FRYER DERMATOLOGY, PLLC

150 BROADHOLLOW ROAD, SUITE 100, MELVILLE NY 11747 631-673-5700

208-01 NORTHERN BLVD, SUITE 4F, BAYSIDE NY 11361 718-224-8200

FIRST NAME: _____ MI: _____ LAST NAME: _____

STREET ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ HOME PHONE: _____ CELL: _____

EMAIL: _____ DOB: _____ AGE: _____ GENDER: M F

MARTIAL STATUS: S M D SOCIAL SECURITY NUMER: _____

RACE: WHITE AFRICAN AMERICAN NATIVE AMERICAN ASIAN HISPANIC OTHER

ETHNICITY: HISPANIC/LATINO NOT HISPANIC/LATINO PRIMARY LANGUAGE _____

EMPLOYER: _____ OCCUPATION: _____

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

PHARMACY: WE ARE LEGALLY REQUIRED TO E-PRESCRIBE

NAME: _____ ADDRESS: _____ PHONE: _____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY: _____

NAME: _____ RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD

STREET: _____ CITY: _____ STATE/ZIP: _____

D/O/B: _____ SOCIAL SECURITY#: _____ GENDER: M OR F

INSURED ID# _____ GROUP # _____

SECONDARY INSURNACE INFORMATION

INSURANCE COMPANY: _____

NAME: _____ RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD

STREET: _____ CITY: _____ STATE/ZIP: _____

D/O/B: _____ SOCIAL SECURITY#: _____ GENDER: M OR F

INSURED ID# _____ GROUP # _____

Authorization to Pay Benefits to Physician: I hereby authorize Fryer Dermatology. PLLC to release any medical information regarding medical history, services or treatments rendered to me or my dependent for purposes of insurance claims and authorize the assignment of benefits directly to Fryer Dermatology, PLLC**. I accept financial responsibility for services not paid by insurance including all deductibles/copayments/coinsurance, non covered services, lack of necessary referrals and any fees not paid by my insurance (for any reason) within 120 days of the date of service**. I understand that all copays are due on the day of my visit and failure of payment at that time will result in an additional fee. There will be a $25.00 fee for appointments missed without being cancelled within 24 hours.

PATIENT OR AUTHORIZED SIGNATURE _____ **DATE** _____

HISTORY AND INTAKE FORM

PAST MEDICAL HISTORY (PLEASE CIRCLE ALL THAT APPLY) **NONE**

ANXIETY	DIABETES	HYPOTHYROIDISM
ARTHRITIS	ELEVATED BLOOD PRESSURE	LIVER DISEASE
ASTHMA	END STAGE RENAL DISEASE	LEUKEMIA
ATRIAL FIBRILLATION	EPILEPSY	MALIGNANT LYMPHOMA
BENIGN PROSTATIC HYPERPLASIA	GASTRO REFLUX DISEASE	MALIGNANT TUMOR BREAST
COVID-19	H/O HYPERTENSION	MALIGNANT TUMOR COLON
CEREBROVASCULAR ACCIDENT	HEARING LOSS	MALIGNANT TUMOR LUNG
CHRONIC OBSTRUCTIVE LUNG DISEASE	HIV INFECTION	MALIGNANT TUMOR PROSTATE
CORONARY ARTERIOSCLEROSIS	HYPERCHOLESTEROLEMIA	RADIATION THERAPY TREATMENT
DEPRESSIVE DISORDER	HYPERTHYROIDISM	TRANSPLANTATION OF BONE MARROW

OTHER_____

PAST SURGICAL HISTORY: **NONE**

ABDOMINAL RESECTION	HISTORY OF LIVER EXCISION	REPLACEMENT OF BILATERAL KNEE
APPENIDX REMOVED	CORONARY ARTERY BYPASS	SPLENECTOMY
BIOPSY OF BREAST (RIGHT, LEFT, BILATERAL)	HISTORY OF TOTAL CYSTECTOMY	SURGICAL BIOPSY OF SKIN
BIOPSY OF PROSTATE	HYSTERECTOMY	TOTAL NEPHRECTOMY
CORONARY ARTERY BYPASS GRAFT	KIDNEY BIOPSY	TOTAL ORCHIECTOMY
KIDNEY TRANSPLANT	RESECTION OF RECTUM	REPLACEMENT OF LEFT HIP JOINT
EXCISION SQUAMOUS CELL CARCINOMA	LUMPECTOMY OF BREAST (RIGHT OR LEFT)	REPLACEMENT OF RIGHT HIP JOINT
EXCISION OF MELANOMA	MASTECTOMY (RIGHT OR LEFT)	REPLACEMENT LEFT KNEE JOINT
EXCISION BASAL CELL CARCINOMA	MECHANICAL HEART VALVE	REPLACEMENT RIGHT KNEE JOINT
H/O COLOSTOMY	OOPHRORECTOMY	HEART TRANSPLANT
H/O TUBAL LIGATION	PANCREATECTOMY	LIVER TRANSPLANT
HISTORY OF APPENDECTOMY	KIDNEY STONE EXTRACTION	
HISTORY OF BILATERAL MASTECTOMY	SHUNT OPERATION	OTHER :_____
HISTORY OF CHOLECYSTECOMY	PROSTATECTOMY	_____
HISTORY OF COLECTOMY	REPLACEMENT OF BILATERAL HIP JOINTS	

SKIN DISEASE HISTORY **NONE**

ACNE	H/O HAY FEVER	POISON IVY	ECZEMA
ACTINIC KERATOSIS	PSORIASIS	DYSPLASTIC NEVUS OF SKIN	PRECANCEROUS MOLES
ASTEATOSIS CUTIS	FLAKING/ITCHY SCALP	SQUAMOUS CELL CARCINOMA	H/O ASTHMA
BASAL CELL CARCINOMA	MALIGNANT MELANOMA	BLISTERING SUNBURNS	

OTHER : _____

DO YOU HAVE ANY MOLES THAT ARE ITCHING, BLEEDING, OR CHANGING _____

DO YOU WEAR SUNSCREEN _____ IF YES, WHAT SPF _____ DO YOU TAN IN TANNING SALON _____

DO YOU HAVE A FAMILY HISTORY OF MELANOMA? YES NO

IF YES, WHICH RELATIVE? _____

MEDICATIONS: PLEASE ENTER ALL CURRENT MEDICATIONS- PLEASE INCLUDE VITAMINS OR SUPPLEMENTS

_____

_____

_____

ALLERGIES: PLEASE ENTER ALL ALLERGIES

_____

_____

_____

SOCIAL HISTORY: PLEASE CIRCLE ALL THAT APPLY

CIGARETTE SMOKING:	**ALCOHOL USE:**
CURRENTLY SMOKING	ETOH- NONE
FORMER SMOKER	ETOH LESS THAN 1 DRINK PER DAY
NEVER SMOKES	ETOH 1-2 DRINKS PER DAY
	ETOH 3 OR MORE DRINKS PER DAY

FAMILY HISTORY (ONLY 1ST DEGREE RELATIVES) SKIN CANCER OR OTHER MAJOR ILLNESSES

_____

_____

_____

REVIEW OF SYSTEMS: ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING? (PLEASE CIRCLE)

NONE

PROBLEMS WITH HEALING	PROBLEMS WITH BLEEDING	PROBLEMS WITH SCARRING
CHILLS OR NIGHT SWEATS	ABDOMINAL PAIN	HEADACHES
HAY FEVER	FEVER/CHILLS	UNINTENTIONAL WEIGHT LOSS
IRREGULAR MENSTRUAL PERIODS	BLOODY STOOL	BLOOD IN URINE
JOINT PAIN/ ACHES	SEIZURES	SHORTNESS OF BREATH
WHEEZING	IMMUNOSUPPRESION	DEPRESSION
ANXIETY	CHEST PAIN	THYROID PROBLEMS
SORE THROAT	MUSCLE WEAKNESS	NECK STIFFNESS

OTHER SYMPTOMS:_____

ALERTS: PLEASE CIRCLE ALL THAT APPLY **NONE**

ALLERGY TO LIDOCAINE	RAPID HEART BEAT TO EPINEPHRINE	COPD
ALLERGY TO TOPICAL ANTIBIOTIC OINTMENT	PREGNANCY OR TRYING TO CONCEIVE	CHF
ARTIFICAL HEART VALVE	BREAST FEEDING	DIABETES
ARTIFICAL JOINT REPLACEMENT	ALLERGY TO ADHESIVE	CAD
BLOOD THINNERS	ALLERGY TO LATEX	
DEFIBRILLATOR	PREMEDICATION PRIOR TO PROCEDURES	
PACEMAKER		

MIPS

PRIMARY CARE PHYSICIAN_____ DATE OF LAST VISIT _____

DO YOU HAVE HISTORY OF MALIGNANT MELANOMA (CIRCLE) YES NO

DO YOU SMOKE YES (FORMER OR CURRENT) NO

PATIENT 65 AND OLDER

NAME OF HEALTHCARE PROXY/EMERGENCY CONTACT? _____

EMERGENCY CONTACT PHONE NUMBER _____

RELATIONSHIP TO PATIENT_____

WOMEN 65 AND OLDER

HAVE YOU BEEN DIAGNOSED WITH URINARY INCONTINENCE? (CIRCLE) YES OR NO

(We understand this question is not directly related to Dermatology, however, the government requires us to ask in order to fulfill a program requirement. We truly appreciate your cooperation.)

MEDICARE PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for proper consideration of a claim. Please read and sign the following statement:

I authorize Fryer Dermatology, PLLC. To release medical or other information to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this Authorization to be used in place of the original, and request payment of medical insurance benefits to Fryer Dermatology, PLLC. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

Signature as it appears on Medicare card Date

If you have a supplemental (secondary insurance) policy and it is a supplemental policy to which your Medicare Carrier automatically "crosses over" we are required to keep a separate signature on file:

I request authorized supplemental benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to _____(please indicate supplemental carrier's name) any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature as it appears on supplemental card Date

RECEIPT OF NOTICE OF HIPPA PRIVACY PRACTICES WRITTEN ACKNOWLEDGE FORM

I have had an opportunity to read and receive a copy of the HIPPA notice of Privacy Practices for FRYER DERMATOLOGY, PLLC.

_____ _____

Patient name – please print Date

_____ _____

Signature of Patient/Guardian Date

I authorize FRYER DERMATOLOGY, PLLC. to discuss my Protected Health Information(PHI) with the following family members or designated individuals.

Name: Relationship:

_____ _____

_____ _____

_____ _____

_____ _____

Signature of Patient/ Guardian Date

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FINANCIAL AGREEMENT

Fryer Dermatology, PLLC. is committed to providing you with the best possible care. We are available at any time to discuss our professional fees. Your clear understanding of our Financial Policy is important to our professional relationship. If you have any questions regarding your financial responsibility or our financial policy, please feel free to ask.

APPOINTMENTS: In the event that an appointment cannot be kept, our office requires 24 hours notice. There will be a $25.00 fee for appointments that are missed without being cancelled. In the event of excessive cancellations, or missed appointments, our office may require that a deposit of $25.00 be made prior to scheduling future appointments. This fee will be refunded or applied to your copay as applicable. In the event that the appointment is not kept, the $25.00 fee will not be refunded.

REFERRALS: Referrals are the responsibility of the patient. If your plan requires a referral it is your responsibility to obtain one for you primary care provider. In the event that you do not have the necessary for your visit, you will be required to pay for your visit. If the appropriate referral is received after the visit you will receive a refund.

CO-PAYMENT: Our office is required by law to collect your carrier designated co-payment. Co-payments are due at the time of your visit. Co-payments are due at every office visit regardless of the reason for your visit. In the event that you do not pay your co-payment at the time of your visit and we have to bill you, you will be charged an additional $10.00 fee.

DEDUCTIBLES AND CO-INSURANCE: Many insurance policies have deductibles and co-insurance requirements. These are the fees that your insurance company designates as your responsibility to pay towards the cost of some procedures and even some office visits, even for providers in your network and even beyond your co-payment. These fees will apply even to services that are "covered" by insurance. **Once again, this is determined by your insurance company, not by our office.** We are required by law and by our contractual agreements with your insurance company to collect these fees from you. You are responsible for payment of these fees. You are also responsible for knowing the details of your deductible and co-insurance obligations. If you have questions regarding these fees you must contact your insurance company as our office will not be able to advise you on the specifics of your policy.

PREVIOUS BALANCES: Previous balances are collected at the time of service. You will be asked to pay your balance prior to being seen by one of our providers. Balances owed for deductibles and/or co-insurance from previous visits is due at the time of service. You are responsible for responding promptly to requests from us or your insurance company to provide and additional information requires from you. Any claims unpaid due to failure to provide timely information will become due from you and payable in full.

SELF-PAY: Payment in full is due and payable at the time of service.

MEDICARE: We will submit claims to Medicare. You are responsible for your deductible and remaining 20% that is not covered by Medicare. We will bill your secondary insurance if applicable.

DIVORCED/SEPARATED PARENTS OF MINOR: The parent who consented to the treatment of a minor child is responsible for payment of any fees not paid by the child's insurance carrier. FRYER DERMATOLOGY, PLLC will not be involved with separation or divorce disputes.

You are responsible for the timely payment of your account. Should it become necessary for our office for our office to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur as a result of this. I agree to pay all monies, including the full original fee and interest, late fees, as well as additional collection fees on amounts due so that FRYER DERMATOLOGY,PLLC receives full reimbursement of monies due. I understand that I am responsible for any and all services not covered by my insurance company. I accept responsibility for payment of my account. I have read the financial agreement and accept the terms of the agreement.

FRYER DERMATOLOGY, PLLC accepts cash, credit cards and check.

PATIENT'S NAME _____ DATE OF BIRTH _____

RESPONSIBLE PARTY SIGNATURE _____ DATE _____

PRINT NAME _____ RELATIONSHIP _____