BigAppleSkin Dermatology
Judith Hellman, MD, PLLC
Board Certified Dermatologist

30 Central Park South, Suite 10A
New York, NY 10019
Tel: 212-751-0577 Fax: 212-751-0118

Name: **Age:**

Occupation: **Referred By:**

Date: **Insurance:**

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PLEASE CIRCLE THE APPROPRIATE ANSWER Have you ever been treated for any of the following?

Question		
Duodenal or peptic ulcer?	Yes	no
Tuberculosis or lung disease?	Yes	no
Heart murmur / disease?	Yes	no
High blood pressure?	Yes	no
Blood clot?	Yes	no
Kidney disease?	Yes	no
Hepatitis?	Yes	no
Emotional disorder?	Yes	no
Diabetes?	Yes	no
Bleeding disorder?	Yes	no
Joint replacement ?	Yes	no
Immuno deficiency disorder? HIV?	Yes	no
Artificial heart valve?	Yes	no
Do you take antibiotics prior to surgery?	Yes	no
Have you been hospitalized? Why?	Yes	no
Are you now taking medicine? (if yes please list)	Yes	no
Are you allergic to any medicine? (if yes please list).	Yes	no
Do you take aspirin?	Yes	no
Do you take blood thinners?	Yes	no
Have you ever had difficulty with**:** healing of wounds?	Yes	no
Excessive bleeding when cut?	Yes	no
Overgrown scars or keloids?	Yes	no
X-ray treatment for acne or other skin conditions?	Yes	no
Do you have a **PACEMAKER?**	Yes	no
Has anyone in your family had a malignant melanoma or other skin cancer?	Yes	no
Do you and/or other family members have large or unusually numerous moles?	Yes	no
Do you have any pigmented spots that have changed in size, color, thickness, texture, etc?	Yes	no
Are there any areas on your skin which bleed or will not heal?	Yes	no
FOR FEMALES. Are you now pregnant, planning a pregnancy in the near future, or nursing a child? (if yes please specify).	Yes	no

Patients signature ______________________ **Date:** __________

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Last Name: **First Name:** **M.I.:**

Address:

City: State: Zip:

Age: DOB: Sex:

* Cell/Pager # ( ) ***REQUIRED: Please provide for emergency notifications.***

* E-Mail: ***REQUIRED: Please provide for emergency notifications.***

Home Tel # ( ) Work Tel # ( )

Soc. Sec. #

Name of Business: Occupation:

Address of Business:

Referred By (please list name): ( )Web Search Engine ___________________________ *If you visited our website, please tell us who referred you to it. ( )Patient ____ ** Please provide a specific source of referral.*

We would like to thank your friend for their kind referral which is the highest form of compliment. ( ) Insurance ______________________

( ) Internist/Primary M.D.____ Or Other: ____

Family Physician/Primary Care Physician:

Address: Tel: # ( )

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Address For Claims:	Address For Claims:
Insured's Name:	Insured's Name:
Insured's DOB:	Insured's DOB:
Soc. Sec. #	Soc. Sec. #
Policy #	Policy #
Group #	Group #
Relationship:	Relationship:

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

I hereby consent to the Notice of Privacy Practices currently in force by BigAppleSkin Dermatology. I certify by my signature that I read and understand the information disclosed in the reverenced notices. I also understand that changes to this notice can be made at any time, and that it is the patient's responsibility to remain current on those changes. A copy of the current Notice of Privacy Practices will be available for inspection at the reception desk at all times, and copies of current notice can be obtained at no charge, upon request.

I confirm that the information provided above is truthful and accurate, and any discrepancy may result in further clarification.

PATIENT'S SIGNATURE: **TODAY'S DATE:**

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Contract of Agreement / For Payment of Services Rendered
(Please Initial the areas that apply to you)

Name of Patient:______________________________ Date of Birth:____________

Parent/Guardian:______________________________ Relationship:____________

(If Applicable)

I, ________________________, understand that I am responsible for all services performed, for the above named patient or myself, at BigAppleSkin Dermatology.

____- **I have Insurance coverage**: I will provide complete and correct information to BigAppleSkin Dermatology to assist in ensuring that my insurance pays for all services rendered. I agree to pay all amounts deemed my responsibility by my insurance company, including, but not limited to; copays, co-insurances and/or deductibles. If any conflicts arise regarding payment on services, I agree to contact my insurance company to resolve the conflict upon notification.

ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL INFORMATION
I, the undersigned, have insurance coverage as stated above and directly assign all medical benefits to BigAppleSkin Dermatology for services rendered by the physicians or other medical providers under their supervision. I also understand that I am financially responsible for all charges. I hereby authorize BigAppleSkin Dermatology to release all information necessary to obtain payment of insurance benefits. I authorize the use of this signature on all insurance claims submitted on my behalf.

____ - **I have no insurance**: I am presenting for services without any insurance coverage and I understand that payment for services is due upon completion of my visit today unless prior arrangements have been agreed upon by BigAppleSkin Dermatology Management and myself in writing.

____**Third party billing**: I am presenting for services that are to be paid by someone other than myself or an insurance company. I understand that BigAppleSkin Dermatology does not bill Third Parties without written consent and a verbal confirmation. I understand that I am responsible for all services rendered at BigAppleSkin Dermatology and if any conflict arises regarding payment, I agree to contact the payer to resolve the conflict upon notification. I understand that I am ultimately responsible for the payment of all services.

Cancellations: I understand that I am expected to give two (2) business days notice if I cannot keep this appointment either by phone or by email (Tuesday appointments must be cancelled by the preceding Friday morning), otherwise I may be charged a cancellation fee of $75.

Consent for Care: I consent for care and treatment as required by the physician. I consent to routine dermatological procedures such as skin biopsy, treatment with liquid nitrogen or the removal of minor skin lesions. These procedures will be explained in detail before treatment.

Returned Checks: I understand that there is a charge of $35.00 for all returned checks.

______________________________ ____________ ______________________
Signature of Patient / Parent or Guardian Date Witness

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. .

3. .

2. .

4. .

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

Fold