PATIENT REGISTRATION / UPDATE INFORMATION FORM

TODAY'S DATE: _____

LAST NAME: _____ FIRST NAME: _____ SEX: _____

DATE OF BIRTH: _____ SINGLE: ___ MARRIED: ___ WIDOW: ___ OTHER: ___

SOCIAL SECURITY NUMBER #: _____

HOME ADDRESS: _____

CITY / STATE: _____ ZIP: _____

HOME PHONE: (_____)_____ CELL PHONE: (_____)_____

BUSINESS PHONE: (_____)_____

CONSENT FOR ELECTRONIC COMMUNICATION: YES NO EMAIL: _____

EMPLOYER: _____ ADDRESS: _____

EMERGENCY CONTACT: _____ RELATION: _____

EMERGENCY PHONE: (_____)_____

PRIMARY CARE PHYSICIAN _____

REFERRED BY (DR.) _____

PRIMARY INSURANCE COMPANY: _____

PRIMARY INSURANCE ID#: _____

SECONDARY INSURANCE: _____

SECONDARY INSURANCE ID#: _____

PHARMACY NAME/ADDRESS/PHONE# _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIM FORMS AND AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY FROM MY INSURANCE CARRIER FOR MEDICAL SERVICES

I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN THE PLACE OF THE ORIGINAL

SIGNATURE: _____ DATE: _____

IF YOUR INSURANCE REQUIRES A REFERRAL, PLEASE PRESENT IT WITH THIS FORM. IF REFERRAL IS NOT PROVIDED YOU MAY BE BILLED FOR SERVICES.

Patient Name_____**Age**_____**DOB**_____**Date**_____**SS#**_____

ALLERGIES_____

Reason for today's visit: (complaint)_____

Current or past problems with: (Review of symptoms)

SYMPTOMS	YES	NO	If yes, Explain	Medications
Asthma				
Diabetes				
General Health				
Eyes				
Ears/Nose/Throat/Mouth				
Heart Disease				
Lungs				
Stomach/Bowel				
Kidneys				
Arthritis/Muscles/Joints				
Skin				
Headaches/Seizures				
Psychological Disorder				
Thyroid				
Blood/Bleeding Disorder				
Allergic/Immunologic				
Hepatitis				

Females: Are you pregnant?____yes____no Planning to become pregnant?____yes____no Birth Control?___yes___no

Family History: (Past Family & Social History)
Mother: Living/Deceased _____ Age____ Father: Living/Deceased____ Age___ No. of Children____Age(s)

Check the following medical conditions that occurred in your family:

DISEASES	Mother	Father	Blood Relative
Allergies			
Arthritis			
Asthma			
Cancer			
Diabetes			
Eczema			
Hay Fever			
Heart Disease			
High Blood Pressure			
Lung Disease			
Malignant Melanoma			
Psoriasis			
Skin Cancer			
Tuberculosis			

Social History: Do you live alone? ____no ____yes Do you smoke? ____no ____yes Frequency: _____

Do you drink alcohol? ____no ____yes Frequency: _____ Do you use recreational drugs? ___no ___yes

Occupation: _____ Hobbies/Leisure Activities: _____

Reviewed_____ Date: _____ Update: _____

New Patient Consent to Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations (aka HIPAA acknowledgement) by Noah Scheinfeld MD PLLC

I, _____, understand that as part of my health care, Noah Scheinfeld, MD, PLLC, originates & maintains paper and/or electronic records describing my health history, symptoms, examination & test results, diagnoses, treatment, & any plans for future care or treatment. Your health information is both private & secure. This table outlines the uses & disclosures of information we use:

Uses and Disclosures of Health Information
• We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. • We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. • We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice on our website www.summithhc.com. You can also request a copy of our notice at any time. For more information about our policy practices, contact the person listed below.

I understand the table of Uses & Disclosures of Health Information above provides Noah Scheinfeld MD PLLC's *Notice of Information Practices* and that I have the following rights & privileges:

Individual Rights
• In most cases, you have the right to look at or obtain a copy of health information about you that we use to make decisions about you. • You may request in writing that we not use or disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. • You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. Your first request for an "Accounting of Disclosures" will be free of charge. Subsequent requests will be granted for a $5.00 fee. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

I understand that (1) I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon (2) refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by § 164.506 of the Code of Federal Regulations (CFR) (3) Noah Scheinfeld, MD, PLLC., reserves the right to change their notice and practices and prior to implementation, in accordance with §164.520 of CFR. Should Noah Scheinfeld, MD, PLLC., change its notice, it will send a copy of any revised notice to the address I've provided (whether U.S mail or, if I agree, email) & (4) as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including via fax. I wish to have the following restrictions to use or disclosure of my health information: _____
_____

I fully understand and accept / decline the terms of this consent.

_____ _____

PATIENT'S SIGNATURE **DATE**

FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____.

[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on _____.

Noah Scheinfeld MD PLLC 150 West 55th Street NYC, NY 10019 (212) 991-6490

AUTHORIZATION OF ASSIGNMENT OF BENEFITS

I hereby authorize Dr. Noah Scheinfeld to use and disclose my protected health information to provide medical services as may be deemed necessary or advisable in the diagnosis and treatment of my condition.

I hereby authorize Dr. Noah Scheinfeld, Noah Scheinfeld MD PLLC and entities related to them to apply for benefits on my behalf for covered services rendered by him, his staff or my orders. I request that payment from my insurance company be made directly to Dr. Noah Scheinfeld (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization can be revoked by either me or my insurance company at any time in writing.

Date: _____ Signature_____

Patient, Parent or Guardian

NOAH SCHEINFELD, MD PLLC - FINANCIAL POLICY AGREEMENT

NOTE: ALL PATIENTS ARE RESPONSIBLE FOR UNDERSTANDING THEIR INSURANCE POLICY – THE OFFICE STAFF IS NOT RESPONSIBLE FOR YOUR BENEFIT DETAILS. AS COURTESY, WE WILL TRY TO TELL YOU AS MUCH THAT IS PROVIDED TO US WHEN VERIFYING YOUR BENEFITS. PLEASE BE AWARE IF YOU HAVE A DEDUCTIBLE, YOU WILL RECEIVE A BILL, WHICH IS DETERMINED BY YOUR INSURANCE PLAN.

IF YOU ARE UNCLEAR ABOUT YOUR INSURANCE BENEFITS, PLEASE CONTACT MEMBER SERVICES.

It is our goal to provide you with the highest quality of care. Administratively, we would also like to attend to your financial needs. As a general office policy, all payments due must be paid at the time of your visit. This includes the following

COPAYS are due at **EACH** visit, unless otherwise noted by the staff.

The following are due **IF** it applies to your insurance

1) **DEDUCTIBLES** are to be paid at the time of your scheduled appointment if you have one, and if it has not been met. If your deductible has been met by other physician services, it will be verified ahead of time with your insurance carrier.

2) **CO-INSURANCE** is also part of the insurance carrier's responsibility, and is due at the time of the scheduled visit. Therefore, you will be charged your portion of the visit. (X% of the fees below)

If there is a secondary policy that covers your co-insurance, the claim will be filed. If for any reason the secondary insurance does not pay their portion, this balance will automatically be the patient's responsibility

Note: One **OR** the other will be charged based on your coverage > Deductible **OR** Co-Insurance
In general, patient fees are as follows:

New Patients: $250.00 **Follow Ups**: $150.00

This does not include any additional charges for procedures done during your visit.

IF YOU ARE SUBJECT TO A DEDUCTIBLE, YOU WILL RECEIVE A BILL.

We will make every effort to reduce your out of pocket expense accordingly working with both you and your insurance company.
We do apologize in advance, but you will **NOT** be seen if payment is not made at the time of your visit.

If you have any questions about this policy, do not hesitate to ask.

I _____, understand that I will be responsible for any charges not covered by my insurance company and authorize the dermatology practice of Noah Scheinfeld, MD to bill me for any outstanding balances.

_____ _____

Patient Signature Date

New Patient Consent to Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations (aka HIPAA acknowledgement) by Noah Scheinfeld MD PLLC

Electronic Protected Health Information (ePHI)

The Privacy Rule allows covered health care providers to communicate electronically, such as through e-mail, with their patients, provided they apply reasonable safeguards when doing so. See 45 C.F.R. § 164.530(c). For example, certain precautions may need to be taken when using e-mail to avoid unintentional disclosures, such as checking the e-mail address for accuracy before sending, or sending an e-mail alert to the patient for address confirmation prior to sending the message. Further, while the Privacy Rule does not prohibit the use of unencrypted e-mail for treatment-related communications between health care providers and patients, other safeguards should be applied to reasonably protect privacy, such as limiting the amount or type of information disclosed through the unencrypted e-mail. In addition, covered entities will want to ensure that any transmission of electronic protected health information is in compliance with the HIPAA Security Rule requirements at 45 C.F.R. Part 164, Subpart C.

Note that an individual has the right under the Privacy Rule to request and have a covered health care provider communicate with him or her by alternative means or at alternative locations, if reasonable. See 45 C.F.R. § 164.522(b). For example, a health care provider should accommodate an individual's request to receive appointment reminders via e-mail, rather than on a postcard, if e-mail is a reasonable, alternative means for that provider to communicate with the patient. By the same token, however, if the use of unencrypted e-mail is unacceptable to a patient who requests confidential communications, other means of communicating with the patient, such as by more secure electronic methods, or by mail or telephone, should be offered and accommodated.

Patients may initiate communications with a provider using e-mail. If this situation occurs, the health care provider can assume (unless the patient has explicitly stated otherwise) that e-mail communications are acceptable to the individual. If the provider feels the patient may not be aware of the possible risks of using unencrypted e-mail, or has concerns about potential liability, the provider can alert the patient of those risks, and let the patient decide whether to continue e-mail communications.

Print Name _____

Signature _____

Date _____

E-Mail _____

Noah Scheinfeld MD PLLC

LABORATORY BILLING INFORMATION

Outpatient laboratory services are billed separately from the physician visit, these are separate benefits provided by your insurance company.

Services provided during your office visit are subject to “medical” benefits. Lab services conducted off premise will be subject to “diagnostic” benefits. This includes biopsies (specimens sent out for examination), wound/viral cultures (swabs sent out for examination), bloodwork, etc. Specimens will be sent to labs in network with your insurance plan, but you should review your laboratory plan to understand your benefits as services might be subjected to copays, deductibles, or coinsurances.

Please notify our staff or physician if you have a preferred laboratory, and please feel free to raise any concerns with a staff member or physician and we will try our best to answer your questions, or we will direct you to your insurance provider.