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 ______________________________________ Home Phone ______________

Address ____ Work Phone: ______________
Street City State/Zip

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 ______________________________ Work Phone ______________________________

Referring Doctor ______________________ City______________ Phone ______________

Family Doctor ______________________ Phone ______________________

NIAGARA DERMATOLOGY ASSOCIATES, LLC

INSURANCE AUTHORIZATION AND 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 them.
2. I understand that all co-pays are due at the time of service.
3. I understand I may request a payment plan prior to seeing the provider.
4. 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.
5. I hereby authorize Niagara Dermatology Associates LLC to furnish information to insurance carriers concerning my illness and treatments.
6. I understand and verify all information is correct to the best of my knowledge.

Patient's Signature: ____ Date: ____________________

(TO BE COMPLETED FOR ALL MEDICARE PATIENTS ONLY)

Are you a veteran? Yes No
Did the VA refer you here for treatment? Yes No
Do you have a VA "fee basis" ID card? Yes No
Do you have a Federal Black Lung Card? Yes No
Is this medical condition due to an accident of any kind? Yes No
If yes, was it: ____Work Related; ___Auto; ___Injured in Own Home; Other ______________________________
Are you covered by an employer's health insurance through your own employment or that of a family member? Yes No
If yes, does that employer have more than 20 employees? Yes No
Have you recently joined a Medicare Advantage Plan? Yes No If yes, which one ______________________________
Are you covered by a commercial HMO/PPO which makes Medicare secondary? Yes No

It is the policy of this office to review the accuracy of this information annually.

ONE TIME AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Niagara Dermatology Associates LLC for any services furnished me by their providers. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Patient's Signature: ____ Date: ____________________

MEDIGAP PAYMENT AUTHORIZATION (Secondary Insurance)

I hereby authorize payment of my Medigap benefits from ______________________________ to Niagara Dermatology Associates, LLC for all claims on my behalf. This authorization applies to all services until it is revoked by me or my representative.

Patient's Signature: ____ Date: ____________________

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's Signature: ____ Date: ____________________

Niagara
Dermatology
Associates, LLC
5320 Military Road, Suite 104 • Lewiston, New York 14092
2780 Delaware Avenue, Suite 202 • Kenmore, New York 14217
Phone: 716.205.8324 • Fax: 716.205.8593 • Web: niagaradermatology.com

Adult and Pediatric Dermatology
Cosmetic Dermatology
Surgical Dermatology Including Mohs Surgery

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: ____________________

Patient Information

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.

______________________________	______________
(Signature)	(Date)

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AUTHORIZATION FOR RELEASE/DISCLOSURE OF HEALTH INFORMATION

______________________________	______________________________
(PATIENT NAME)	(STREET ADDRESS)
______________________________	______________________________
(DATE OF BIRTH)	(CITY, STATE, ZIP)

I AUTHORIZE:	TO RELEASE/DISCLOSE PROTECTED HEALTH INFORMATION TO:
Niagara Dermatology Associates, LLC 5320 Military Road, Suite 104 - Lewiston, NY 14092 2780 Delaware Avenue, Suite 202 – Kenmore, NY 14217 Phone: 716.205.8324 Fax: 716.205.8593	(PHYSICIAN NAME) (STREET ADDRESS) (CITY, STATE, ZIP)

INFORMATION TO BE RELEASED/DISCLOSED:

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

PURPOSE OF DISCLOSURE:

- Continued Care ☐
- Personal Use ☐
- 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: ______________________________

Witnessed by: ______________________________ Date: ______________

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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 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.

Copayments: All copayments must be paid at the time of service. There will be an additional ***$25.00*** charge for copayments not received 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 ***$100.00*** payment 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.

Full Pay Accounts/Uninsured: You are responsible for full payment at the time of service. Initial visit fee is ***$100.00*** and follow-up visit fee is ***$75.00***. Patient will be advised of procedure fee which will be due at the time of service.

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.

Missed Appointments: If appointments are cancelled ***less than 24 hours***, there will be a ***$25.00*** charge for any missed appointments and a ***$75.00*** charge for procedure appointments. This cannot be billed to your insurance carrier.

Returned Check Charges: There will be a ***$25.00*** charge for any checks returned to us.

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.

Unpaid Personal Balances: No appointment will be made with ***personal*** balances more than ***30 days*** outstanding.

If you have any questions on the Patient Financial Policy, please ask to speak to the Office Manager, Carol Kajdasz.

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

____ ____________________________
Signature of Patient or Responsible Party Date

NIAGARA DERMATOLOGY ASSOCIATES, LLC

Patient Name: ____ Date of Birth: ___________________________

Medication Name	Dose	Frequency