NIAGARA DERMATOLOGY ASSOCIATES, LLC

PATIENT INFORMATION FORM (Please Print Clearly and Complete All Information)

PATIENT NAME:

Last _____ First _____ Middle Initial _____

Address _____ Home Phone: _____
Street City State/Zip

Birth Date _____ Age _____ Nickname _____ Work Phone: _____

Sex: Male / Female Employer _____ Cell Phone: _____

□Minor □Single □Married □Widow □Divorced Contact Preference: □Home □Cell □Work

Email Address _____

Spouse's Name _____ Employer_____ Work Phone_____

Responsible Party (Parent/Medical Proxy) _____ Home Phone _____

IF PATIENT IS A MINOR OR DEPENDENT:

Father's Name: Last _____ First_____ Middle Initial ____

Address _____ Home Phone: _____
Street City State/Zip

Birth Date _____ Employer _____ Work Phone: _____

Mother's Name: Last _____ First_____ Middle Initial ____

Address _____ Home Phone: _____
Street City State/Zip

Birth Date _____ Employer _____ Work Phone: _____

□Lives with Both Parents □ Lives with Mother □Lives with Father Other _____

□ I understand that any child under the age of eighteen (18) must be accompanied by a parent or legal guardian/designated individual with written permission from the child's parent or legal guardian at the time of appointment. I authorize Niagara Dermatology Associates, LLC to perform the treatment and/or procedures necessary to deliver appropriate healthcare. I understand this will include evaluation and management for the presenting problem. I understand this may also include prescription of medication, application of liquid nitrogen, as well as other minor procedures. I also understand that if my minor child is not accompanied by an adult, he/she will not be seen.

_____ _____
(Parent or Guardian Signature) (Date)

Nearest friend or relative NOT living with you _____ Relationship _____
Home Phone _____ Cell/Work Phone _____

Referring Doctor _____ City _____ Phone _____

Family Doctor _____ Phone _____

NIAGARA DERMATOLOGY ASSOCIATES, LLC

INSURANCE AUTHORIZATION AND PATIENT FINANCIAL PAYMENT POLICY

Primary Insurance _____

Name of Policy Holder _____

Policy No. _____

Policy Holder Date of Birth _____

Relationship to Patient _____

Secondary Insurance _____

Name of Policy Holder _____

Policy No. _____

Policy Holder Date of Birth _____

Relationship to Patient _____

1. I understand that I am responsible for any amounts not covered by my insurance plan.
2. I understand that all co-pays and/or deductibles are due at the time of service.
3. I request that payment of benefits be made either to me or on my behalf to Niagara Dermatology Associates, LLC for any services furnished by their providers.
4. I hereby authorize Niagara Dermatology Associates LLC to furnish information to insurance carriers concerning my illness and treatments.
5. I understand and verify all insurance information provided is correct to the best of my knowledge.

Patient's Signature: _____ Date: _____

PATIENT FINANCIAL PAYMENT POLICY

The Patient Financial Payment Policy has been developed to help our patients understand their financial responsibilities related to their healthcare and to answer any questions regarding patient and insurance responsibility. If there are any questions regarding your healthcare benefits, you should contact your health plan with the phone number located on your insurance card.
We will keep a copy of your current insurance identification card(s) in your medical chart. You are responsible to notify us of any changes to your health plan coverage.

We accept cash, check, or credit card (***Visa, MasterCard or Discover***) for any payments required below. If there is any financial hardship and you are unable to make payments at the time of service, we will discuss payment options available to you. ***There will be a $25 charge for any checks returned to us.***

CO-PAYMENTS: All co-payments must be paid at the time of service.

DEDUCTIBLE PLANS: All deductibles must be paid at the time of service. We will electronically verify the current deductible amount with your health plan. If your deductible has not been met or the information is not available, you will be asked to make a ***$100*** payment if you are a new patent and a ***$75*** payment if you are an established patient toward the deductible. You will be billed for the balance after the insurance is processed.

Elective Procedures Not Covered by Insurance: You are responsible for full payment at the time of service.

Self-Pay/Uninsured: You are responsible for full payment at the time of service. Initial visit fee is ***$100***, and follow-up visit fee is ***$75***.

Collection Process: All past due accounts of 120 days or more will be turned over to a collection agency, unless arrangements have been made previously. The additional fees associated with the collection agency will be the responsibility of the patient.

No Show/Missed Appointments: If appointments are cancelled ***less than 24 hours***, there will be a ***$25*** charge for any missed appointments and a ***$100*** charge for procedure appointments. This cannot be billed to your insurance carrier.

Referrals: If your benefits require referrals, it is your responsibility to make the office aware of this and verify that the referral is in place, prior to the visit, or you will be responsible for the visit.

If you have any questions on the Patient Financial Policy, please ask to speak to the Office Manager, Alyssia Vaughn, BSHA/HM.

I, _____, have read, understand, and agree to the above policy.
(Print Name)

Signature of Patient or Responsible Party _____ Date _____

NIAGARA DERMATOLOGY ASSOCIATES, LLC

NOTICE OF PRIVACY PRACTICES/HIPAA & ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have had an opportunity to review and/or receive Niagara Dermatology Associates LLC's "Notice of Privacy Practices."

1. I consent to Niagara Dermatology Associates LLC's use and disclosure of my personal health information to carry out treatment, payment, and healthcare operations.
2. I understand this means Niagara Dermatology Associates LLC may call and leave a message on voice mail or in person in reference to any items that assist in meeting my healthcare needs, such as appointment reminders, insurance items, laboratory results, clinical care information among others. I also understand Niagara Dermatology Associates, LLC may also mail items to my home or other designated location such as appointment reminders, statements, brochures, and other items.
3. I understand I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. I understand if I do not sign this consent, Niagara Dermatology Associates, LLC may decline to provide treatment to me.

Patient Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

_____ _____

Print (Name of Patient) (Date of Birth)

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must sign this form. By signing this form, we will only give information to family members indicated below.

I authorize Niagara Dermatology Associates, LLC to release my medical and/or billing information to the following individual(s):

1. _____ Relationship to Patient: _____
2. _____ Relationship to Patient: _____
3. _____ Relationship to Patient: _____

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

Patient's Signature: _____ Date: _____

NIAGARA DERMATOLOGY ASSOCIATES LLC

Adult and Pediatric Dermatology
Cosmetic Dermatology
Surgical Dermatology including Mohs Surgery

5320 Military Road, Ste. 104 * Lewiston, NY 14092 * 2780 Delaware Ave, Ste. 202 *Kenmore, NY 14217
6105 Transit Road, Ste. 100 * E. Amherst, NY 14051
Phone: 716-205-8324 * Fax: 716-205-8593 * Web: niagaradermatology.com

AUTHORIZATION FOR RELEASE/DISCLOSURE OF HEALTH INFORMATION

_____ _____
(NAME / Date of Birth) (STREET ADDRESS)

_____ _____
(PHONE) (CITY, STATE, ZIP)

I AUTHORIZE:	TO RELEASE/DISCLOSE PROTECTED HEALTH INFORMATION TO:
Niagara Dermatology Associates, LLC 5320 Military Road, Suite 104 Lewiston, NY 14092 Phone : 716-205-8324 Fax : 716-205-8593	PHYSICIAN NAME
	STREET ADDRESS
	CITY, STATE, ZIP

Please release the following information:

- Surgery Notes ☐
- Last Two Office Visit Notes ☐
- Pathology Reports ☐
- All Medical Records ☐
- Other – Please Specify ☐ _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Niagara Dermatology Associates, LLC. Unless otherwise revoked, this authorization will expire on the following date/event or condition: _____

I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I may contact Niagara Dermatology Associates.

Patient Signature: _____ Date: _____

If patient is a minor or unable to sign:

Signed by: _____ Date: _____

Relationship: _____ Date: _____

Witnessed by: _____ Date: _____

NIAGARA DERMATOLOGY ASSOCIATES, LLC

Patient Name: _____ Date of Birth: _____

Medication Name	Dose	Frequency	Date Started