SINY DERMATOLOGY

PLEASE FILL OUT THE ENTIRE FORM

PATIENT NAME			
DATE OF BIRTH	SEX: PLEASE CIRCLE ONE MALE FEMALE	SOCIAL SECURITY NUMBER	
STREET ADDRESS	CITY	STATE	ZIP
HOME TELEPHONE EMAIL ADDRESS	BUSINESS TELEPHONE	CELL NUMBER	
PRIMARY CARE DOCTOR	**ADDRESS**	**OFFICE TELEPHONE**	

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION		*SECONDARY INSURANCE INFORMATION*	
SUBSCRIBERS NAME		SUBSCRIBERS NAME	
RELATIONSHIP TO PATIENT	SUBSCRIBERS DATE OF BIRTH	RELATIONSHIP TO PATIENT	SUBSCRIBERS DATE OF BIRTH
HEALTH INSURANCE COMPANY		HEALTH INSURANCE COMPANY	
POLICY/ID NUMBER	GROUP NUMBER	POLICY/ID NUMBER	GROUP NUMBER

OFFICE POLICY

1. **Patient to obtain referral from primary physician with correct date of visit, if required by insurance company.**
2. **Patient to pay co-payment at time of visit and any outstanding balances.**
3. **Under Federal Laws, you are required to pay your annual deductible and 20% coinsurance.**
4. **All video/audio recording is strictly prohibited in all patient areas.**

I authorize the release of any medical or other information to process a claim on my behalf. I authorize payment of benefits directly to the provider of the Skin Institute of New York. Any amount not paid by the insurance company, I agree to pay. I am aware of the 2017 Health Portability and Accountability Act (HIPAA) Privacy Notice.

May we discuss your medical information?

We suggest if you are between 18 and 25 and you have your parents help you, place your parent's information here.

On Answering Machine? (Please circle one) Yes or No

With another Person? (please circle one) Yes or No…….. if Yes (Please indicate below)

Name and Phone#_____

Relationship_____

PATIENTS SIGNATURE: _____ **DATE:** _____

Continue on Back

PAST MEDICAL HISTORY: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplant
BPH
Breast Cancer
Colon Cancer
COPD
Other _____

Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood Pressure
HIV/AIDS
Hay Fever/Allergies

Thyroid Problems (Hyper / Hypo)
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Pacemaker
Radiation Treatment
Seizures
Stroke
High Cholesterol

Are you pregnant? YES NO

PAST SURGICAL HISTORY:

_____

SKIN DISEASE HISTORY: (Please circle all that apply)

Psoriasis
Eczema
Flaking or Itchy Scalp
Precancerous Moles
Melanoma (Family or Self)
Warts
Actinic Keratosis

Keratoacanthoma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Squamous Cell Skin Cancer
Acne

Do you wear sunscreen?
YES NO
If yes, what SPF? _____
Do you tan in a tanning salon?
YES NO

MEDICATIONS: (Please enter all current medications)

_____

_____

DRUG ALLERGIES:

_____

Cigarette Smoking: (Please circle one)
Never Smoked
Quit: Former Smoker
Smokes Daily

Alcohol intake:
Less than one drink per day
1-2 drinks per day
3 or more drinks per day

Have you had your Flu vaccine within the past year? YES NO
Have you had your Pneumonia vaccine? YES NO

If you are 65+ do you a health care proxy? YES NO
If yes please list Name and phone number _____

Pharmacy Name / Phone # _____

Address _____

Referring or Primary Physician:
Name: _____ Phone/Fax: _____

Referred by:
Social Media_____
Website_____
Insurance Company_____
Friend_____
Other_____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
SINY Dermatology.

8. Name and address of person(s) or category of person to whom this information will be sent:
to Self, to P.C.P., to any Specialty of choice.

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.