SOUTHERN WESTCHESTER DERMATOLOGY
ELLEN D. TEPLITZ, M.D.

REGISTRATION SHEET

Please Print:
Date: _____

Last Name:_____ **First**_____

Address:_____ **Apt.#:** _____

City: _____ **State:** _____ **Zip:** _____

Home telephone: ( )_____ **Cell phone: ( )** _____

Date of Birth: _____**Age:** _____ **Birthplace:** _____

Social Security #: _____ **Referred by:**_____

E-mail address: _____**Pharmacy:** _____

Employer:_____ **Business Telephone:**_____

Employer Address: _____ **City:**_____**State:**____**Zip:**_____

Occupation: _____ **Primary Care Physician (PCP)**_____

Emergency Contact: _____**Relationship:** _____**Telephone:**_____

PLEASE CHECK ONE: Male _____ **Female** _____
Married____ **Single** ___ **Widowed** ____ **Divorced** _____

INSURANCE INFORMATION:

Primary Insurance:_____
Policy Holder's Name_____**DOB:** _____
Member ID#:_____**Social Security #:**_____

Secondary Insurance:_____
Policy Holder's Name_____**DOB:**_____
Member ID#:_____**Social Security #:**_____

I, _____**, hereby authorize my insurance plan, or its agents, to pay the attached claim directly to the physician for the services described. In the event that my insurance plan is one that your practice does not participate with, I agree to accept full responsibility for the remaining balance.**

Signature of patient: _____**Date:** _____

Southern Westchester Dermatology
Ellen Teplitz, M.D.
1 Elm Street, Suite 2B
Parkway Plaza Medical Center
Tuckahoe, NY 10707

Medical History

Name: _____

Medical Doctor: _____ Tel: _____

Reason for your visit: _____

Past Medical History:

If you have any of the following conditions please circle.

High blood pressure	Kidney disease	AIDS
Heart disease	Liver disease	Asthma
Excessive bleeding	Hepatitis ABC	Diabetes
Stroke, CVA	Malignancies	Arthritis
Rheumatic fever	Glaucoma	Cataracts
Sexually transmitted diseases	Heart valve replacement	Joint replacement
Mitral valve prolapse/Heart murmur		

If you have had any of the following skin diseases please circle:
Herpes Shingles Blisters
Skin cancers

Please indicate any drug allergies

_____

_____

Please list all medication you are currently taking:

_____ _____

_____ _____

_____ _____

_____ _____

Southern Westchester Dermatology
1 Elm Street Suite 2B
Tuckahoe NY 10707
Phone: (914) 337-9485
Fax: (914) 337-9485

Protected Health Information Consent Form

Please read and sign:

You agree to permit your Protected Health Information to be used and Disclosed solely for the purpose of medical treatment, payment for treatment and Health care operations. If you would like more information regarding the use and disclosure of information, please see our Privacy Notice.

We reserve the right to change our privacy policy as described in the Privacy Notice. You may call us at (914) 337-9100 to receive an updated Notice.

You have the right to request that we restrict how your protected information is used or disclosed for the purpose of treatment, payment or health care operations. We are not required by law to agree with this request, but we are bound by it.

You have the right to revoke your consent in writing. A revocation, however, will not apply to the extent we have taken action in reliance upon the use or disclosure of your information.

Signature:_____ Date:_____

SOUTHERN WESTCHESTER DERMATOLOGY P.C.

FINANCIAL POLICY

Thank you for choosing **Southern Westchester Dermatology P.C.** for your dermatological care. We are dedicated to providing you with the best possible care and we have developed this policy in response to the increasingly confusing and complex healthcare system.

It is important for you to understand that your insurance plan constitutes an agreement between yourself and your insurance company and not between **Southern Westchester Dermatology P.C.** and your insurance company. Therefore, it is your responsibility to understand and meet the requirements of your plan. It is also important that you bring your insurance card to each visit and that you notify use as soon as possible of any change in coverage. Failure to notify the office of a change in coverage may result in charges for services becoming your responsibility regardless of whether or not we participate in your insurance plan.

All payments are due at the time of service unless arrangements have been made in advance with our billing manager. We accept cash, check, money orders and credit cards.

Additionally, **Southern Westchester Dermatology P.C.** requires valid credit card information prior to services being rendered. Your credit card account will not be charged until your claim has been processed by your health insurance carrier and the balance has been deemed to be your responsibility. You will be notified by mail or telephone of the outstanding balance prior to charging your credit card at which time you will have a choice of payment options.

INSURANCE: You are responsible for any co-insurance, deductibles or non-covered services as required by your insurance. You will receive a statement from our office indicating what your insurance has paid. Any remaining balance is due upon receipt of this statement.

CO-PAYS: Your insurance company requires that co-payments be collected at the time of service. The co-pay requirement cannot be waved by our practice as it is requirement placed by your insurance carrier.

REFERRALS: Most HMO and POS insurance plans require a referral from your primary care doctor before specialty services are rendered. It is your responsibility to obtain the referral and to make sure that our office has received it prior to your visit. The cost of any services received without a referral or proper authorization will be your responsibility.

MEDICARE: We accept assignment on Medicare claims. If you have Medicare and do not have secondary coverage, you will be required to pay your 20% co-pay (and your deductible if applicable) at the time of the visit.

NO INSURANCE: Payment is due at the time of service. Payment questions and issues should be discussed in advance of the visit with the billing manager.

RETURNED CHECKS: A $30.00 charge will be added to your account for any check returned for any reason.

DISABILITY OR INSURANCE FORMS: If you request, we will be happy to assist you in completing disability forms. There may be a charge for completing these forms; $10.00 for one page (front and back); $25.00 for 2-4 pages; $250.00 for booklets and completion by a physician. There may be additional fees for a detailed narrative report. Please ask about charges at the time of your request as charges must be paid before the report is released.

MEDICAL RECORDS: We will provide you with a copy of your medical records upon request. You will be asked to sign a release form at the time of pick-up. Please allow 7-10 days for us to copy your records. If you wish us to mail your records there may be an associated fee to cover the mailing costs. Additional copies of your medical records may be obtained but there is a per page charge.

I have read and understand the financial policy of Southern Westchester Dermatology P.C. My questions have been answered and I agree to abide by the policy.

_____ _____

Signature **Date**