DERMATOLOGY
ASSOCIATES OF ITHACA
Healthier Skin Since 1983

PATIENT PAPERWORK

Ithaca Office: 1051 Craft Road, Ithaca, NY
Cortland Office: 3773 Luker Road, Cortland, NY
T: 607-257-1107 | F: 607-257-0369
office@ithacaderm.com

Patient Name _____
First Middle Last

Address _____
Street Number Street Name Apt #

_____
City State Zip Code

Date of Birth _____
Cell Phone # _____
Home Phone _____
Email address _____ (Your email will be used to set up your online patient portal)

INSURANCE INFORMATION

Primary Insurance
Insurance Company _____
Insurance Phone # _____
Insurance ID # _____

Secondary Insurance
Insurance Company _____
Insurance Phone # _____
Insurance ID # _____

DO YOU HAVE SEPARATE PRESCRIPTION DRUG COVERAGE? ☐ YES ☐ NO

If yes, please complete the following:

Insurance Company _____
Insurance Phone # _____
Insurance ID # _____
Insurance Bin # _____
Insurance PCN # _____
Insurance Group # _____

Gender
☐ Male ☐ Female ☐ Transgender (Please circle: M to F/ F to M)
☐ Non-Binary ☐ Prefer not to answer ☐ Other:

Marital Status
☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced

PATIENT NAME _____

Preferred/Nick Name_____

Preferred pronouns (optional) _____

Reason(s) for today's visit: (include location; duration of problem – i.e. weeks, months, years; symptoms, treatments tried) _____

How did you hear about us? ☐ Family/Friend ☐ Instagram ☐ Google/Internet Search ☐ Facebook ☐ Dr./Provider Recommendation ☐ Other:

PATIENT HISTORY

Medical History: (please list all medical problems you have – i.e. diabetes, high blood pressure, cancer, etc.)

History of Surgeries: (include date, location and type)

History of skin problems: (Cancer, precancer, psoriasis, eczema, acne, other: include date, location and type)

Do you wear sunscreen? ☐ Yes ☐ No If yes, which type/SPF? _____
Have you ever had a blistering sunburn? ☐ Yes ☐ No If yes, how many? _____
Do you use a tanning booth? ☐ Yes ☐ No
Do you have more than 50 moles? ☐ Yes ☐ No

Can we pull Rx history from pharmacy? ☐ Yes ☐ No

Medication	**Dosage**	**Route** (eg. oral, injection)	**Frequency**

*Please attach additional medications if space provided is not enough.

Allergies: (list all medication allergies and reactions, e.g. rash) ☐ I do not have any known allergies

PATIENT NAME _____

SOCIAL HISTORY

Who is your Primary Care Provider (PCP)? _____

When was your last PCP Visit? _____

What is your preferred pharmacy? _____

Tobacco Use Status (cigarettes, e-cigarettes, cigars, pipes, etc.): *Please check the box that best fits.*

- ☐ Never Used Tobacco Products
- ☐ Former Tobacco User
- ☐ Current Everyday Tobacco User _____ pack/day for _____ years
- ☐ Current Some Day Tobacco User _____ pack/day for _____ years

Alcohol Use: *Please check the box that best fits.*

- ☐ Do not drink
- ☐ Less than 1 drink/day
- ☐ 1-2 drinks/day
- ☐ 3 or more drinks/day

Advanced Care Directive: *Please select all that apply* .

- ☐ I want full cardiopulmonary resuscitation measures to be made (Full Code)
- ☐ I do not wish to have a breathing tube, even if it is necessary to save my life (Do not Intubate)
- ☐ If my heart were to stop beating, I do not wish to have chest compressions or defibrillation, even if it is necessary to save my life
- ☐ I have a living will
- ☐ I have a healthcare proxy Name: _____ Phone Number: _____

What is your ethnicity (e.g. Caucasian, Asian, African American)? _____

Hispanic/None Hispanic: _____

Where did you grow up? _____

What is your occupation? _____

If retired, what was your previous occupation? _____

What are your hobbies? _____

FAMILY HISTORY

Please check the following medical conditions that have occurred in your family and list the family members with the condition(s):

Melanoma	☐ Yes ☐ No	Family member(s):	_____
Skin cancer	☐ Yes ☐ No	Family member(s):	_____
Unusual moles	☐ Yes ☐ No	Family member(s):	_____
Severe acne	☐ Yes ☐ No	Family member(s):	_____
Asthma	☐ Yes ☐ No	Family member(s):	_____
Hay fever	☐ Yes ☐ No	Family member(s):	_____
Eczema	☐ Yes ☐ No	Family member(s):	_____
Psoriasis	☐ Yes ☐ No	Family member(s):	_____

PATIENT NAME _____

ALERTS

Do you have:	Pacemaker	☐ Yes	☐ No
	Defibrillator	☐ Yes	☐ No
	An artificial heart valve	☐ Yes	☐ No
	Artificial joints within past two years	☐ Yes	☐ No
Do you require:	Premedication prior to procedures	☐ Yes	☐ No
	Antibiotics prior to surgical/dental procedures?	☐ Yes	☐ No
	If yes, please explain: _____		
Do you have:	Allergy to adhesive	☐ Yes	☐ No
	Allergy to topical antibiotic ointments	☐ Yes	☐ No
Do you take:	Blood thinners	☐ Yes	☐ No
Are you:	Pregnant or planning a pregnancy	☐ Yes	☐ No
	If yes, please explain: _____		
Do you have:	An allergy to lidocaine	☐ Yes	☐ No
	Rapid heartbeat with epinephrine	☐ Yes	☐ No
	Yeast infections with antibiotics	☐ Yes	☐ No
	GI upset with antibiotics	☐ Yes	☐ No
	Problems with bleeding	☐ Yes	☐ No
Do you have a history of:	HIV/AIDS	☐ Yes	☐ No
	Hepatitis B/C	☐ Yes	☐ No
Have you been diagnosed with:	Diabetes (DM)	☐ Yes	☐ No
	Coronary Artery Disease (CAD)	☐ Yes	☐ No
	Heart Failure (HF)	☐ Yes	☐ No
	Chronic Obstructive Pulmonary Disorder (COPD)	☐ Yes	☐ No

Have you been vaccinated against Covid-19? ☐ YES ☐ NO

If yes, please list Covid-19 Vaccine(s) and Date(s):

_____

PATIENT NAME _____

Billing Policies

Welcome to Dermatology Associates of Ithaca. We are dedicated to providing the best possible care and service to you and regard your understanding of our billing policies as an element of your care and treatment. Please let us know if you have any questions or concerns. At every visit, we will ask you to present your up-to-date insurance card, as well as to verify your current address and phone number to ensure that we have your correct information on file.

Referrals and Preauthorization: If your insurance plan requires that you have a referral or preauthorization to see a specialist, we must have that before you will be seen. Referrals are obtained through your primary care physician, and preauthorization are obtained from your insurance company. If your insurance company does not pay your bill due to a referral or preauthorization dispute, you will ultimately be responsible for payment.

Courtesy Billing: As a courtesy to you, we will bill your insurance regardless of our participation status. If we do not participate with your insurance, you are responsible for all charges and will be billed accordingly. Please refer to your insurance company for confirmation of participation status and coverage of benefits.

Co-Pays: Payments are due at the time of service. There is a $25 fee if we have to send your unpaid bill to collections (see Unpaid Personal Balances below).

No-Show/Late Fees: If you are unable to keep your appointment we require at least one business days' notice. Office appointments not cancelled or rescheduled with one business days' notice are subject to a $50 no-show fee, which is not covered by insurance. If you are more than five minutes late to your scheduled appointment time and cannot be seen you may be subject to a $50 fee. No-show fees must be paid before your next visit. Repeated no-shows may prevent you from being able to schedule future appointments until the fees are paid. We understand that extenuating circumstances may prevent you from calling beforehand. If that is the case, please call us as soon as you are able to do so. We are happy to discuss it with you.

Returned Check Fee: You will be subject to a returned check fee of $20 if a check is returned from your bank.

Unpaid Personal Balances: Any unpaid personal balance over 90 days (either self-pay, co-pays, or balances after insurance) is subject to 1.5% per month interest. If you need to make payment arrangements for personal balances, we are happy to consider this; however, the request must be made in writing to our billing department to avoid the interest charge.

Self-Pay Patients: Dermatology Associates of Ithaca offers a 50% prompt pay discount to uninsured patients/guarantors. (For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.) Payment is due at the time of service unless other arrangements are made with our billing department. We will request your written signature validating you have no other medical coverage.

During the course of your visit the provider may perform certain procedures that result in additional charges, such as but not limited to: skin biopsies, skin surgeries, and liquid nitrogen treatment. These charges may be subject to co-pays and/or deductibles by your insurance company. If a biopsy is performed, then you may be subject to a charge from the pathology laboratory. By signing this you agree to all terms and conditions, and are responsible for any and all outstanding balances incurred by these services.

Thank you for choosing Dermatology Associates of Ithaca.

I authorize Dermatology Associates of Ithaca to bill my insurance and to release any information to my insurance that is necessary to settle a claim on my behalf for services rendered while a patient of Dermatology Associates of Ithaca. I also authorize payment to be made directly to Dermatology Associates of Ithaca.

If my insurance denies payment for certain services, I agree to be personally and fully responsible for payment.

X _____ _____

Patient Signature Date

☐ **Uninsured Patients:** I hereby attest that I am not insured.

x _____ _____

Patient Signature Date

PATIENT NAME _____

INSURANCE AND PRIVACY CONSENT FORM

This practice accepts assignment and files insurance for Medicare, Aetna (including student health plan), Excellus Blue Cross Blue Shield, The Empire Plan, GHI, HealthNow, Martin's Point (US Family Health Plan), MVP/Cigna, POMCO, RMSCO, WellCare, Fidelis, and Molina. We will provide an itemized bill for patients with other insurance. If we will be filing your insurance claim for any of the above-mentioned insurances, please sign the payment authorization below.

I hereby authorize my insurance benefits to be paid directly to this practice and acknowledge that I am financially responsible for any unpaid balance.

X _____ _____

Patient/Guardian Signature Date

Occasionally, we will need to communicate information to you by telephone (for example, regarding biopsy results or a prescription called into the pharmacy).
Do we have permission to:

leave a detailed message on your preferred phone number? ☐ YES ☐ NO
leave a message at your place of employment? ☐ YES ☐ NO
discuss your medical condition(s) with anyone in your household? ☐ YES ☐ NO

If yes, whom and relationship: _____
Phone? _____

contact you via text message? ☐ YES ☐ NO
contact you via email? ☐ YES ☐ NO
If yes, please list email address(s) _____

The policy of this office is to maintain strict confidentiality of your personal health records. On occasion we do need to routinely disclose some information for treatment (for example: to a pharmacy), payment (for example: to your insurance company), and health care operations (for example: interoffice statistics). Your information will not otherwise be disclosed without your specific consent.

We are now required by law to give you a copy of the HIPAA Privacy Practices and to have you sign the following:
I hereby acknowledge that I have received a copy of the HIPAA Privacy Practices. I understand that if my personal medical information is given to me, then I am personally responsible for keeping those records confidential.

X _____ _____

Patient/Guardian Signature Date
