BROOKS DERMATOLOGY PC
444 COMMUNITY DR. SUITE 102. MANHASSET, NY 11030. (516) 439-4707

PATIENT INFORMATION

□ **New Patient** □ **Established PT**

Patient's FIRST Name:	MIDDLE:	LAST:	Social Security#:

Birth date:	Sex:	Marital status (circle one)	Employment Status (circle one)	Employer Name:
/ /	□M □ F	Single / Mar / Div / Sep / Wid	Employed / Retired / Student/ Not-Employed	

Your Address:	City	State:	Zip Code:

Race: □Decline □White □American Indian /Alaska Nat. □Asian □Black/ African American □Nat.Hawaii/0th Pac Islander □Other	Ethnic Group: □Non-Hispanic □Hispanic/Latino □Decline	Language: □English □Spanish □Other:___ _

Primary Phone#: □Cell □Work □Home ( )	Alternate Phone#: □Cell □Work □Home	Email Address: Appointment reminder by email?□Yes□ No

Referring Physician Name:	How did you hear about our office?

Primary Physician Name:	Reason for visit:	Date of Inj/Onset:

ACKNOWLEDGEMENT:

The above information is true to the best of my knowledge. I consent to the use and disclosure of my protected health information for treatment, payment and health care operations as described in this clinic's Notice of Privacy Practices. I authorize my insurance benefits be paid directly to XXXX as indicated on the claim. I understand that I am financially responsible for all fees and balances, regardless of insurance coverage.

Patient/Guardian signature: _____ Date _____

Thank you for choosing Brooks Dermatology PC as your healthcare provider. We are dedicated to delivering exceptional medical care while ensuring a smooth and transparent financial experience. This policy outlines our guidelines to maintain efficient payment processes, enabling us to continue providing quality care to our patients.

1. Insurance and Payment at the Time of Visit: We kindly request that you present your insurance card, referral (if applicable), and co-payment during your visit. This ensures that your appointment proceeds as scheduled. All co-payments and anticipated procedure deductibles are due at the time of your visit. Payment in full, as well as expected coinsurance payments, will be determined by your insurance coverage, billing codes, and the agreement between your insurance company and Brooks Dermatology PC. Our practice accepts cash and major credit cards; however, we do not accept checks.

2. Missed Appointments and Cancellation Policy: We value both your time and our resources. If you are unable to make a scheduled appointment, we kindly ask for **at least 24 hours'** notice to reschedule. Missed appointments not canceled with 24-hour advanced notice will **incur a $50 fee**. Missed procedures not canceled within the same timeframe **will incur a $200 fee.** These policies help us maintain a smooth appointment schedule and ensure prompt care for all our patients.

3. Cosmetic Consultation Deposit: For cosmetic consultation visits, a $200 deposit is required upfront. This deposit will be applied towards a procedure if utilized within two months.

4. Outstanding Balances and Collections: Unpaid balances not resolved within 90 days of the statement date will incur a 35% collection agency processing fee. Delinquent accounts will be forwarded to collections, resulting in a suspension of future appointments until the account is brought up to date.

5. Credit Card on File Policy: To streamline payment processes and ensure prompt handling of outstanding balances, we **require patients to keep a valid credit card on file**. Your credit card information will be securely stored. If a payment remains unpaid after two billing cycles, your credit card will be charged for the outstanding balance. This policy helps us maintain efficient billing practices and ensures seamless patient care.

6. Insurance Claims: You have 60 days from the filing date to allow your insurance company to process or pay a claim. It is your responsibility to provide requested information to your insurance company for accurate claim processing. Any changes in insurance coverage, residence, or contact information must be promptly communicated to Brooks Dermatology PC. Please be aware of your insurance benefits to ensure effective utilization.

7. Responsibility for Payment: In the event that insurance is denied or terminated on the date(s) of service, you are responsible for the payment of services.

By continuing to receive medical services at Brooks Dermatology PC, you acknowledge and agree to the terms of our financial policy.

I have read and agree to all the provisions of the above financial policy. I understand I am fully responsible for all the professional fees incurred for all professional services performed by the attending physician.

Signature of Responsible Party: _____. Date: _____

Assignement of Benefits: *We require insured patients to complete assignement of benefits authorizing insurance to remit payment to physcians office.*

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitiled, private insurance, and any other health plans to: Brooks Dermatology PC. This assignemt will remain in effect until revoked by me in writing. A photocopy of this assignemtn is to be considred as valid as original. I understand I am responsible for all charges where or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure payment.

Signature of Responsible Party: _____. Date: _____

Financial Policy - Mandatory Credit Card on File

At Brooks Dermatology, we are committed to providing quality medical care and ensuring a seamless experience for our patients. To enhance the efficiency of our billing and payment process, we have implemented a mandatory credit card on file policy. This policy is designed to simplify the payment process and reduce the number of outstanding balances.

Why We Collect Credit Card Information:

The credit card on file will be securely stored in our encrypted and PCI DSS-compliant system. We will use this information to process outstanding balances, including deductibles, co-pays, and any other patient responsibilities as outlined in your insurance plan.

Benefits of the Credit Card on File Policy:

- Convenience: Having a credit card on file allows us to automatically process payments, eliminating the need for you to remember to pay each bill individually.
- Reduced Paperwork: With automatic payment processing, there's no need to handle paper invoices and checks.
- Timely Payments: This policy helps ensure that your payments are processed promptly, avoiding any potential delays that could impact your medical care.

Your Privacy and Security:
We understand that your personal and financial information is sensitive. Please be assured that we take the security and privacy of your data seriously. Our systems are equipped with the latest security measures to safeguard your credit card information from unauthorized access or misuse.

Disputes and Concerns:
If you believe there has been an error in the processing of a payment or if you have any concerns about the credit card on file policy, please contact our billing department as soon as possible. We are here to address any questions you may have.

Alternative Payment Methods:
While the credit card on file is the primary method of payment, we also offer alternative payment options, such as cash. If you prefer an alternative method, please let us know, and we will accommodate your choice.

By continuing to receive medical services at Brooks Dermatology you acknowledge and agree to the terms of our mandatory credit card on file policy.

We appreciate your understanding and cooperation as we work to improve the payment process for all our patients. If you have any questions or require further information, please do not hesitate to contact our billing department at 516 490 6060

Sincerely,

Brooks Dermatology.

Brooks Dermatology PC
444 Community Dr. Suite102. Manhasset, NY 11030.
(516) 439-4707

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This Notice *of* Privacy Practices describes how **we** may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for purposes required by law. It also describes your rights to access and control your protected health information. 'Protected Health Information'. i inform tion about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information (PHI)

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose *of* providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment We will use and disclose your protected health information to provide coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; OR your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has necessary information todiagnose or treat you.

Payment Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a medical procedure may require that your relevant protected health information be disclosed to the health plan to establish medical necessity.

Healthcare Operations We may use or disclose, as needed, your protected health information in order to conduct normal operations of the physician's practice. These activities include, but are not limited to:

Quality control
Licensing
Employee reviews
Training *of* medical students

For example, we may disclose your protected health information to medical students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary to contact you for test results or to remind you *of* your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as Required By Law, Public Health Issues, Communicable Disease, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, law Enforcement; Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures, Under Lay, we must make a disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in relation to the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your Protected Health Information.

You have the eight to inspect and copy your Protected Health Information Under federal law, however, you may not inspect or copy the following records - psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.

You have the eight to request a restriction of your Protected Health Information This means you may ask us not to use or disclose *any* part of your Protected Health Information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of vour protected health information not be disclosed to family members or friends who may be involved in your care of for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restrictions, and whom they apply.

Your physician is not required to agree to a restriction that you may request. If physician believes your restriction is unreasonable and it is in your best interest to permit use and disclosure of your Protected Health Information, your Protected Health Information will not be restricted. If you wish, you then have the right to use another Healthcare Professional.

You have the eight to request and receive confidential communications from us by alternative means or at an aiternative location You have the eight to obtain a paper copy of this notice kom us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically or by fax.

You may have the eight to have your physician amend your Protected Health Information If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with acopy *of* any such rebuttal.

You have the eight to receive an accmmtioq of certain disclosures we have made, if an¥, of your Protected Health loformat;on

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints - You may complain to the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201 if you believe your privacy rights have been violated by us; OR you may file a complaint with us by notifying our HIPAA Privacy Officer. **We wm not retaliate against you for filing a complaint**

This notice was published and becomes effective onApril Pt, 2016.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to Protected Health Information. If you have any objections to this form, please ask to speak with our privacy officer.

ACKNOWLEDGEMENT

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name Signature Date:

BROOKS DERMATOLOGY
MEDICAL • SURGICAL • COSMETIC

PATIENT INTAKE FORM

Please answer the following questions so we can comply at our practice. Thank you.

Name _____ **Date**_____

Dyou have any oftbe following?

Congestive Heart Failure	YES or NO
(CHF) Coronary Arte1y	YES or NO
Disease (CAD)	YES or NO
Chronic Obstructive Pulmona1y Disease	YES or NO
(COPD) Diabetes Mellitus (DM)	

2) Did you receive the flu vaccine before this past flu season? YES or NO

3) Have you ever received the pneumonia vaccine? YES or NO

4) Do you smoke tobacco? YES or NO

5) How many ti.mes in the last year (starting from 2021) have you had 4 or more alcoholic drinks in one day?

_____

6) Who is your **Primary Care Physician** (PCP) and their **Office Phone Number?**

_____

Month and Year of **Last Visit:** _____

7) Medical Allergies:

_____ _____ _____ _____

8) Past Medical Problems:

_____ _____ _____ _____

9) Please list all your current medications (Please specify dose and frequency):

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____

_____ _____