *Cuidad* *Estado* *Codigo Postal*	*Calle* *Cuidad* *Estado* *Codigo Postal*
Telefono: ______________________	Telefono: ______________________

Informacion del primario del seguro

NO LLENE ESTA PARTE SI EL PACIENTE ES EL PRIMARIO EN EL SEGURO

Nombre______________________________ ______________________________

Apellido *Primero*

Dirección ____

Calle *Apartamento/ piso* *Cuidad* *Estado* *Codigo Postal*

Telefono de casa__________________ Telfono de trabajo ________________________ Telfono cellular ________________________

Relacion del paciente al primero del seguro: ☐Hijo ☐Padre ☐Esposa/ Esposo

Fecha de nacimiento _____/_____/_____ Sexo_____ Número de seguro social: _____-_____-________

Mes *dia* *año*

Informacion de Seguro	Farmacia Preferrida
Primario del seguro:______________________________	Nombre:______________________________
Numero de policia: ______________________________	Numero de telfono: ( )______________________
Numero de grupo: ______________________________	Direcion: ______________________________
Nombre de empleador: ______________________________	
Numero de empleador: ______________________________	

Rose Dermatology P.C.

Insurance Acceptance Agreement

30-74 31st, Astoria NY 11102 718-728-3376

FOR MEDICARE PART B: HAVE YOU RECENTLY JOINED A MEDICARE HMO? YES____ NO____

I request that payment of authorized Medicare benefits be made to ROSE DERMATOLOGY, P.C. for any services provided to me by the physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these 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.

MEDICARE Beneficiary Signature (Patient) X____

FOR ALL OTHER INSURANCE:

I understand that it is my responsibility to have proper authorization for **every visit** at ROSE DERMATOLOGY, P.C. **Applicable co-payments apply to each visit.** In the event my referral is invalid due to **expired date** or **terminated coverage, I understand that I will be responsible for full payment for the services rendered.**

I understand that deductibles and coinsurance (in addition to co-payment) may apply according to the terms of my contract and I will pay for said deductible and copayment at the time service is rendered. 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.

PATIENT SIGNATURE X**____

*This information is required under laws regarding meaningful use of health records.

(Under 18, parent or guardian must sign above) **Date

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 [30-74 31st street, 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: ______________________________