Cayuga Dermatology, PLLC

NEW PATIENT FORM

PATIENT INFORMATION

Full Name: _____
First *Middle* *Last*

Street Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ Occupation: _____

Sex: _____ Pronouns: _____ Nickname:_____

Primary Care Provider:_____ Referring Provider (if applicable):_____

How did you hear about us? _____

PARENT/GUARDIAN INFORMATION (Complete if patient is under 18 years of age)

Parent/Guardian Name: _____ DOB: _____

Phone: _____ Address: _____

Parent/Guardian Name: _____ DOB: _____

Phone: _____ Address: _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Phone Number: _____

PHARMACY INFORMATION

May we have permission to automatically import a medication list from your pharmacy? Yes_____ No_____

Preferred Local Pharmacy:_____ Preferred Mail Order Pharmacy (optional): _____

INSURANCE INFORMATION *(You do not need to fill out this information if you have your insurance card with you)*

Primary Insurance: _____ Subscriber Name: _____ DOB: _____

Group Number: _____ Subscriber Number: _____

Secondary Insurance: _____ Subscriber Name: _____ DOB: _____

Group Number: _____ Subscriber Number: _____

Cayuga Dermatology, PLLC

HEALTH AND MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Alerts: *(Check all that apply)*

- ☐ Are you pregnant or currently trying to become pregnant?
- ☐ Allergy to adhesive
- ☐ Allergy to Epinephrine
- ☐ Allergy to Lidocaine
- ☐ Allergy to rubber or latex
- ☐ Allergy to topical antibiotics
- ☐ Currently have a pacemaker
- ☐ Currently have a defibrillator
- ☐ History of artificial heart valve
- ☐ History of artificial joint placement
- ☐ History of MRSA
- ☐ Require antibiotic prophylaxis prior to surgery or dental procedures
- ☐ Taking blood thinners

Past and Present Health Conditions: *(Check all that apply)*

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer (if yes, what type)

  _____
- ☐ COPD/Emphysema
- ☐ Coronary Artery (Heart) Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End-stage Renal Disease
- ☐ Hepatitis B or C
- ☐ High Blood Pressure
- ☐ History of trauma
- ☐ HIV/AIDS
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ **NONE**

Any other conditions: _____

Past Surgical History: *(Check all that apply)*

- ☐ Breast Surgery (If so, what type)

  _____
- ☐ Colectomy
- ☐ Coronary Artery Bypass
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Kidney Removed/Nephrectomy
- ☐ Ovaries Removed
- ☐ Hysterectomy
- ☐ Prostate surgery
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ Transplant (If yes, what type & date)

  _____
- ☐ **NONE**

Any other surgeries: _____

Cayuga Dermatology, PLLC

HEALTH AND MEDICAL INFORMATION (CONTINUED)

Patient Name: _____ Date of Birth: _____

Skin Disease History: *(Check all that apply)*

- ☐ Actinic Keratoses
- ☐ Atypical (Dysplastic) Moles
- ☐ Cutaneous T Cell Lymphoma
- ☐ Basal Cell Carcinoma
- ☐ Squamous Cell Carcinoma
- ☐ Melanoma
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Blistering Sunburns
- ☐ **NONE**

Any other skin conditions: _____

Do you have a family history of melanoma? Yes ____No____

If yes, which relative(s)? _____

Adopted, unsure of family history? Yes ____No____

Do you use sunscreen? Yes ____No ____

Please list all prescription and non-prescription medications you are currently taking:

_____

_____

_____

_____

Do you have any medication allergies? Yes ____No____

If yes, please list allergy and type of reaction:

_____

_____

Do you currently smoke? Yes _____ No_____ If yes, how much? _____

Are you a former smoker? Yes _____ No_____ Quit date? _____

Do you drink alcohol? Yes _____No_____ If yes, how much? _____

RESPONSIBLE PARTY ACKNOWLEDGEMENT

Patient Name: _____ Date of Birth: _____

RESPONSIBLE PARTY

The Responsible Party is the person who is financially responsible for the patient's account and who will receive all account statements to their address. If you are age 18 or older, you are your own responsible party.

Name of Responsible Party (PLEASE PRINT) Relation to Patient (If Other Than Self)

WAIVER OF LIABILITY

_____ I understand that the treatment/service from the physician at Cayuga Dermatology for the patient listed above may not be a covered treatment/service or may not be covered at 100%. I agree to be personally and fully responsible for any balance due.

Responsible Party Initials

PAYMENT POLICY

_____ Cayuga Dermatology is committed to providing the best treatment for our patients. Our pricing structures are representative of the usual and customary charges for our area. Thank you for adhering to our payment policy. Signing below indicates that you are the responsible party, which means you are financially responsible for this patient and have read and understand the payment policy and agree to abide by its guidelines.

Responsible Party Initials

- Payments are required at the time of service, including co-pays, coinsurance, and any other unpaid balances.
- We participate with several insurance plans; however, each insurance plan has different benefits and policies. You are responsible, as the insured party, to verify your benefits and coverage with your insurance company prior to your appointment. Our policy is to file your medical visits with your insurance company, but as the insured party, you are responsible for any unpaid balance, which may include co-pays, coinsurance, deposits, and/or deductibles.
- Pathology services are independent from those of our practice. You (or your insurance company) will be charged an entirely separate fee from the dermatopathologist.

RESPONSIBLE PARTY ACKNOWLEDGEMENT

I understand that I am the responsible party for the patient listed above and I agree to the terms of the Waiver of Liability and Payment Policy.

Signature of Responsible Party Date

Cayuga Dermatology, PLLC

PATIENT PRIVACY FORM

Patient Name: _____ Date of Birth: _____

SHARING INFORMATION

Please list family members or friends who have your permission to receive information from Cayuga Dermatology:

Name of Person	Phone Number	Relationship to Patient
_____		_____
_____		_____

Please list any medical providers who you would like to receive a copy of our office notes:

- ☐ Primary Care Provider
- ☐ Referring Provider: _____
- ☐ Do not send notes

COMMUNICATION

I authorize Cayuga Dermatology to leave a message regarding: Check ONLY ONE

- ☐ All information including appointments, general information, updates, billing, etc.
- ☐ Appointment information ONLY

On my voicemail on the: Check ALL that apply

- ☐ Cell Phone Number
- ☐ Home Phone Number

RIGHTS OF THE PATIENT

I understand that I have the right to revoke this authorization at any time by sending notification to Cayuga Dermatology, PLLC (821 Cliff Street, Suite 2; Ithaca, NY 14850). I understand that a revocation is not effective in cases where the information has already been used or disclosed, but will be effective going forward. I understand that information used or disclosed as a result of this authorization may result in re-disclosure by the recipient and may no longer be protected by federal or state law. Information received by this office is for our own use and will continue to be protected by our Privacy Policy. I understand that I have the right to inspect or copy the protected health information disclosed as described in this document. I can do this by sending written notification to: Cayuga Dermatology, PLLC (821 Cliff Street; Suite 2, Ithaca, NY 14850). I understand that I have the right to refuse to sign this authorization.

I have read and received a copy of the Notice of Privacy Practices for Cayuga Dermatology, PLLC.

Signature	Date	Relationship (if not patient)
_____	_____	_____

Cayuga Dermatology, PLLC

Cayuga Area Plan, Inc.
Cayuga Area Preferred, Inc.
New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name:_____Date of Birth:_____

Other names used (e.g., maiden name)_____

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow Cayuga Area Plan, Inc ("CAP") and the physicians, physician practices, and hospitals participating in CAP (see http://www.CAPNY.com for full list) to obtain access to my medical records through the health information exchange organization called HealtheConnections, and any viewer or portal displaying data supplied by HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealtheConnections website at http://healtheconnections.org/ .

My information may be accessed in the event of an emergency, unless I complete this form and check box #3, which states that I deny consent *even* in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

□ **1. I GIVE CONSENT for Cayuga Area Plan, Inc ("CAP") and the physicians, physician practices, and hospitals participating in the Cayuga Area Physicians Alliance, Inc. to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).**

□ **2. I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY for Cayuga Area Plan, Inc ("CAP") and the physicians, physician practices, and hospitals participating in the Cayuga Area Physicians Alliance, Inc. to access my electronic health information through HealtheConnections.**

□ **3. I DENY CONSENT for Cayuga Area Plan, Inc ("CAP") and the physicians, physician practices, and hospitals participating in the Cayuga Area Physicians Alliance, Inc. to access my electronic health information through HealtheConnections for any purpose,** *even in a medical emergency.*

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)