Vive Dermatology

1250 Ocean Parkway
Suite LN
Brooklyn, NY 11230

(718) 500-3505
vivedermatology.com

PATIENT DEMOGRAPHICS:

Patient Name_____ Date of Birth_____

Address_____Apt._____

City_____State_____ Zip_____

Mobile phone ( )_____ Home phone ( )_____

Email_____ Consent to electronic communication? Yes □ No □

Sex: □ Female □ Male Age_____ Race/Ethnicity_____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Partnered x ____ years

Emergency Contact:_____Relationship_____Phone ( )_____

Preferred Pharmacy _____ Phone ( )_____

Primary Physician_____Phone ( )_____

Occupation_____ Employer_____

Primary Insurance_____ID Number_____Group Number_____

Secondary Insurance_____ID Number_____Group Number_____

How did you hear about us? □ Dr_____ referred me □ Google □ Friend □ Other_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND RECORDS:

Below, please list the name(s) and relationship of any person other than yourself that you authorize Vive Dermatology to release your medical information to.

I authorize the following third parties (i.e. spouse, parent, partner) to view or receive information regarding my care and record(s):

Name: _____ Relationship _____

Patient Signature_____ Date_____

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MEDICAL HISTORY:

Patient Name_____ Date of Birth_____

Reason for Visit #1 _____ Location_____

Duration_____Treatment_____

Reason for Visit #2 _____ Location_____

Duration_____Treatment_____

Medications You Are Currently Taking_____

Medication Allergies_____ Reaction_____

Surgical History _____ Date_____

History of Skin Cancer? □ Yes □ No Type? □ Basal Cell □ Squamous Cell □ Melanoma □ _____

Location_____ Year _____ Treatment_____

Family History of Skin Cancer? □ Yes □ No Type _____

Do you currently have or have you ever had any of the following? (check all that apply):

Anemia	___	Allergies	___	Herpes	___	Keloids/scars	___
Arthritis	___	Cancer	___	Heart Murmur	___	Kidney issues	___
Autoimmunity	___	Chemotherapy	___	Hepatitis	___	Radiation	___
Artificial Joints	___	↑ Cholesterol	___	HIV/AIDS	___	Thyroid Issues	___
Artificial Valves	___	Depression	___	Hypertension	___		
Asthma/COPD	___	Diabetes	___	IBD	___		

Aspirin Consumption	□ Daily	□ Occasionally	□ Never
Ibuprofen Consumption	□ Daily	□ Occasionally	□ Never
Alcohol Consumption	□ Daily	□ Occasionally	□ Never
Tobacco/Smoking	□ Daily	□ Occasionally	□ Never

WOMEN ONLY

Are you Pregnant?	□ Yes	□ No
Are you Nursing?	□ Yes	□ No
Taking Birth Control?	□ Yes	□ No
Hormone Replacement?	□ Yes	□ No

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HIPAA PRIVACY PRACTICES NOTIFICATION:

I, the undersigned, have been issued the HIPAA Notice of Privacy Practices and this office's "Patient Rights and Responsibilities". I fully understand that Vive Dermatology is required by law to maintain the privacy of my medical and health information. I acknowledge that the Practice will use and disclose any health information for the purposes of treating me, obtaining payment for services referred to me and conducting health care operations.

Patient Signature_____ Date_____

REFERRALS:

I realize that my particular insurance plan might require a referral for me to be seen by any of the providers employed by Vive Dermatology. If at any time I fail to obtain a referral for a particular visit, I will be responsible for obtaining a valid referral from my primary care physician (PCP). If a valid referral is not possible, I will be solely responsible for all charges. It is my responsibility to know whether or not my medical insurance carrier offers out-of-network benefits for non-participating physicians and to be aware of any deductibles, copays and co-insurances. I acknowledge and agree that I am fully responsible for any and all co-payment, co-insurance, deductible and/or other claim amount that my insurance company terms "patient responsibility".

Patient Signature_____ Date_____

ASSIGNMENT AND RELEASE:

I certify that I (and/or my dependent(s)) have insurance coverage with the above-named insurance company(ies) and assign directly to Vive Dermatology (and its associated providers) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Vive Dermatology and associated providers may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Insured/Guardian_____ Date _____

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OFFICE FINANCIAL POLICIES

CANCELLATION POLICY:

We understand that sometimes it is necessary to re-schedule an appointment. We ask at least 24 hours notice prior to cancelling and we will gladly reschedule. Monday appointments should be cancelled by noon the previous Friday. Please be sure to speak to our receptionist. Leaving a phone message, sending an email or text will not be considered a cancellation. If you arrive after your appointment was scheduled to begin, you will be seen but only for the amount of time remaining. If you are 15 minutes late, this will be considered a missed appointment. In the event that you are unable to give 24 hours' notice, a cancellation fee of $50.00 for medical appointments, or $150.00 for cosmetic or surgical procedures will be billed to your account. We regret any inconvenience this may cause. Pre-paid packages are not refundable.

Patient Signature_____ Date_____

CREDIT CARD ON FILE:

Vive Dermatology requires all patients to leave a valid credit card on file. By providing your credit card information below, you authorize payment for uncovered service and/or those that are determined to be your responsibility by your health plan. If you choose not to provide your credit card authorization, your account will be subject to a $25.00 statement fee per month for any outstanding balance over 30 days. Our practice has implemented stringent security measures to protect your credit card information and will make every attempt to contact you prior to charging your account.

Credit Card# (MC, VISA, DISCOVER): _____-_____-_____-_____Exp:_____Security Code:_____

Patient Signature_____ Date_____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT:

I have reviewed and agree to abide by the Physician-Patient Arbitration Agreement.

Patient Signature_____ Date_____