NEW PATIENT INFORMATION

Name **(Required)**_____
Street Address**(Required)**_____
City_____ State_____ Zip _____
Date of Birth**(Required)** ____/____/_____ Marital Status_____ Sex_____
SS#**(Required)**_____
Race_____Ethnicity_____Primary Language_____
Home Phone**(Required)** ( ) _____ Work Phone ( ) _____
Cell Phone **(Required)** ( )_____
Employer _____
E-mail Address_____
(May we please have your email address so we can send you information about our services)

Emergency Contact(Required) _____ Relationship to Patient_____
Home Phone ( )_____ Work Phone ( ) _____ Cell Phone ( )_____

Who Is Your Medical Doctor Internist/General Practitioner

Name _____
Address _____ Phone ( )

_____
City _____ State _____ Zip _____
Did he refer you for consultation? Yes ❑ No ❑ Letter to referring Doctor? Yes ❑ No ❑

Referred By: ❑ Physician ❑ Family/Friend ❑ Advertisement ❑ Yellow Pages ❑ Insurance Plan ❑ Website
If you were referred by a physician, who is your referring physician_____

Pharmacy_____**Address**_____**Phone #**_____

Policy Holder / Primary Insurance Information

Name _____ SS#_____ DOB ____/____/_____
Name of Insurance Company _____ ID/Policy # _____ Group # _____
Insurance Company Address _____
Relationship to Patient _____ Employer _____

Secondary Insurance to File

Name _____ SS#_____ DOB ____/____/_____
Name of Insurance Company _____ ID/Policy # _____Group # _____
Insurance Company Address _____
Relationship to Patient _____ Employer_____

Patient Signature_____**Date**_____

NEW YORK COSMETIC SKIN & LASER SURGERY CENTER

CAMERON K. ROKHSAR, M.D., F.A.A.D., F.A.A.C.S

901 Stewart Avenue, Suite 240
Garden City, NY 11530
Phone: (516) 512-7616
Fax (516) 512-7617

328 E. 75th Street, Suite A
New York, NY 10021
Phone: (212) 285-1110

PATIENT MEDICAL HISTORY

Name: _____ Height: _____ Weight: _____ Date: _____

Reason for your visit: _____

Please check and, if applicable, circle, any of the following conditions you currently have or have had in the past.

_____ Skin Cancer (type: _____)
_____ Other Cancer (type: _____)
_____ Heart Disease (heart attack, angina, rheumatic fever, heart valve replacement, atrial fibrillation, mitral valve prolapse)
_____ High Blood Pressure
_____ Pacemaker
_____ Stroke or TIA (transient ischemic attack)
_____ Blood Clots
_____ Immune Deficiency
_____ Endocrine Disorder (diabetes, Cushings)
_____ Artificial Joints
_____ Blood/Lymph Gland Disorder (anemia, leukemia, low Platelets, lymphoma, hemophilia, sickle cell)
_____ Taken Accutane (for acne treatment)
_____ Neurologic Disorder
_____ Frequent Skin Infections
_____ Ear Disease (deafness, Meniere's, acoustic neuroma
_____ Eye Disease (glaucoma, cataracts, blindness)
_____ Duodenal or Peptic Ulcer
_____ Intestinal Disease (irritable bowel, ulcerative colitis, Crohn's)
_____ Liver or Gall Bladder Disease
_____ Lung Disease (tuberculosis, asthma, emphysema, pleurisy)
_____ Kidney Disease
_____ Urinary or Bladder Problem/Infection
_____ Arthritis, Joint, Muscle or Bone Disease (lupus, Raynauds, scleroderma)
_____ Radiation Treatment _____ Chemotherapy
_____ Emotional or Psychiatric History

- Have family members had: ____ Melanoma _____ Insulin-Treated Diabetes _____ Excessive Scarring ____ Cancer (type: _____)
- Do you: _____ Smoke (cigarettes, cigars, pipes) _____ socially drink alcohol (_____ drinks/week) _____ Use street drugs (type: _____)
- Please circle if you take any of the following on a Regular basis:
  Coumadin Aspirin Vitamin E Garlic Tablets Ginkgo Biloba Ginseng Ginger
- Do you have any allergies to any medications (please circle) YES or NO, if yes please list medications and your reaction to them:
- Please circle if you have ever had an allergy or problem with any of the following and indicate on the line below you reactions:
  Local Anesthetic Epinephrine (Adrenaline) Latex Adhesives/Band-aids Antibiotic Ointment (i.e. – Neosporin, Bacitracin)
- Have you or any family member had problems with anesthesia? NO YES _____
- Have you ever had any problems with sulfites, commonly found in red wines and salad bars? NO YES _____
- Please list any prior hospitalizations & surgeries: _____

FOR WOMEN ONLY: Do antibiotics cause you to have yeast vaginitis? _____ Are you pregnant or nursing? _____ Have you missed you last menstrual period? _____ Are you planning a pregnancy? _____ Date of last mammogram? _____
** Please inform us if any of these become true during the course of your treatment at subsequent visits.*

- If a spouse, parent, child, sibling or friend were to ask questions reguarding your care, do you authorize Dr. Cameron Rokhsar to discuss your care? If so, with whom? (Please write names & relationship to you) _____
- Do you allow us to leave medical information, such as laboratory results or answers to medical questions that were asked of us, on your voice mail or answering machine? NO YES

Signature _____ **Date** _____

CAMERON K. ROKHSAR, MD, FAAD, FAACS

• LASER & COSMETIC SURGERY • MOHS SURGERY

NEW YORK COSMETIC, SKIN
& LASER SURGERY CENTER

Credit Card Authorization and Collections Acknowledgement

Patient Name:_____ Date of Birth:_____

Due to changes instituted by the Affordable Health Care Act, most insurance providers now have high deductibles, coinsurances, and copayments. If you have a deductible plan, your insurance company holds you responsible to pay their contracted rate (what they would have paid us for your office visit and/ or procedures) until your deductible is met. However, until your deductible is met, we are not paid anything by your insurance provider. Additionally if your insurance plan has a coinsurance provision, you will be responsible to pay a percentage of the charges.

Our office requires that a credit card be kept on file so that these balances are satisfied promptly. By signing below you agree to have your credit card billed for any balances not paid by your insurance carrier. Please note that this will not compromise your ability to dispute a charge or your insurance company's determination of payment. It is your responsibility to contact your insurance provider to inquire about your remaining yearly deductible balance and/ or coinsurance responsibility to avoid any unexpected costs. You will be financially responsible if services exceed the limits of your plan.

I am irrevocably consenting to allow to any credit card entity, bank or financing company, access to my explanation of benefits as provided to Cameron Rokhsar MD, PC, if such information is requested, in order to process a payment or assist in reconciliation of my account.

Please present your credit card and a valid photo ID to the receptionist at the time of check-in. Thank you.

Master Card/Visa/Amex Card #_____ CCV _____ Exp _____

Patient Name_____Date_____

Patient Signature_____

Credit card verified by: Raj Jessica Ginny Joscelyne

328 EAST 75TH STREET, SUITE A • NEW YORK, NY 10021 • PHONE: 212.285.1110
901 STEWART AVENUE, SUITE 240 • GARDEN CITY, NY 11530 • PHONE: 516.512.7616
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NEW YORK COSMETIC, SKIN
& LASER SURGERY CENTER

CAMERON K. ROKHSAR, M.D., F.A.A.D., F.A.A.C.S

Cancellation Policy for Appointments

Any time you are unable to keep your appointment, we would appreciate a call in advance from you so that we may cancel your appointment and use the appointment time for another patient. This serves as notice that if you fail to give us a 48-hour notice of cancellation for an appointment, there will be a $75.00 cancellation fee billed to your account that is non-covered by your insurance. You will bear complete financial responsibility for this fee.

I understand Dr. Rokhsar's appointment cancellation policy and understand my responsibility to plan appointments accordingly and notify the office appropriately if I have difficulty fulfilling my scheduled appointments.

_____ _____

Patient Signature Date

Credit Card Policy

A valid photo ID is required when paying by credit card.
We apologize for any inconvenience. Thank you.

_____ _____

Patient Signature Date

NEW YORK COSMETIC, SKIN
& LASER SURGERY CENTER

Dr. Cameron Rokhsar
Dermatology
328 E. 75th Street Suite A, New York, NY 10021
901 Stewart Ave., Suite 240, Garden City, NY 11530
516-512-7616 212-285-1110

NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have been informed that the U.S. Government requires
Patient Name
I sign this Notice of Privacy Practices. The privacy regulations were created by the U.S. Health Insurance Portability and Accountability Act of 1996 (HIPAA) to protect patient privacy. I understand that the full text of the Act is available to me upon request. In order to request any amendments, restrictions or disclosures I must make a written request to the office privacy officer.

_____ _____
Signature of Patient Date

Do we have your permission to:

Leave a message on your answering machine at home?	❑ YES	❑ NO
Leave a message at your place of employment?	❑ YES	❑ NO
Discuss your medical condition with any member of your household?	❑ YES	❑ NO

If yes, whom: _____

Relationship: _____

Dr. Cameron Rokhsar
Dermatology, MOHS Surgery, Laser and Cosmetic Surgery
328 E. 75th Street Suite A, New York, NY 10021* 901 Stewart Ave., Suite 240, Garden City, NY 11530

Office Policies

1. Payment. I understand that payment in full is due at the time of service except for those services which have been pre-authorized in advance or subject to insurance payment. We accept cash, American Express, Master Card, Discover and Visa and all debit cards with the Visa and Master Card logo. **We do not accept personal checks.**

2. Non-payment policy. If it becomes necessary for us to initiate collection proceedings, we will be adding 30% of outstanding balance in order to cover costs of any collection activity.

3. Financial Policy re: Insurance. It is my responsibility to contact my insurance provider to inquire about my remaining yearly deductible balance and/ or coinsurance responsibility to avoid any unexpected costs. I understand that I will be financially responsible if services exceed the limits of my plan. I also understand that there may be certain procedures that may not be reimbursable under my insurance plan. This may be due to the procedure being considered cosmetic. Also, certain visits or procedures may require a referral for or pre-certification that I do not have at the time of a visit. Therefore, I understand that I am personally responsible for any fees or procedures not covered by my insurance plan by virtue of plan limitations or lack of referrals and pre-certifications or any other reason. I am also responsible for any co-pays, co-insurance or deductible payments. *Your insurance company may refuse to approve your procedure in advance. In such case, you will not know if your procedure is covered by insurance until after the claim is submitted. Should your insurance company disapprove, after the procedure is done, it is your responsibility to pay all charges.* I understand it is also my responsibility to notify my insurance plan of any hospital admissions. I understand that it is my responsibility to present valid insurance cards and to get any referrals from my primary care physician as needed. If I do not, I will be responsible for payment that day but will be reimbursed if I present such within 24 hours and after insurance pays for services received. I will notify the doctor's office if I am no longer insured by my insurance plan and will be responsible for all bills from the date that my coverage ceases. I understand and agree that if for any reason my insurance carrier does not ultimately cover a procedure that was supposed to be covered, I am 100% responsible for the charges.

4. Medicare Patients. We are participating providers in the Medicare program. We will accept assignment on all pre-approved claims. Patients are responsible for meeting their annual deductible and paying for the 20% coinsurance. We will also file with secondary carriers if applicable. In the event that the secondary does not pay within 60 days, patients will be balance billed.

5. Authorization of Treatment. I hereby authorize Dr. Cameron Rokhsar to give me reasonable and proper care by today's standards. I further authorize and direct the above named clinical practice to release to governmental agencies, insurance carriers or others who are financially liable for my medical care all information requested to substantiate payment for medical services provided. I also permit representatives thereof to examine and make copies of all records relating to such treatment. I hereby assign and transfer over to the above named clinical practice sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care, to cover the costs of medical services rendered.

6. Governance Policy. A copy of the following information has been made available to me: Information regarding the ownership of the practice; expertise of the physicians associated with this practice, the Patient Rights and Responsibilities; HIPAA Policy and the Grievance policy of this organization.

7. Release of Information. I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to Cameron Rokhsar, MD.

I have read the above and agree to the terms. This agreement will remain in effect indefinitely.

Print Patient Name	Signature of Patient	Date

PRIVACY AGREEMENT

Dr. Cameron Rokhsar and The New York Cosmetic Skin & Laser Surgery Center (collectively labeled "*Physician*") agree to provide treatment to the below named patient. The Physician takes pride in being able to extend a greater degree of privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Physician believes this is improper and may not be in the patients' best interest. Accordingly, Physician agrees not to provide medical information for the purpose of marketing directly to Patient. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Nothing in this Agreement prevents a patient from posting commentary about the Physician - his practice, expertise, and/or treatment - on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if Patient prepares such commentary for publication on web pages, blogs, and/or mass correspondence about Physician, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Physician for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary.

This Agreement shall be in force and enforceable for a period of five years from Physician's last date of service to Patient. As a matter of office policy, Physician is requiring all patients in its practice sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Physician's patients. Further, this Agreement will survive for a minimum of three years beyond any termination of the Physician-Patient relationship.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

PRINT NAME: SIGNATURE: DATE: