MANHATTAN DERMATOLOGY, PLLC

71 PARK AVENUE SUITE 1A
NEW YORK, NY 10016
WILLIAM LONG, M.D.
WENDY LONG MITCHELL, M.D.
FORREST N. WHITE, M.D.
PHONE (212) 689-9587 FAX (212) 689-8519

36A EAST 36TH STREET
NEW YORK, NY 10016
GEORGE G. KIHICZAK, M.D.
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PHONE (212) 683- 6073 FAX (212) 689-8519

NAME OF PATIENT (LAST) _____ (FIRST) _____ (M.I.)_____
SOCIAL SECURITY NUMBER _____ **DATE OF BIRTH** _____ **AGE** _____
SEX M / F **GI:** _____ **PRONOUNS:** _____ **MARITAL STATUS** S / M / D / W / DP
ADDRESS _____**APT. #**_____
CITY _____ **STATE** _____ **ZIP CODE** _____
PREFERRED PHONE # _____-_____-_____ **CELL/HOME #** _____-_____-_____ **WORK #**_____-_____-_____
EMAIL _____@_____ **PHARMACY PHONE #** _____-_____-_____

NAME OF EMPLOYER _____ **OCCUPATION** _____
EMERGENCY CONTACT NAME _____ **PHONE #** _____-_____-_____

DO YOU HAVE A PRIMARY CARE PHYSICIAN? Y /N

IF SO, PLEASE PROVIDE THE FOLLOWING:
PRIMARY CARE PHYSICIAN NAME _____ **PHONE #** _____-_____-_____

IF YOU WERE REFERRED BY A PHYSICIAN, PLEASE PROVIDE THE FOLLOWING:
NAME OF REFERRING PHYSICIAN _____ **PHONE #** _____-_____-_____

IF NOT REFERRED BY A PHYSICIAN, HOW DID YOU HEAR ABOUT OUR OFFICE? _____

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOU:

ACNE	HEART DISEASE	LYME DISEASE	ROSACEA
ASTHMA	HIGH BLOOD PRESSURE	MRSA	SEASONAL ALLERGIES
HIGH CHOLESTEROL	HEART ARRHYTHMIA	PACEMAKER	STOMACH ULCER/GERD
BLEEDING PROBLEMS	HEPATITIS A B C	PSORIASIS	THYROID DISEASE
CHICKEN POX/SHINGLES	HERPES	ONYCHOMYCOSIS	TINEA VERSICOLOR
DEPRESSION	HIV	PARKINSON'S DISEASE	URTICARIA (HIVES)
DIABETES I OR II	HPV	RHEUMATOID ARTHRITIS/ LUPUS	VITILIGO
ECZEMA	KIDNEY/LIVER DISEASE		

OTHER MEDICAL PROBLEMS _____ CANCER, PLEASE SPECIFY_____

ARE YOU PREGNANT, NURSING, OR TRYING TO CONCEIVE? _____
Do you currently smoke? Y/ N If yes, how many stick/pack_____ per day **Are you a former smoker?** Y / N
Do you drink alcohol? Y / N If yes, how much per week? _____

PERSONAL HISTORY OF SKIN CANCER

_____
_____

FAMILY HISTORY OF SKIN CANCER OR SKIN DISEASE

_____
_____

LIST ALL ALLERGIES

_____
_____
_____

LIST ALL MEDICATIONS, SUPPLEMENTS, VITAMINS

_____
_____
_____

REASON FOR TODAY'S VISIT

_____

DO YOU HAVE, OR WISH TO HAVE AN ADVANCED CARE PLAN OR SURROGATE DECISION MAKER?

_____Yes, I have an Advanced Care Plan or Surrogate Decision Maker (Please furnish copy of plan) or
Name of your Surrogate Decision Maker: _____Phone #_____
_____No, I do not wish to have an Advanced Care Plan or name a Surrogate Decision Maker at this time

WILL YOU FURNISH A PHONE NUMBER WHERE WE MAY LEAVE A MESSAGE WITH CONFIDENTIAL MEDICAL INFORMATION, SUCH AS LAB RESULTS? YES / NO

IF YES, PLEASE PROVIDE NUMBER _____-_____-_____

MAY WE TEXT APPOINTMENT REMINDERS TO YOUR CELL PHONE NUMBER? Yes _____ No _____

CANCELLATION POLICIES

IF YOU MUST CANCEL OR RESCHEDULE YOUR APPOINTMENT, YOU MUST DO SO AT LEAST **ONE BUSINESS DAY** PRIOR TO YOUR APPOINTMENT. IF YOU MISS AN APPOINTMENT WITHOUT DOING SO, WE WILL PUT THROUGH A **$50.00** CHARGE ON YOUR CREDIT CARD. *** **PLEASE INITIAL HERE _____** ***

FOR SURGICAL PROCEDURES, ½ HOUR COSMETIC APPOINTMENTS, MOHS MICROGRAPHIC SURGERY APPOINTMENTS, SCITON AND FRAXEL LASER APPOINTMENTS OR PATCH TESTING APPOINTMENTS, YOU MUST CANCEL AT LEAST **ONE BUSINESS DAY** PRIOR TO YOUR APPOINTMENT OR YOU WILL BE CHARGED A **$250** FEE.
*** **PLEASE INITIAL HERE _____** ***

FINANCIAL POLICIES

ALL COPAYS ARE EXPECTED AT THE TIME OF THE VISIT.
YOU MAY RECEIVE A SEPARATE BILL FOR LAB CHARGES.

IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR INSURANCE PLAN'S POLICIES AND TO GET REFERRALS FROM YOUR PRIMARY CARE PHYSICIAN IF REQUIRED BY THE PATIENT'S INSURANCE PLAN. EVEN IF WE ARE IN NETWORK WITH YOUR INSURANCE, DEDUCTIBLES OR COINSURANCE MAY APPLY FOR MEDICALLY REQUIRED SERVICES, WHICH MEANS YOU MAY BE RESPONSIBLE FOR A PORTION OF THE CHARGES. *** **PLEASE INITIAL HERE _____** ***

THIS FORM AND MY SIGNATURE AFFIXED HERETO MAY SERVE AS A SIGNATURE-ON-FILE TO BE USED TO AUTHORIZE DISCLOSURE OF THE MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM, INCLUDING THE DIAGNOSIS AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME, AND TO FILE ALL FUTURE INSURANCE CLAIMS RELATED TO MY CARE.

I ALSO AUTHORIZE MY INSURANCE COMPANY TO PAY DIRECTLY TO DR. WILLIAM T. LONG, DR. WENDY S. LONG MITCHELL, DR. FORREST N. WHITE, DR. GEORGE G. KIHICZAK, DR. VICKI J. LEVINE, AND/OR DR. MICHELE LEVY THE AMOUNT DUE TO ME IN PENDING CLAIMS FOR MEDICAL OR SURGICAL TREATMENT OR SERVICES RENDERED TO ME.

I ACKNOWLEDGE I HAVE RECEIVED/HAVE ACCESS TO A COPY OF THIS PRACTICE'S NOTICE OF PRIVACY PRACTICES.

PATIENT'S OR RESPONSIBLE PARTY'S NAME _____

RESPONSIBLE PARTY'S SOCIAL SECURITY # _____DATE OF BIRTH _____

PATIENT'S OR RESPONSIBLE PARTY'S SIGNATURE _____DATE_____

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Dear Patient:

We value you as a patient and appreciate that you have entrusted us with your health care needs.

Insurance companies and employers do not cover deductibles, coinsurances and copayments, as you know. It is our office policy to collect patients' credit card information to allow payment for these items and so avoid the need to bill you later. This saves expense for the billing and time for you and the office.

By signing below, you authorize payment by credit card in the amounts listed as patient responsibility by your health benefit plan for services (including, but not limited to, co-insurance, deductibles and/or uncovered services). We do not store your sensitive credit card information in our office. We store it in a secure site called a gateway. We access your information on this site only to process a payment.

We appreciate your cooperation in this matter and will guard your financial information under government HIPAA and HITECH guidelines.

Patient Name: _____

Signature: _____Today's Date: _____

New York State Department of Health

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

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

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 Manhattan Dermatology to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically to improve the quality of healthcare and meets the privacy and security standards of HIPAA, the requirements of the federal confidentiality laws, 42 CFR Part2, and New York State Law. To learn more visit Healthix's website at www.healthix.org.

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 Manhattan Dermatology to access ALL of my electronic health information through Healthix to provide health care.

□ **2. I DENY CONSENT** for Manhattan Dermatology to access my electronic health information through Healthix for any purpose.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

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)

Details about the information accessed through Healthix and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization listed may access ALL of your electronic health information available through Healthix. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems · Sexually transmitted diseases · Discharge summary · Employment Information
   - Birth control and abortion (family planning) · Medication and Dosages · Diagnostic Information · Living Situation · Social Supports
   - Genetic (inherited) · Allergies · Claims Encounter Data diseases or tests · Substance use history · Lab Test
   - HIV/AIDS summaries
   - Mental health conditions · Clinical notes
3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Healthix. You can obtain an updated list at any time by Healthix's website at www.healthix.org or by calling 877-695-4749.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Healthix for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Manhattan Dermatology at (212) 683-6073; or visit Healthix's website: www.healthix.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as Healthix ceases operation ***(or until 50 years after your death whichever occurs first).*** If Healthix merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form**.**

HIPAA Omnibus Notice of Privacy Practices

Revised 2013

Effective as of April/14/2003

Manhattan Dermatology

71 Park Avenue, Ste. 1A 36A E. 36th Street, Ste. 202

New York, NY 10016

212-689-9587 212-683-6073

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

- **Complaints**

  You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will never share any substance abuse treatment records without your written permission.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

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. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Acknowledgment of Receipt of the Notice of Privacy Practices

Name of patient or representative