NORTHPOINT
DERMATOLOGY & MOHS SURGERY

1000 Northern Boulevard, Suite 140 • Great Neck, NY 11021
Tel: (516) 846-3300
Fax: (516) 846-3305
www.NorthPointDerm.com

Dear Patient,

Welcome to North Point Dermatology & Mohs Surgery! Thank you for choosing our practice for your dermatologic and skin care needs. We strive to deliver high quality, personalized medical care in a comfortable environment. For our new patients, we would like to provide you with the following information to make your visit a smooth and enjoyable experience.

We are located at 1000 Northern Boulevard, Suite 140 in Great Neck, NY 11021. Self-parking and free valet parking are both available.

New Patients: To expedite your visit, please complete the attached forms and bring them with you to your appointment. We ask that you do not mail them to us.

Photo ID/Insurance Card(s): Please bring your photo ID and insurance card(s) with you. We will need to make copies of these and keep them on file.

Referrals: If you have an HMO plan that requires a referral, please make sure to have it at the time of your visit. If it is not available, we will have to reschedule your appointment.

Minors: Patients under the age of 18 must have a parent or guardian with them at the time of the visit. If a parent or guardian is unavailable, please bring a signed “Authorization for Treatment of a Minor” waiver to the visit. This form can be found on our website under the “Patient Resources > Forms” tab.

If you have any questions, please call our office at (516) 846-3300. We look forward to meeting you.

Sincerely,

Joshua Farhadian, M.D.

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PATIENT INFORMATION

PATIENT NAME: LAST | FIRST | M.I. | SUFFIX | AGE | SOCIAL SECURITY NUMBER

MAILING ADDRESS: STREET OR P.O. BOX | APT, SUITE, OR UNIT # | CITY | STATE | ZIP

DATE OF BIRTH | GENDER | HOME PHONE NUMBER ( ) | CELL PHONE NUMBER ( ) | WORK PHONE NUMBER ( ) | PREFERRED PHONE NUMBER? ☐ Home ☐ Cell ☐ Work

E-MAIL ADDRESS | MARITAL STATUS ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed | ETHNICITY ☐ Hispanic ☐ Non-Hispanic

MAY WE LEAVE MEDICAL INFORMATION ON YOUR VOICEMAIL? ☐ Yes ☐ No | MAY WE E-MAIL YOU NOTIFICATIONS? ☐ Yes ☐ No

PHARMACY NAME | PHARMACY: ADDRESS | CITY | ZIP | PHARMACY PHONE ( )

HOW DID YOU HEAR ABOUT US?
☐ Google ☐ Web Search ☐ Newspaper ☐ Mailer ☐ Physician ☐ Insurance ☐ Friend/Family ☐ Other: ____________

PERSON RESPONSIBLE FOR CHARGES

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY:
☐ Spouse ☐ Child ☐ Other: ________________

FULL NAME OF RESPONSIBLE PARTY | GENDER

MAILING ADDRESS: STREET OR P.O. BOX | APT, SUITE, OR UNIT # | DATE OF BIRTH

CITY | STATE | ZIP | PREFERRED CONTACT PHONE NUMBER

REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN: NAME | PHONE | FAX

REFERRING PHYSICIAN: NAME | PHONE | FAX

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY NOTIFY (FULL NAME) | RELATIONSHIP | PHONE NUMBER

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE NAME: ____________	INSURANCE NAME: ____________
POLICY/ID #: ____________	POLICY/ID #: ____________
GROUP/ACCOUNT #: ____________	GROUP/ACCOUNT #: ____________
CARDHOLDER'S NAME: ____________	CARDHOLDER'S NAME: ____________
DOB: ____________ SOC. SEC. #:____________	DOB: ____________ SOC. SEC. #:____________
RELATION TO PATIENT: ____________	RELATION TO PATIENT: ____________

PERSONAL REPRESENTATIVE

I hereby authorize North Point Dermatology & Mohs Surgery and its employees to discuss, send and/or receive medical information to/with:

1) NAME: ____________ RELATIONSHIP: ____________ PHONE: ____________

2) NAME: ____________ RELATIONSHIP: ____________ PHONE: ____________

3) NAME: ____________ RELATIONSHIP: ____________ PHONE: ____________

SIGNATURE: ____________________ DATE: ____________________

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Medical History Intake Form

PATIENT NAME	DATE OF BIRTH

Past Medical History (please check all that apply)

☐ Anxiety	☐ Breast cancer	☐ GERD	☐ Leukemia specify type:
☐ Arthritis	☐ Cervical Cancer	☐ Hearing Loss	☐ Lung Cancer
☐ Asthma	☐ Colon Cancer	☐ Hepatitis specify type:	☐ Lymphoma specifiy type:
☐ Atrial Fibrillation	☐ COPD	☐ Hypertension	☐ Prostate Cancer
☐ Bleeding Disorder specify type:	☐ Coronary Artery Disease	☐ HIV/AIDS	☐ Radiation Treatment
☐ Bone Marrow Transplant	☐ Depression	☐ Hypercholesterolemia	☐ Seizures
☐ BPH	☐ Diabetes	☐ Hyperthyroidism	☐ Stroke
☐ Brain cancer	☐ End Stage Renal Disease	☐ Hypothyroidism	☐ NONE
☐ OTHER:			

Past Surgical History (please check all that apply)

☐ Appendix Removed	☐ Heart: Heart Transplant	☐ Prostate: Prostatectomy
☐ Bladder Removed	☐ Heart: Mechanical Valve Replacement	☐ Rectum: Abdominoperineal Resection
☐ Brain: Craniotomy	☐ Joint: Hip Replacement ☐ left ☐ right ☐ both	☐ Rectum: Low Anterior Resection
☐ Brain: Deep Brain Stimulator	☐ Joint: Knee Replacement ☐ left ☐ right ☐ both	☐ Skin: Basal Cell Cancer
☐ Brain: Shunt	☐ Joint: Shoulder Replacement ☐ left ☐ right ☐ both	☐ Skin: Melanoma
☐ Breast: Implant(s) ☐ left ☐ right ☐ both	☐ Kidney: Kidney Transplant	☐ Skin: Skin Biopsy
☐ Breast: Mastectomy ☐ left ☐ right ☐ both	☐ Kidney: Nephrectomy	☐ Skin: Squamous Cell Carcinoma
☐ Breast: Lumpectomy ☐ left ☐ right ☐ both	☐ Liver: Hepatectomy	☐ Spleen Removed
☐ Colon: Colectomy	☐ Liver: Liver Transplant	☐ Testicle(s) Removed ☐ left ☐ right ☐ both
☐ Colon: Colostomy	☐ Liver: Shunt	☐ Uterus: Cervical Cancer
☐ Facelift	☐ Ovaries Removed: Endometriosis	☐ Uterus: Hysterectomy - Fibroids
☐ Gallbladder Removed	☐ Ovaries Removed: Ovarian Cancer	☐ Uterus: Hysterectomy - Uterine Cancer
☐ Heart: Angioplasty	☐ Ovaries Removed: Ovarian Cyst	☐ NONE
☐ Heart: Biological Valve Replacement	☐ Ovaries: Tubal Ligation	
☐ Heart: Coronary Artery Bypass	☐ Pancreas: Pancreatectomy	
☐ OTHER:		

Dermatological History – Have you had any of the following? (please check all that apply)

☐ Actinic Keratoses	☐ Filler Injections (i.e.: Juvéderm, Radiesse, Restylane, Sculptra)	☐ Psoriasis
☐ Asthma	☐ Hay Fever/Seasonal Allergies	☐ Squamous Cell Skin Cancer
☐ Basal Cell Skin Cancer	☐ Laser Skin Procedures	☐ NONE
☐ Blistering Sunburns	☐ Melanoma	☐ OTHER:
☐ Chemical Peels	☐ Neuromodulator Injections (i.e.: Botox, Dysport, Xeomin)	
☐ Eczema	☐ Pre-cancerous Moles	

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? (NOT the same as basal cell skin cancer or squamous cell skin cancer)? ☐ YES ☐ NO

If yes, which relatives? ____

Current Medications

Please list below all current medications (including vitamins, supplements, aspirin and pain medications):

CONTINUED ON NEXT PAGE

History and Intake Form (Page 2)

PATIENT NAME	DATE OF BIRTH

Allergies (Please list ALL allergies)

Social History (please check all that apply)

Smoking Status: ☐ Non-Smoker ☐ Former Smoker ☐ Current Smoker Packs Per Day: __________

Alcohol Consumption: ☐ None ☐ Less than 1 drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day

Occupation: ____

Alerts (please check all that apply to you)

☐ Allergy to adhesive	☐ Blood thinner(s)	☐ Pacemaker
☐ Allergy to betadine/iodine	☐ Bone stimulator	☐ Pregnancy or planning pregnancy
☐ Allergy to Hibiclens	☐ Cochlear implant(s)	☐ Premedication prior to procedures
☐ Allergy to lidocaine	☐ Deep brain stimulator	
☐ Allergy to topical antibiotics	☐ Defibrillator	
☐ Artificial heart valve	☐ History of MRSA infection	
☐ Artificial joint(s) within past 2 years	☐ Nerve or spinal cord stimulator	

What is the reason for your visit today?

____

____

____

I hereby certify that the above information is true and correct to the best of my knowledge.

______________________________	______________________________	____________________
Patient/Representative Name (print)	Signature	Date

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Patient Financial Policies

I acknowledge and understand that by signing below, I hereby accept (i) all financial policies listed below and (ii) authorize payment directly to Dermatology & Mohs Surgery of Long Island, PLLC (Doing Business As: North Point Dermatology & Mohs Surgery), Suite 140, Great Neck, NY 11021 **for services rendered to me, as specified more fully below.**

1. **MEDICARE PATIENTS:** I hereby request that payment of Medicare benefits be made on my behalf to Dermatology & Mohs Surgery of Long Island, PLLC and/or its providers for services rendered to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services ("CMS" or "Medicare") and its agents, any information needed to determine my Medicare benefits or the benefits payable for related services. I authorize the release of medical information necessary to complete any insurance claim forms and to pay the claim. The Practice accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for any deductible and/or coinsurance payment and payment for any non-covered services. Coinsurance and deductibles for covered services will be based upon the charge determination of the Medicare carrier. I authorize the release of my information to any MediGap or other health insurance carrier I maintain and authorize payment of these secondary insurance benefits to be made on my behalf to the Practice, if possible.

2. **INSURANCE COVERAGE:** I will notify the Practice of any change(s) in my insurance coverage at the time of each visit. I understand that it is my responsibility to provide the Practice with any required authorizations or referrals in advance of the appointment or service. If I do not provide these before care is provided, then I will be responsible for the cost of the care.

3. **ASSIGNMENT OF BENEFITS:** I hereby authorize my insurance benefits to be paid directly to Dermatology & Mohs Surgery of Long Island, PLLC. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.

4. **NON-COVERED SERVICES:** I understand that each Plan (i.e., HMOs, PPOs) defines what items and services are covered and what items and services are not covered by the Plan. I accept full financial responsibility for payment for any non-covered items or services that I have accepted, if my Plan determines that such items or service are not covered. Examples of non-covered services include, but are not limited to, services not specified as being covered by a Plan, services not listed in the benefit summary furnished to patients by the Plan, and/or treatment or tests not authorized by the Plan. I agree to cooperate with the Practice to obtain all authorizations required by my plan.

5. **PAYMENT FOR SERVICES RENDERED:** I hereby request Dermatology & Mohs Surgery of Long Island, PLLC (D&MSLI) to render the services to me. I understand and acknowledge that I am responsible for any amount payable as a result of the services I receive that my insurance company does not remit to D&MSLI, including copayments and deductibles. I agree to utilize my best efforts to ensure that my insurance company reimburses NPD&MS for services rendered to the extent covered by my healthcare insurance. Should my insurer remit reimbursement for the services I received from D&MSLI to me directly, I agree to immediately forward the checks I receive from my insurance company to D&MSLI. Insurance checks must be endorsed to Dermatology & Mohs Surgery of Long Island, PLLC (signed on the back). I understand and acknowledge my failure to remit any sums owed to D&MSLI when due shall result in D&MSLI engaging in good faith collection efforts, and thereafter, my potential referral to a collection agency or D&MSLI instituting legal action against me. I agree to pay any and all costs, expenses and fees (including attorney's fees) incurred by D&MSLI in connection with its efforts to collect any sums owed by me to D&MSLI in connection with the requested services. I also understand and acknowledge that, should D&MSLI commence such collection efforts, any payment reductions I may have previously negotiated with D&MSLI will be null and void, and I understand that D&MSLI can, and will, seek payment in full for the full cost of the services rendered to me by D&MSLI.

6. **OUTSIDE PATHOLOGY & LAB FEES:** Pathology and laboratory samples sent outside of our office are billed independently of Dermatology & Mohs Surgery of Long Island, PLLC. You may receive a bill from the outside lab and will be responsible for payment to that facility.

7. **RETURNED CHECKS:** A $30 fee will be billed for returned checks. If your check is returned from the bank, we may not accept an additional check as payment on your account. Future payments must be made with cash, money order, or credit card.

8. **RELEASE OF INFORMATION:** I understand that the Practice may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, (1) to any person or corporation that is or may be liable or under contract to the Practice for reimbursement for services rendered, and/or (2) to any health provider for continued patient care. I also understand that the Practice may disclose on an anonymous basis any information concerning my care that is necessary or appropriate for the advancement of medical science, medical education, medical research, and/or for the collection of statistical data or pursuant to Local, State, or Federal law.

I hereby understand and agree to the financial policies listed above on these two pages:

____ ______________________________

Signature of Beneficiary or Authorized Party Date

____

Printed Name of Beneficiary or Authorized Party

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Acknowledgement of Receipt of HIPAA Privacy Policy

I ____ acknowledge that I have received
Name of Patient

a copy of Dermatology & Mohs Surgery of Long Island, PLLC's **'HIPAA Privacy Policy'**. This Privacy Policy describes how Dermatology & Mohs Surgery of Long Island, PLLC may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

____ ________________________________
Signature of Patient or Personal Representative Date

____
Relationship to Patient