15-01 Broadway, Suite 38
Fair Lawn, NJ 07410

150 River Rd, Unit A2
Montville, NJ 07045

Phone: 201-623-9438 Fax: 201-623-2999

GARDEN STATE DERMATOLOGY

Please present ALL insurance cards (primary and secondary) and Driver's License to receptionist.

If the patient is a minor and you are not the legal guardian please speak with the receptionist immediately.

NEW PATIENT REGISTRATION

LAST NAME	FIRST NAME
MIDDLE NAME	DATE OF BIRTH
SSN	GENDER
HOME ADDRESS	
CITY, STATE, ZIP	
HOME PHONE	CELL PHONE
WORK PHONE	
EMAIL ADDRESS	
MARITAL STATUS: SINGLE ___ MARRIED ___ DIVORCED ___ WIDOWED___	
REFERRED HERE BY	
PRIMARY CARE PHYSICIAN	PHONE OR TOWN
DRUGSTORE NAME	PHONE OR TOWN

INSURANCE INFORMATION

	Primary Insurance	Secondary Insurance (if applicable)
Insurance Company		
Policy Holder's Name		
Policy Holder's DOB		
Relationship to Patient		

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY	
RELATIONSHIP TO PATIENT	PHONE NO

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Patient Release: MUST BE SIGNED BY PATIENT OR IF PATIENT IS A MINOR, THE LEGAL GUARDIAN: I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare) for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I understand I am responsible for co - insurances, copayments and deductibles. If I am not insured or Garden State Dermatology LLC does not participate in my plan I am responsible for payment in full at the time of service.

I certify that I hereby authorize Garden State Dermatology LLC , its providers and staff to provide my minor child in my absence with examinations and basic treatments **following the initial visit** for which **additional consents are not required**. I understand additional written consent may be necessary for these types of procedures and that the legal guardian must be present for such consent.

I agree to receive news and information about the practice via email, which may include offers for special events or offers from the practice and my physician____ (initial)

Patient or legal guardian signature: _____

Date: _____

Name of Legal Guardian if applicable: _____

Policy Regarding Patient Financial Responsibility

The following is a summary of our financial policy. We would be happy to provide further clarification if necessary. We ask that you read and sign the following to acknowledge that you have been advised of your financial responsibility for medical services provided here.

Please initial each item and sign below

____Prior to seeing a medical professional at this office I can request that a staff member can discuss the likely costs involved in my procedure(s) and review my financial responsibility.

____This office participates with some insurance plans. It is my responsibility to provide this office with an up-to-date insurance card, any refferals that are needed and to notify this office of any changes to my insurance plan.

____I understand that insurance may not cover all fees. I am responsible for understanding my specific insurance plan and for payment of all co-pays and/or deductible charges at the time of service. (A billing form can be supplied to you for out of network insurance submission if requested.)

____I understand that some procedures performed at Garden State Dermatology, LLC are considered cosmetic and will not be covered by insurance. (You will be notified before any procedure is performed if this is the case.)

____Any laboratory analysis(except biopsy specimens) that is required can be sent to an external laboratory of my choice and/or as required by my insurance.

____This office does accept Medicare and will file all claims for patients with Medicare. (Please give us your secondary insurance card and we will also file it.)

____This office accepts payment in the form of CASH, MASTERCARD, VISA, and DISCOVER. Personal checks are only accepted for billing statements that we send out to you from the office. I understand that any checks returned due to insufficient funds will result in a fee of $25.00 each.

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____No show appointments are subject to a $50 no show fee and cancellations done on the day of are subject to $50 cancellation fee.

____I understand that I have financial responsibility for payment of medical services provided by this office, and hereby assume and guarantee payment of all expenses incurred during my office visit. Should legal action be required to secure payment of this account, I agree to pay the legal expenses incurred by this office.

I have read and understand this financial policy and agree to accept responsibility as described.

Signature of responsible party _____Date_____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed by Garden State Dermatology, LLC and how you can get access to this information. Please review it carefully.

As required by HIPAA, this notice explains how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for the following purposes: **treatment, payment, and health care operations**.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be contacting a previous health care professional to discuss your case.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- Health care operations include the business aspects of running our practice such as conducting quality assessment and improvement activities, auditing functions, cost- management analysis, and customer service.

We may also create and distribute “de-identified” health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to our office:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to your immediate family members, other relatives, close personal friends or other individuals you identify. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

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We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

Please note that there is no violation of privacy when you are called by name for your examination or if you should overhear part of a telephone conversation while checking out. These types of incidental disclosures are acknowledged by HIPAA as being an inevitable consequence of the practical limitations of space. The office makes every attempt to protect your personal health information as the act requires by being careful that it is not available to those who should not have access to it.

This notice is effective as of September 15, 2014, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. You may request a written copy of Notice of Privacy Practices from this office.

Please feel free to speak with a staff member if you have any questions about this notice.

Signature of responsible party _____Date _____

DERMATOLOGY PATIENTS

I understand that Dermatologists often perform biopsies, liquid nitrogen treatments, steroid injections and minor skin surgeries.

I also understand that any time a procedure is done such as biopsy, minor surgery, liquid nitrogen therapy there is a risk of scarring, bleeding, infection, allergic reactions. In addition to the above for procedures done near the eye or forehead there is a risk of bruising and swelling.

I also understand that any time liquid nitrogen is used to treat my skin, a blister may form and the treatment may result in a lighter or darker discoloration of the area treated.

I also understand that with steroid injections the risks include but not limited to atrophy of skin and fatty tissue, discoloration of the skin, redness, thinning of the skin and telangiectasia which can resolve with time but in some cases can be permanent.

By my signature below, I hereby give Dr. Preethi Ramaswamy of Garden State Dermatology, LLC authorization to treat my skin with a biopsy, steroid injection, liquid nitrogen or minor skin surgery. The above consent applies to every office visit.

Signature of responsible party _____Date _____

ALL PATIENTS:

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish any and all records, medical history, medications, services rendered or treatment given to me or any dependent for purposes of review, investigation, or evaluation of any claim submitted to my insurer. I also authorize my insurer to disclose to a hospital or health care service plan, self-insurer, or any insurer, any medical information obtained if such disclosure is necessary to allow the processing of any claim.

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If my coverage is under a Group Contract held by an employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with my insurer, including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon, me, my dependents, and our heirs, executors, and administrators.

Signature of responsible party _____Date _____

Past Medical History

Do you have a history of or are currently being treated for any of the following?

Asthma	☐	**Yes**	☐	**No**	**History of stroke**	☐	**Yes**	☐	**No**
Arthritis	☐	**Yes**	☐	**No**	**Heart disease**	☐	**Yes**	☐	**No**
Blood clots	☐	**Yes**	☐	**No**	**HIV**	☐	**Yes**	☐	**No**
Bowel disorders	☐	**Yes**	☐	**No**	**Lupus**	☐	**Yes**	☐	**No**
Cancer	☐	**Yes**	☐	**No**	**Mitral valve prolapse**	☐	**Yes**	☐	**No**
Cancer, basal cell	☐	**Yes**	☐	**No**	**Melanoma**	☐	**Yes**	☐	**No**
Cancer, squamous cell	☐	**Yes**	☐	**No**	**Pregnant (currently)**	☐	**Yes**	☐	**No**
Depression	☐	**Yes**	☐	**No**	**Problems with healing**	☐	**Yes**	☐	**No**
Diabetes	☐	**Yes**	☐	**No**	**Psoriasis**	☐	**Yes**	☐	**No**
Eczema	☐	**Yes**	☐	**No**	**Peptic ulcer disease**	☐	**Yes**	☐	**No**
Environmental allergies	☐	**Yes**	☐	**No**	**Seizures**	☐	**Yes**	☐	**No**
Gall stones	☐	**Yes**	☐	**No**	**Tuberculosis**	☐	**Yes**	☐	**No**
High Blood Pressure	☐	**Yes**	☐	**No**	**Thyroid disease**	☐	**Yes**	☐	**No**
High cholesterol	☐	**Yes**	☐	**No**	**Urinary tract infections**	☐	**Yes**	☐	**No**
Hepatitis C	☐	**Yes**	☐	**No**					

If you answered “yes” to any of the last 5 questions, or have a medical condition that is not listed, please specify below:

_____

_____

Do you take any medications? Please list them here:

_____

_____

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Do you have any allergies to any medications, drugs or over the counter preparations? If yes, please list them here:

_____

_____

Family History

Have you or any members of your family had any of the following?

Asthma	☐	**Yes**	☐	**No**	**Diabetes**	☐	**Yes**	☐	**No**
Eczema	☐	**Yes**	☐	**No**	**Psoriasis**	☐	**Yes**	☐	**No**
Skin Cancer	☐	**Yes**	☐	**No**		☐	**Yes**	☐	**No**

Social History

Do you drink alcohol?	☐	**Yes**	☐	**No**	☐	**Sometimes**
Do you smoke?	☐	**Yes**	☐	**No**	☐	
Do you have a history of venereal diseases?	☐	**Yes**	☐	**No**	☐	
Have you travelled outside US in the past three months?	☐	**Yes**	☐	**No**	☐	

Please list and date any prior surgeries or hospitalizations:

_____

_____

_____