

New Patient Information Form

Please present your insurance card/s and picture identification to the receptionist. In order to file your insurance you must present a current insurance card.

Patient Name: _____
LAST FIRST MIDDLE INITIAL

Local Address: _____
Street/P.O. Box City/State Zip

Other Address: _____
Street /P.O. Box City/State Zip

Home Phone # _____ Cell Phone# _____ Sex: Male Female

Social Security Number _____ Date of Birth : ____ / ____ / ____

Marital Status: (circle) Married Divorced Widowed Single Partners name: _____

Please List name of any person/s (living in your household), who is a patient here and their relationship to you: _____

Who referred you and/or how did you find our office today?

Physician (list name and city) _____ Yellow Pages _____
Insurance Directory _____ Friend/Family Member (list) _____ Website _____

Occupation: _____ Employed by: _____

If we may contact you at work, please list phone number _____

Who is your Family/Primary Care Physician? _____

For all patients under 18 please list child's legal guardian: _____

If you're not the primary policy holder of your insurance (for example your insurance is through your parent or spouse's employer), please complete:

Insurance Subscriber Name: _____ Social Security# _____

Subscriber's date of birth: ____ / ____ / ____ Relationship to patient: _____

It is our policy that payment for services is expected at the time of your visit today. To help expedite your visit, the patient specialist, will collect your copayment before you're seen today. Thank you for your understanding.

Office Policies for Dr.Sidney Possick, M.D. ,P.A.

Thank you for choosing Dr.Possick as your Dermatologist. Dr.Possick is a board certified Dermatologist and has been in practice since 1972. We believe your understanding of our office policies in advance is an essential element of this practice. This is why we have created this informational sheet. If you have any questions about any of our policies please feel free to speak to our Office Manager, Brigitte.

- **Please make any address or insurance changes at the time of your visit.** This will help your insurance claim to process efficiently.
- **Please understand that we collect all co-payments and deductibles at the reception window before your visit.** Any additional services will then be collected during check out .
- **Insurance Policy: As of January 2009, we accept limited Secondary Insurances. They are the following: Blue Cross, Aetna, United Health Care (including AARP), VHN, Cigna and Humana.** If your secondary is not listed above we will be collecting your copayment today, and we will provide you with a detailed receipt. It is your responsibility to then file your secondary claim.
- **If your insurance company asks that you fill out any information in order to process our claim, it is important that you do so in a very timely manner.** Insurance companies only allow a certain amount of time before they deny or close your claim. IF your insurance company denies your claim for this reason you will be billed for the entire balance.
- **If we are an assigned provider with your insurance company, we will file your claim. However, it is ultimately your responsibility to understand what your insurance benefits are.** We will verify your benefits today and collect according to those benefits at the reception window. We can only collect based on the information we are given from your insurance company. If you think your benefits are quoted incorrectly please let us know before your visit.
- **Billing Policy:** We will balance bill you for any remaining patient responsibility portion of your bill, after we file your insurance. Please call right away if you need to make monthly payments, we are always willing to work with our patients financially. If we send you three bills and we still do not hear from you, we will call you personally. If we still do not receive payment, we will send your account to an outside collection agency. You will then be discharged as a patient from this practice. This could also negatively affect your credit rating.
- **We have a \$25.00 fee for ALL returned checks.** We cannot deposit a check once it is returned to us from the bank.
- **Cancellation Policy: We have a 24 hour notice on all cancellations. If you miss an appointment without this notice, a fee of \$20.00 may be assessed to your account.** If you cancel an elective surgery without this notice, it is at Dr.Possick's discretion if he chooses to reschedule your surgery or if he refers you to another specialist.
- **Refill Policy: If you need a 90 day supply of medication please ask Dr.Possick at the time of your visit.** This expedites the process. If you fail to ask for a 90 day supply today, please understand it may take up to 2 business days to rewrite your prescription. **If you have no further refills on your current prescription do NOT call us, instead ask your pharmacy to fax us a request.** This is the easiest way to get your prescription filled and it usually takes less than 1 business day. Please do NOT call our answering service to ask Dr. Possick to refill your prescription/s during the weekend or during non-business hours as he will not be able to process such requests.

MEDICAL QUESTIONNAIRE

Patient: _____ **Date:** ____/____/____

Why are you coming in to see Dr. Sidney Possick today?

Have you been seen by another dermatologist this year? YES NO

Have you ever been treated for any of the following? (circle one)

Duodenal or Peptic Ulcers.....	YES	NO
Tuberculosis or Lung Disease.....	YES	NO
Heart Disease.....	YES	NO
High Blood Pressure.....	YES	NO
Kidney Disease.....	YES	NO
Liver Disease.....	YES	NO
Mental Illness or Depression.....	YES	NO
HIV/AIDS.....	YES	NO

Have you ever been treated for a cancer or malignancy? YES NO

If yes, please list what type of cancer and date: _____

Have you ever been diagnosed with serious illness/medical condition? YES NO

If yes, please list _____

Have you ever been treated with (X-Ray) Therapeutic Radiology Treatments to your skin for the treatment of Acne or Skin Cancers? YES NO

Have you or any immediate relative been diagnosed with the following?

(Circle)	(List)	
Asthma	Self	Family Member _____
Hay fever	Self	Family Member _____
Hives	Self	Family Member _____
Eczema	Self	Family Member _____
Diabetes	Self	Family Member _____

Do you have a history of over grown scars or keloids? YES NO

Are you allergic to any medications or local anesthetics? YES NO

If yes, please list _____

Please list ALL medications you are taking below (if you take nothing by mouth indicate below N/A) include over the counter products such as aspirin, laxatives, vitamins and herbal supplements _____

Notice of Privacy Practices

By signing below I am acknowledging that I have (1) received a copy of HIPPA notice of privacy practices for Sidney Possick, M.D., P.A. or (2) I have been offered a copy but declined to accept a copy.

X _____

At times it may become necessary to speak to someone other than yourself to confirm appointments and/or discuss medical status with. Please list anyone that we have permission to speak with below and their relationship to you. If you do not wish to list anyone, please indicate "nobody" below.

May we leave a message on your voicemail or answering machine? _____

Lifetime Authorization for Insurance Benefits

I certify that the information I have provided today is correct. I hereby request payment of authorized medical benefits to, Sidney Possick, M.D., P.A. on my behalf. I also understand that by signing below, I release all of my medical records (including psychiatric, drug/alcohol abuse, HIV, AIDS information) to my Primary Care Physician, referring Physician/s, coordinating Labs and/or Insurance Companies (including third party agencies), for the purpose of processing insurance claims or continuity of care.

X _____ Date ____/____/____

Consent for Office Procedures

My signature below authorizes Dr. Sidney Possick to perform office surgical procedure/s. Prior to being treated I have been informed and understand why it is necessary. I also understand that there are risks inherent to the performance of any surgical procedures, such as the formation of thick or objectionable scars. I realize that these or other natural complications may result from the surgical procedure/s. By signing below, I also give permission for any tissue(s) removed during the procedure/s, be sent to an outside pathologist for histological examination. I also understand this Lab may bill separately (after filing insurance) for the examination of the tissues.

X _____ Date ____/____/____

Witnessed on ____/____/____ by _____

HIPAA Notice of Privacy Practices for Sidney Possick, M.D., P.A.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, authorization or opportunity to object unless required by law. **You may revoke this authorization,** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 386-252-5578.