Date____________________

Patient Name_________________________________ Age __________ Date of Birth ____/____/____

Social Security #:_________________ Place of Birth (city, state, country) ____________________________

Sex: MALE FEMALE

Marital Status: Married Single Divorced Widowed Separated Other_______________________

Language: English Other________________________ Race: ____________________________

Contact Information

Emergency Contact Name:____________________________ Emergency Contact Phone #:____________

Spouse's Name: _____________________________ Spouse's Phone #:____________________

Caretaker's Name: _________________________________ Caretaker's Phone #:__________________

Patient's Phone Numbers

Home: _____________________ Work: _____________________ Mobile: _____________________

Email: ____

Please circle your preferred contact #: Home Work Mobile

Is it ok to leave a detailed message: Yes No

Home/Mailing Address (Street, City, State, Zip Code)

____

Seasonal Address (Street, City, State, Zip Code)

____

Employer Information

Employer Name____

Occupation____ Industry_______________________________

Preferred Pharmacy (Please be aware that this will be the pharmacy we e-scribe your prescriptions to)

Name:________________________ City, State, Zip Code:____

Phone:____ Fax:__________________________________

Primary Care Physician (Full Name, Phone Number, City)

____

Referring Physician (Full Name, Phone Number, City)

____

Patient Name_______________________________ Date of Birth ____/____/____

HIPAA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose health information about you. The Notice contains a Patient Rights Section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke the Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability of Accountability Act of 1996 (HIPAA).

The patient understands that: Protected Health Information may be disclosed or used for treatment, payment, or health care operations. The Practice has a Notice of Privacy and that the patient has the opportunity to review this Notice. The Practice reserves the right to restrict the uses of their information but the Practice does not have to agree to those restrictions. The patient may revoke this Consent in writing at any time and all future disclosures will then cease. The Practice may condition receipt of treatment upon execution of this Consent.

This consent was signed by: ____

Printed name – Patient or representative

____ Date______________

Patient Signature

____

Relationship to Patient if other than patient

Insurance Authorization and Assignment

I hereby authorize Kenneth T. Kircher, D.O., Advanced Dermatology, PLLC, to release medical information concerning my condition & treatment to my insurance carrier and/or the Health Care Financing Administration. I hereby request that payment of authorized insurance and/or Medicare benefits be made on my behalf to the above Physician for services rendered by them. I understand that I am responsible for any amount not covered.

____ Date______________

Patient Signature

Lifetime Beneficiary Claim Authorization (MEDICARE PATIENTS ONLY)

PATIENT NAME_________________________________ MEDICARE #_______________________

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Kenneth T. Kircher,D.O., for any services furnished me by Kenneth T. Kircher, D.O. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If item 9 of the CMS 1500 claim form is completed, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

____ Date______________

Patient Signature

Patient Name________________________________ Age __________ Date of Birth ____/____/____

Please state nature, location, and duration of your skin problem:

____

____

Previous treatments:

____

____

Are you **currently** having problems with any of the following: (please circle any that apply):

problems with bleeding	night sweats	muscle weakness
problems with healing	unintentional weight loss	neck stiffness
problems with scarring	thyroid problems	headaches
(hypertrophic or keloid)	sore throat	seizures
rash	blurry vision	cough
immunosuppression	abdominal pain	shortness of breath
hay fever	bloody stool	wheezing
chest pain	bloody urine	anxiety
fevers or chills	joint aches	depression

Past Medical History: (Please circle any that apply)

None	Coronary Artery Disease	Hypothyroidism
Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Artificial joints	End Stage Renal Disease	Lymphoma
Year:____________	GERD (Acid reflux)	Pacemaker
Asthma	Hearing Loss	Prostate Cancer
Atrial fibrillation	Hepatitis (Please circle one):	Radiation Treatment
BPH (Benign Prostatic	A B C	Seizures
Hyperplasia)	High Blood Pressure	Stroke
Breast Cancer	HIV/AIDS	Valve Replacement – Heart
Colon Cancer	High Cholesterol	Year:____________
COPD (Emphysema)	Hyperthyroidism	

Other:

____________________________________ ____________________________________

____________________________________ ____________________________________

Past Surgical History: (Please circle any that apply)

None

Appendix Removed

Bladder Surgery, Type:__________________

Mastectomy: Right Left Bilateral

Lumpectomy: Right Left Bilateral

Breast Biopsy: Right Left Bilateral

Colon Surgery

Gallbladder Removed

Heart: Coronary Artery Bypass

Heart Valve: Mechanical Biological

Knee Replacement: Right Left Bilateral

Hip Replacement: Right Left Bilateral

Ovaries Removed

Prostate Biopsy/TURP

Hysterectomy

Other Joint Replacements within the last 2 years:____

Dates Replaced:____

Other Surgeries:

____________________________________ ____________________________________

____________________________________ ____________________________________

Patient Initial_________

Skin Disease History: (Please circle any that apply)

NONE	Dry Skin	Melanoma
Acne	Eczema	Poison Ivy
Actinic Keratosis	Flaking or Itchy Scalp	Precancerous Moles
Asthma	Hay Fever/Allergies	Psoriasis
Basal Cell Skin Cancer	Keloid	Squamous Cell Skin Cancer

Other ____

____

Have you had any severe or blistering sunburns? Yes No If yes, how many? __________
Do you wear Sunscreen? Yes No If yes, what SPF:__________
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes, please list relative(s) **and** around what **age** they were diagnosed:__________

____

Please list your **Present Medications** **(Including Non-prescription, Vitamins/Supplements, etc.)**
Please write dosage and frequency:

______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________

Please list **what medication(s) you are allergic to**, if any, and **name the reaction(s)** you have:

____

____

Social History: (Please circle one)

Cigarette Smoking: Never smoked Former smoker Smokes less than daily Smokes daily

Alcohol Use: Yes No If yes, number of drinks daily__________

If **FEMALE**:
Are you pregnant: Yes No
Are you nursing now: Yes No
Do you plan to become pregnant within the next year: Yes No

Family History: Please circle any that apply and **specify which relative(s) is affected**

Skin Cancer __________ Type:__________	Diabetes__________
Psoriasis__________	Eczema__________
Tuberculosis__________	Asthma__________
Lupus__________	Seasonal Allergies__________
Heart Disease__________ Type:__________	Cystic Acne__________
High Blood Pressure__________	Keloids__________

Other____

____

Patient Initial__________

Patient Insurance Information
Please bring your insurance cards to your appointment **at every visit** so copies and updates to this information can be made as needed. **You must have a referral*, if required, for your visit or you will be asked to reschedule your appointment.**

PRIMARY Insurance Information:
NAME OF INSURANCE CARRIER: ______________________________

Please **print your name exactly** as it appears on your insurance card (even if incorrectly spelled on your card)

FIRST:______________________ M.I.:______ LAST:______________________

DATE OF BIRTH:______________________

IDENTIFICATION #:______________________ GROUP #:______________________

If you are not the policyholder, please **print the name of the policyholder**

FIRST:______________________ M.I.:______ LAST:______________________

RELATIONSHIP TO PATIENT:______________ POLICY HOLDER DATE OF BIRTH:______________

NAME OF POLICY HOLDER'S EMPLOYER (COMPANY NAME):______________________

SECONDARY Insurance Information:
NAME OF INSURANCE CARRIER: ______________________________

Please **print your name exactly** as it appears on your insurance card (even if incorrectly spelled on your card)

FIRST:______________________ M.I.:______ LAST:______________________

DATE OF BIRTH:______________________

IDENTIFICATION #:______________________ GROUP #:______________________

If you are not the policyholder, please **print the name of the policyholder**

FIRST:______________________ M.I.:______ LAST:______________________

RELATIONSHIP TO PATIENT:______________ POLICY HOLDER DATE OF BIRTH:______________

NAME OF POLICY HOLDER'S EMPLOYER (COMPANY NAME):______________________

*** If your policy requires a referral (most HMOs require them), please complete the information below:**
PRIMARY CARE PHYSICIAN: ______________________
REFERRAL NUMBER:______________________
OF VISITS AUTHORIZED:__________
SPECIALTY OFFICE COPAY $____________
IN-OFFICE PROCEDURE COPAY $____________

TELEPHONE CONSENT

Patient Name________________________________ Date______________

- I GIVE CONSENT FOR ANY LAB/PATHOLOGY RESULTS TO BE CALLED TO THE FOLLOWING, **AND A MESSAGE CAN BE LEFT ON**:

(PLEASE WRITE IN THE TELEPHONE NUMBER)

HOME PHONE: # __________________YES □ NO

CELL PHONE: # __________________YES □ NO

WORK PHONE: # __________________YES □ NO

- PERMISSION IS GIVEN TO RELEASE INFORMATION TO:

NAME____

RELATIONSHIP___________________________

PATIENT'S SIGNATURE:____

PARENT/GUARDIAN SIGNATURE:____

OFFICE FINANCIAL POLICY

Patient Name ______________________________ Date of Birth ______________________________

We would like to share the following policies with you so that you can understand your responsibility regarding the charges for the services rendered to you by this office:

We are Medicare participating providers. We will bill Medicare. You will be responsible at the time of service for payment of the annual deductible, copayments, and charges for services that are not covered or cosmetic. You may be asked to sign an Advanced Notice of Liability form in the event that a service, cosmetic or otherwise, is provided which we know is not a covered service by Medicare. If you have a secondary insurance which is part of the Medicare Medigap, Medicare is responsible for submission of your claim. If payment from your Medigap is not received within 30 days of Medicare payment, you will be billed and will be responsible for payment of that balance. Since we do not participate with all secondary insurance carriers, it may be necessary for you to submit your Medicare Explanation of Benefits to your secondary insurance.

We currently participate in a full spectrum of insurances including: Emblem Health, GHI, MVP Healthcare, CDPHP, National Health Administrators, Blue Cross Blue shield, NYSHIP, and United Health Care. See our webpage drkircher.com for a complete listing. We will bill the carrier for all charges that are covered, medically necessary services. You will be responsible at the time of service for any deductibles, copayments, or charges that are non-covered or cosmetic services. If you have a secondary insurance which we participate with, we will file your secondary insurance claim for you. Please note that copayments and deductibles are determined by your insurance carrier. We may not know at the time of service exactly what your responsibility will be and will balance bill upon receipt of your explanation of benefits. Any question regarding that balance or the policy by which it is determined should be directed to your carrier since we may not be able to provide that information to you accurately.

If you have an insurance which requires prior authorization for your visit, it is your responsibility to obtain that referral prior to your visit. Any amount denied by your insurance for lack of appropriate authorization will be billed to you directly and will be your responsibility to pay.

For non-Medicare patients and patients with an insurance carrier with which we do not have a contractual relationship, payment is expected at the time of visit. Please understand that since we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits.

Cosmetic services will not be billed to any insurance carrier for any reason. Payment is expected in advance or at the time of service at the discretion of our office.

I FULLY UNDERSTAND THAT AT THE TIME OF MY VISIT IF MY INSURANCE IS NOT ACTIVE OR IS AN INSURANCE THAT YOUR OFFICE DOES NOT PARTICIPATE WITH, I AM 100% RESPONSIBLE FOR PAYMENT IN FULL AT THE TIME OF THE VISIT.

IF MY INSURANCE HAS CHANGED SINCE MY LAST VISIT IT IS MY RESPONSIBILITY TO HAVE VERIFIED WITH MY INSURANCE COMPANY THAT YOUR OFFICE IS PARTICIPATING PROVIDER

______________________________ ______________________________

Patient Signature Date

CANCELLATION PROTOCOL

If you do not show up for your reserved appointment time it leaves us with an opening in our schedule AND it also prevents us from scheduling patients that are in need of immediate treatment. In an effort to prevent this from happening we need your help.

IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT OR NEED TO MAKE A CHANGE WE REQUIRE A 24 HOUR NOTICE. This will allow another patient who is in need of treatment to be called in.

FOR THOSE PATIENTS WHO FAIL TO PROVIDE A 24 HOUR NOTICE, THE FOLLOWING WILL PERTAIN:
MISSED APPOINTMENT: A broken appointment fee of **$25.00** will be charged to your account for a regular visit and **$100.00** for a surgery/cosmetic visit and **$50.00** for a new patient visit.

Inclement Weather Policy

If the **KINGSTON CITY SCHOOLS** are **CLOSED** due to inclement weather **OUR OFFICE WILL BE CLOSED** for that day. If there is any kind of delay due to the weather our office will be open, but please call before coming in for your appointment.

______________________________ ______________________________

Patient Signature Date

Updated 7/15/15