Urban Dermatology

Elizabeth I. Goldberg, M.D., FAAD

PATIENT DETAILS

First Name:

Middle Name:

Last Name:

Street Address:

Apt/Unit#:

City:

State:

Zip Code:

Home Telephone:

Mobile Telephone:

Work Telephone:

Date of Birth:

Age:

Occupation:

Email Address:

REFERRAL INFORMATION

Referred By Internet:

Referred By Friend:

Referred By Physician:

Referred By Other:

PHARMACY INFORMATION

Pharmacy Name:

Pharmacy Telephone

Pharmacy Zip Code:

PLEASE PROVIDE

Reason for your visit:

WHAT ARE YOUR AREAS OF CONCERN? (OPTIONAL)

- ☐ Frown lines between the brows
- ☐ Significant lines around nose & mouth
- ☐ Facial Veins/Redness
- ☐ Facial Hair
- ☐ Acne
- ☐ Sun Damage
- ☐ Fine Lines and Wrinkles
- ☐ Rough Skin Texture
- ☐ Sagging Skin
- ☐ Brown Spots
- ☐ Hyperpigmentation
- ☐ Dark Circles Under The Eyes
- ☐ Other | Please specify:

PATIENT/FAMILY HEALTH HISTORY

Are you under the care of a physician? For what:

	Me	Family
Heart Disease?	☐	☐
High/Low Blood Pressure?	☐	☐
Shortness of breath/Fainting?	☐	☐
Palpitations/irregular heartbeat?	☐	☐
Mitral Valve prolapse/heart disease?	☐	☐
Hepatitis/liver disease?	☐	☐
Asthma/TB/cough/pulmonary disease?	☐	☐
Kidney Failure or problem?	☐	☐
Migraines/headaches/chronic pain?	☐	☐
Lupus arthritis/autoimmune disease?	☐	☐
Psychological/emotional disorder?	☐	☐
Phlebitis/varicose veins/blood clots?	☐	☐
Stroke/seizure/neurological disorder?	☐	☐
Herpes/fever blister/shingles?	☐	☐
Anemia/blood disorder?	☐	☐
Excessive or abnormal bleeding?	☐	☐

	Me	Family
Blood transfusion?	☐	☐
Hives/rashes?	☐	☐
Skin Cancer?	☐	☐
Alcohol or drug abuse?	☐	☐
Diabetes?	☐	☐
Thyroid disease?	☐	☐
X-ray/radiation treatment?	☐	☐
Bad reaction to anesthesia?	☐	☐
Poor scar formation/healing?	☐	☐
Stomach Ulcers?	☐	☐
Anaphylaxis?	☐	☐
Recent weight gain or loss?	☐	☐
Do you have a pacemaker?	☐	☐
Venereal Disease?	☐	☐
HIV/AIDS?	☐	☐
Other?	☐	☐

PATIENT SURGICAL HISTORY

Have you had any past surgeries? Please list:

PATIENT SOCIAL HISTORY

Do you use alcohol? If so, how often?

Do you smoke? If so, Packs per day? For how long have you smoked?

PATIENT MEDICATIONS

Do you take any medications? Please list:

Have you taken any of the following in the last six months?

	YES	NO
Accutane	☐	☐
Prednisone	☐	☐
Birth-control pills	☐	☐
Anti-coagulants or blood thinners?	☐	☐
Aspirin	☐	☐

	YES	NO
Vitamin E	☐	☐
Ibuprofen	☐	☐
Anti-inflammatories	☐	☐
Herbs/Supplements	☐	☐

Are you allergic to any medications?

Have you had any adverse reactions to:

	YES	NO
Lidocaine/Novocaine/Anesthetic	☐	☐
Iodine/Betadine/Chlorhexidine/Other skin wash?	☐	☐
Adhesive Tape	☐	☐
Latex Rubber	☐	☐

Pregnancy

	YES	NO
Are you pregnant?	☐	☐
Are you breast feeding?	☐	☐
Are you currently using birth control?	☐	☐

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

URBAN DERMATOLOGY, PLLC. Elizabeth Goldberg, MD

With my consent, Urban Dermatology, P.C., may use and disclose protected health information (Pill) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Urban Dermatology's Notice of Privacy Practices for a more complete description uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Urban Dermatology reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice may be obtained by forwarding a written request to Urban Dermatology, PLLC's privacy officer at 594
Broadway Suite 505, New York, New York 10012.

With my consent, Urban Dermatology, PLLC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder cards, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Urban Dermatology, PLLC may mail (or e-mail) to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal & Confidential.

I understand that I have the right to restrict how it uses or discloses my Pill to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Urban Dermatology's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Urban Dermatology, PLLC may decline to provide treatment to me.

Patient Signature
(or legal guardian):

Patient Name:

Dated:

OPTIONAL:

I give my consent to discuss my personal medical information with the following person(s):

Name:

MEDICATION REFILL / PRESCIPTION AUTH POLICY

URBAN DERMATOLOGY, PLLC. Elizabeth Goldberg, MD

For your safety, we have established policies regarding medications refills. Please review them carefully.

• Please plan ahead and request your refill before your prescription has run out or expired. Our medication refills and prescription authorization policy allows up to three days (72 hours) to process a request.

• Medications will not be refilled after hours. Message left after 4:30pm daily will be sent to the appropriate doctor on the next business day. Refills will not be granted on weekends.

• When leaving a message, please leave your full name, date of birth, phone number, and the name and phone number of your pharmacy. Please also leave the name and dosage (strength) of the medication.

• Someone from our office will call you the same business day to review the Information before sending your request to the doctor. If you have not received a call after one business day, you may call again. You will then receive a call from someone in our office with the outcome of your request.

• if you have not been seen during the last six months, please call the office to schedule an appointment. Again, this is for your safety. Your medication(s) condition can change significantly in that period of time and we need to have the most up to date information. Refills will not be granted if you have not been seen during this time.

• If you feel that your circumstances or symptoms are an emergency, we encourage you to go to your nearest emergency room.

• Urban Dermatology is enrolled in EMed history, which grants access to all medication history.

Thank You for your cooperation and understanding.

Patient Signature:	Patient Name:	Dated:

URBAN DERMATOLOGY PLLC | FINANCIAL POLICY AGREEMENT

Over the past decade the number of different health care programs has increased at an amazing rate. Within one insurance company there may be several programs with varying benefits and requirements. It is the patient's responsibility to know and keep up with their program and provisions.

Please understand your insurance plan's regulations and protocol because unless you follow them carefully your insurance company may decline all or part of your claim. Your insurance carriers should have provided you with a telephone number to call if you have any questions or concerns about your coverage.

Insurance
We will bill your insurance plan as may be necessary. If we do not participate with your managed care plan, payment in full is required at the time of service. Knowing your insurance benefits-including eligibility, covered benefits, and medically necessary procedures is your responsibility. **You are responsible for any charges not covered by your plan.**

Proof of Insurance
All patients must complete and/or update our patient information form at each office visit. You must furnish valid and up-to-date proof of insurance coverage. If you provide false or expired insurance information you will be responsible for the balance of the claim. Please notify us of any changes in insurance coverage prior to time of service. Insurance denials for termination of coverage will be automatically billed to you.

Co-payments and deductibles
All co-payment and unsatisfied deductibles must be paid at the time of service. By contractual law your insurance company requires us to charge for, and you to pay for, all required co-payments, co-insurance, deductible and covered services.

Claim submission
We will submit your insurance claims and assist you in any way reasonable to help get your claim paid. Your insurance company may need you to supply information directly to them. It is your responsibility to comply with their request in a timely manner.

Billing
Bills will be sent by email and /or post. It is your responsibility to give us up to date email and mailing addresses. Please check your spam folder as it is still your responsibility should the email go to spam.

Referrals
If your managed care plan requires approval or authorization for referrals to specialist it is your responsibility to inform the office of this requirement prior to the visit. We require 72 hours' notice to facilitate a referral request and cannot issue retroactive referrals.

Missed appointments
Broken appointments represent not only a cost to us, but also an inability to provide services to others who could have been seen in the time set aside for you. We require 24-hour (business day) notice of cancellation to avoid a **$75.00 cancellation fee for medical appointments and $150 fee for cosmetic appointments**. It is your responsibility to remember your appointment. Please be aware the cancellation fee also applies to ZocDoc appointments.

Cosmetic Consultations
Cosmetic consultations are not covered by insurance. The cost is $350.00. It is your responsibility to pay this fee, along with any other charges that may occur at the time of the visit.

Patient Signature: Printed Name: Dated: