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: _____

Financial Agreement

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

As a new patient, you will be required to pay a consultation fee for the services provided to you. **Fees for services will be collected at the time services are rendered.** Please be advised that if a procedure is done and a specimen is sent to the laboratory for processing, you will receive a separate bill from the laboratory. The bill you receive from the laboratory is not for services rendered in our office but, for the diagnostic testing of the specimen that was collected in our office and sent to the lab for testing.

Signature X_____

Preferred Pharmacy

Name:_____

Phone Number: ( )_____
Area Code

Address: _____

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: _____