Weill Cornell Medicine
Dermatology

Please Note: All information is confidential and will become part of your medical record
Do not leave any boxes empty, mark N/A for not applicable or None if appropriate. **PLEASE PRINT CLEARLY**.

Patient Name:		***Date of Visit:***
Date of Birth:	**Social Security Number:**	
Gender ☐ **Male** ☐ **Female**	**Marital Status:** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Domestic Partner**	
Home Address:	***Home Phone#:*** ***Other Phone#:***	
Preferred Email Address:	**Emergency Contact (Name and Phone Number):** **Relationship to Patient:**	
PRIMARY INSURANCE CARRIER:	**INSURANCE ID #:**	
INSURANCE PHONE #:	**Are you the Primary Insurance policy holder?** ☐ **Yes** ☐ **No**	
If No, Please list the Name and Date of Birth of the Policy Holder:		
Does your insurance plan require referrals for specialty visits? ☐ **Yes** ☐ **No**	**If YES, do you have a referral for today's visit?** ☐ **Yes** ☐ **No**	
SECONDARY INSURANCE CARRIER: ☐ **N/A**	**INSURANCE ID #:**	

Physician and Pharmacy Information
Referring Physician (Name/Phone/ Fax Number): **Were you referred by the above mentioned physician for a Consultation?** ☐ **Yes** ☐ **No**
Primary Care Provider (Name/Phone/Fax Number)**:** ☐ **Same as Referring?**
Preferred Pharmacy (Name/Phone/Fax Number)**:**

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that all information above is true and correct. I authorize the holder of medical information about me to release to my insurance and, if I am a Medicare patient, to the Centers for Medicare and Medicaid Services and its agents, any information necessary to determine these benefits or the benefits payable for related services. I request that payment of any benefits be made on my behalf to the provider of services. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for payment in full for these services including any amounts not paid by my insurance carrier such as Copayments, Deductibles, and other Non-covered services.

I understand that cosmetic and other non-medically necessary services are not covered by my insurance carrier and that I will be financially responsible for any such non-covered services at the time of the visit.

_____ _____

Patient Signature **Date**

WCMC Department of Dermatology – Patient Exam Questionnaire

Patient Name: _____ **Patient Date of Birth**_____

Why are you here today? (Please list)

1. _____ 3. _____

2. _____ 4. _____

Please answer each of the following questions by checking off the appropriate box. Fill in explanation when necessary.

SOCIAL HISTORY

Do you smoke? ☐ NO ☐ YES How much? _____
Do you drink? ☐ NO ☐ YES How much? _____
Do you use IV drugs? ☐ NO ☐ YES
Have you had or have you been exposed to HIV (AIDS)? ☐ NO ☐ YES

ALLERGIES

Has your doctor ever requested you take antibiotics before a dental procedure? ☐ NO ☐ YES
Are you **allergic** to any of the following?
Penicillin ☐ NO ☐ YES _____ **Sulfa** ☐ NO ☐ YES _____
Any other drugs? ☐ NO ☐ YES If **yes** what?_____
If yes, what type of reaction did you have?_____
Any foods? ☐ NO ☐ YES If **yes**, what?_____
Nail polish/cosmetics? ☐ NO ☐ YES If **yes**, what?_____

SKIN

Have you ever had a skin biopsy? ☐ NO ☐ YES If yes, when?_____Biopsy Site?_____
Have you ever had skin cancer? ☐ NO ☐ YES If yes, what type? _____
Any other form of cancer? ☐ NO ☐ YES If yes, what type?_____
Any abnormal skin moles? ☐ NO ☐ YES If yes, where? _____
Do you have a history of any skin diseases? ☐ NO ☐ YES If yes, what?_____
Do you bleed easily? ☐ NO ☐ YES
Do you develop keloid scars? ☐ NO ☐ YES
Has any one in your family ever had skin cancer? ☐ NO ☐ YES If yes, who? _____What type?_____

MEDICINES

Are you taking any medications (prescriptions, over-the-counter) regularly now? ☐ NO ☐ YES
If **yes**, fill out the following:

Name of medication	**Reason for taking this**

OPERATIONS AND HOSPITALIZATIONS

Have you ever been hospitalized? ☐ NO ☐ YES
If **yes**, fill out the following:

Date of hospitalization	**Reason for hospitalization**

SYSTEMS REVIEW

Do you have any of the following complaints?

GENERAL

Fatigue	☐ NO	☐ YES
Weight loss	☐ NO	☐ YES
Weakness	☐ NO	☐ YES
Swollen Lymph nodes	☐ NO	☐ YES
Easy bruising	☐ NO	☐ YES

HEAD

Visual problems	☐ NO	☐ YES
Ear pain, decreased hearing	☐ NO	☐ YES
Difficulty swallowing	☐ NO	☐ YES
Severe headaches	☐ NO	☐ YES
Strokes	☐ NO	☐ YES

Other _____

MEN ONLY

Hair growth or loss	☐ NO	☐ YES
Discharge from penis	☐ NO	☐ YES
Sore on penis	☐ NO	☐ YES

Other _____

CHEST, HEART AND LUNGS

Shortness of breath	☐ NO	☐ YES
Chest pain or pressure attacks	☐ NO	☐ YES
Frequent cough	☐ NO	☐ YES
Swollen ankles	☐ NO	☐ YES
Valve disorder	☐ NO	☐ YES

Other _____

GASTROINTESTINAL

Poor appetite	☐ NO	☐ YES
Indigestion or vomiting	☐ NO	☐ YES
Change in bowel habits	☐ NO	☐ YES
Pass blood from rectum	☐ NO	☐ YES

Other _____

ENDOCRINE

Thyroid condition	☐ NO	☐ YES
Diabetes	☐ NO	☐ YES

Other ☐ NO ☐ YES_____

GENITALIA (WOMEN ONLY)

Breast lump	☐ NO	☐ YES
Discharge from nipple	☐ NO	☐ YES
Vaginal discharge or spotting (not from period)	☐ NO	☐ YES
hot flashes	☐ NO	☐ YES
Change in periods	☐ NO	☐ YES
Are your periods irregular?	☐ NO	☐ YES
Possibly pregnant	☐ NO	☐ YES

Number of times pregnant _____

Number of children _____

KIDNEY

Difficulty in passing urine	☐ NO	☐ YES
Getting up at night to urinate	☐ NO	☐ YES

Other _____

NEUROMUSCULAR

Weakness in arms or legs	☐ NO	☐ YES
Dizzy spells	☐ NO	☐ YES
Fainting spells	☐ NO	☐ YES

Other _____

BONES/JOINTS

Painful or swollen ankles	☐ NO	☐ YES
Loss of muscle strength	☐ NO	☐ YES
Prosthetic bone replacements	☐ NO	☐ YES
Back pain	☐ NO	☐ YES

Other _____

ANY OTHER PROBLEMS OR CONCERNS? (PLEASE DESCRIBE)

_____

_____

_____

_____

_____ _____

Physician's Signature **Date**

Weill Cornell Medicine
Dermatology

Patient Name: _____

MRN#: _____

The following is our Financial Policy which we require you to read and sign prior to your visit(s).

Thank you for choosing WCM- Dermatology to provide your health care. We are committed to your successful treatment.

You are required to inform us immediately of any changes in demographic (home address, telephone numbers) Or medical insurance information. You are expected to pay all previous outstanding balances prior to scheduling the next visit. If you have questions about billing, please ask to speak with one of our Billing Representatives or call 646-962-4521.

If we are participating providers: You must present your Insurance Card, and, if applicable, Insurance Referral Forms at every visit. We will submit bills directly to your insurance company for payment on your behalf. Patients without insurance card(s) and/or a proper referral will be asked for payment in full at time of service or to reschedule the visit. **It is the patient's responsibility to obtain new and up to date Insurance Referrals, if applicable.** All co-payments and cosmetic charges will be collected at time of service. In the event that your insurance coverage changes to a plan where we are not participating providers, please refer to the below section.

_____*Initial*

We are legally required to collect your copayments, coinsurance and or deductibles: The Health Care Financing Administration (otherwise known as HCFA) is the federal government agency responsible for setting policy and overseeing the Medicare and Medicaid programs. HCFA has mandated that physicians and other providers of health care must collect co-pays, deductibles and co-insurances. This is enforced by the Office of the Inspector General (OIG). Copays, coinsurance, and deductibles are all part of Insurance cost-sharing, or your out-of-pocket costs agreement. This agreement is between you and your insurance company. You are responsible for Out of pocket costs applied by your insurance company.

_____*Initial*

If we are Out of Network with your insurance plan Or You do not have medical insurance: Payment is due at time of service. It is the responsibility of the patients to submit an original claim and receipt directly to their insurance company along with any pertinent information/documents. _____*Initial*

Cosmetic Services

Payment in full is due at the time of service for all services that are considered not medically necessary or cosmetic. (E.G. Botox, Cosmetic fillers, Laser services, Cosmetic removal of lesions) Understand that medicine is not an exact science and the possibility that the treatment may not have the benefits or results intended exists. There are no refunds after procedure is complete.

_____*Initial*

24 Hour Cancellation & "No Show' Fee Policy. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, we reserve the right to charge a fee for all missed appointments ("no shows") and appointments which, absent of a compelling reason, are not cancelled with a 24-hour business day advance notice. The fee for a missed office visit is $75.00 or $150.00 for a missed procedure visit. This charge is not reimbursable by your insurance company. You will be billed directly for it.

_____*Initial*

Laboratory and Pathology Fees: Many times it is necessary to obtain tissue or perform lab tests to confirm a diagnosis or to determine a course of treatment. If any tissue is removed for a pathology examination or if a laboratory test (blood work, culture, etc.) is done in our office, the actual test is performed by that department. This means you may receive a separate bill from the Weill Cornell Medicine - Dermatopathology Department and/or the New York Presbyterian Laboratory for the processing of these tests. You are responsible for payment to those departments. If you receive a bill from the lab, please contact that lab directly to resolve any billing concerns. _____*Initial*

Usual and Customary Rates: *Your insurance policy is a contract between you and your insurance company. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.*

We appreciate your faith and trust in us and thank you for the opportunity to serve your healthcare needs.

I authorize payments to be made directly to the Weill Cornell Medicine- Department of Dermatology and fully understand that I am the responsible party for all charges incurred by me or my dependents at this facility. I also authorize the release of any and all information required to collect and process my medical insurance claims. Refusal to Initial and/or Sign this document does not remove your financial responsibility and/or obligations to its contents.

I have read the policy; I understand and agree to it.

_____	_____	_____
Print Name of Patient or Responsible Party	*Signature of Patient or Responsible Party*	*Today's Date*

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 review it carefully.

This Notice will tell you about the ways we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding such medical information. We are required by law to make sure that medical information which identifies you is kept private; give you this Notice of our legal duties and privacy practices with respect to your medical information; and follow the terms of the Notice that is currently in effect. This Notice covers the physician practices of Weill Cornell Medical College (collectively "Weill Cornell", "we" or "us"), including its employed physicians and other personnel. (If you are being treated by a Weill Cornell physician while in another institution, such as New York-Presbyterian Hospital, you should refer to that other institution's Notice of Privacy Practices for information about how your medical information may be used and disclosed and whom to contact to exercise your rights).

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information.

Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other Weill Cornell personnel or personnel of New York-Presbyterian Hospital or Columbia University Health Sciences (collectively "our Affiliated Institutions"), who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes**,** because diabetes may slow the healing process. Different departments of Weill Cornell and our Affiliated Institutions also may share medical information about you, such as prescriptions, lab work and x-rays, to coordinate your treatment. We also may disclose medical information about you to people outside Weill Cornell who may be involved in your medical care.

Payment. We may use and disclose medical information about you so that we may bill for treatment and services you receive at Weill Cornell and can collect payment from you, an insurance company or another party. For example, we may need to give information about surgery you received or are going to receive to your health plan so that the plan will pay us or reimburse you for the surgery. In the event a bill is overdue, we may need to give information to a collection agency as necessary to help collect the bill or may disclose an outstanding debt to credit reporting agencies. We may also disclose information about you to our Affiliated Institutions and other healthcare facilities for purposes of payment as permitted by law.

Health Care Operations. We may use and disclose medical information about you for operations of Weill Cornell and our joint operations with our Affiliated Institutions. These uses and disclosures are necessary to run Weill Cornell or such joint operations and make sure that all of our patients receive quality care. For example, we may use medical information to evaluate the performance of our staff in caring for you. We may also disclose information to doctors, nurses, technicians, medical students, and other Weill Cornell personnel for educational purposes. We may also disclose information about you to other healthcare facilities as permitted by law.

Appointment Reminders; Treatment Alternatives; Health-Related Benefits and Services. We may use and disclose medical information to contact you to remind you that you have an appointment for treatment or medical care, or to contact you to tell you about possible treatment options and health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care or who helps pay for your care. We may also tell your family or friends your condition. If you do not wish us to share this information with your friends and family, please follow the procedures described in the Right to Request Restrictions section of this Notice below. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

Special Privacy Protections. If your medical information includes HIV-related information, alcohol or substance abuse, mental health or genetic information, special protections may apply to such information, and you can contact the Privacy Officer if you have any questions.

To Avert a Serious Threat to Health or Safety. of you, the public or another person, we may use or disclose medical information about you.

Organ and Tissue Donation. If you are an organ or tissue donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank.

Military and Veterans. If you are a member of the armed forces of the United States or another country, we may release medical information about you as required by military command authorities.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs.

Public Health Risks. We may disclose to authorized public health or government officials medical information about you for public health activities when required or authorized by law. These activities generally include the following: to a person subject to the jurisdiction of the Food and Drug Administration (FDA) for purposes related to the quality, safety or effectiveness of an FDA-regulated product or service; to prevent or control disease, injury or disability; to report disease or injury; to report births and deaths; to report reactions to medications and food or problems with products; to notify people of recalls or replacements of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other legal demand by someone else involved in the dispute, but only if efforts have been made by us or someone else to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement/National Security/Protective Services. We may release medical information if asked to do so by a law enforcement official: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct on the premises of Weill Cornell; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime; to authorized federal officials so they may provide protection for the President and other authorized persons, or conduct special investigations, or for intelligence, counterintelligence, and any other national security activities authorized by law.

Coroners, Medical Examiners and Funeral Directors. We may release medical information about deceased persons to a coroner, medical examiner or funeral director so they can carry out their duties.

Other Uses of Medical Information. Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made with your written authorization, on a Weill Cornell authorization form. You may revoke such an authorization by writing to the Privacy Officer, and such revocation will be effective to the extent that we have not already released the information pursuant to the authorization or otherwise taken action in reliance on the authorization.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process before your medical information may be used or disclosed. We may use or disclose medical information about you to researchers who are preparing to conduct a research study, for example, to help them look for patients with specific medical needs who might be asked to participate in this project. In this case, information they review will not leave Weill Cornell or our Affiliated Institutions. When legally required, we will ask for your specific written permission (authorization) if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at Weill Cornell or our Affiliated Institutions. Finally, we may permit a researcher to look at your medical information and use and disclose it for research purposes if, after going through an approval process, an evaluation is made that the proposed use and disclosure complies with legal and ethical requirements regarding the privacy of medical information.

Fundraising Activities. We may use certain information about you (name, address, telephone number or email information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money for Weill Cornell Medical College (including its graduate school) or joint fundraising activities involving Weill Cornell and our Affiliated Institutions. For the same purpose, we may provide your name to our institutionally related foundation. The money raised will be used to expand and improve the services and programs we provide the community. You are free to opt out of fundraising solicitations at any time, and your decision will have no impact on your treatment or payment for services at Weill Cornell Medical College.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records. This right does not include: psychotherapy notes; information compiled for use in a legal proceeding; or certain information maintained by laboratories.

In order to inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at the address listed at the end of this Notice. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request in writing to the Privacy Officer that the denial be reviewed. A licensed healthcare professional who was not directly involved in the original decision to deny access will conduct the review. We will comply with the outcome of the review.

Right to Request Amendments. If you think that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address listed at the end of this Notice. In addition, you must give a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for Weill Cornell;
- is not part of the information you would be permitted to inspect and copy; or
- is accurate and complete.

We will provide you with written notice of action we take in response to your request for an amendment.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of certain disclosures we have made of medical information about you. We are not required to account for any disclosures you specifically requested or for disclosures related to treatment, payment, or healthcare operations, made pursuant to an authorization signed by you, or and which fall into certain other limited categories of disclosures.
To request an accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address listed at the end of this Notice. Your request must state a time period, which may not be longer than six years prior to the date of your request. You may request one accounting in any 12-month period free of charge, and we will charge you for any subsequent request in the same 12-month period. Such charge may include reasonable retrieval, list preparation, and mailing costs.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. If you wish to request such a restriction, you must contact the Privacy Officer in writing at the address listed at the end of this Notice.
We are not required to agree to your request. If we agree to your request, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request an Electronic Copy of your Medical Record. You have a right to request that we provide you with an electronic copy of your medical record. WCMC will try to provide the information in the format you request. However, if the format is not available, we are permitted to offer other electronic formats. If none for the offered formats are acceptable to you, WCMC is permitted to provide you with a "hard copy".

You may also request that WCMC transmit the electronic copy directly to a third party designated by you and we will comply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must contact the Privacy Officer in writing at the address listed at the end of this Notice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will attempt to accommodate reasonable requests.

Right to Restrict Disclosures of your PHI to your Health Plan with Respect to Healthcare for which you have paid out of pocket and in full. If you pay for a service out of pocket and in full, you may request that WCMC not disclose information about that visit to your insurance plan and WCMC must honor that request. However, if you want us to bill your insurance plan for any subsequent care, we may have to provide the original information to your carrier in order for us to be paid for the subsequent service.

Prohibition on Certain Disclosures or Sale of PHI Without Authorization. Weill Cornell Medical College (WCMC) will not disclose your health information for the purpose of marketing non-WCMC products or services without an authorization (which authorization would state whether WCMC received any payment for such marketing). If your medical record contains psychotherapy notes, WCMC will not use or disclose the psychotherapy notes except for your specific treatment or for our training programs, or in the event of a legal proceeding brought by you or your representative against us, unless you specifically grant permission (authorization). Lastly, any other uses or disclosures not specifically described in the Notice of Privacy Practices will not be made without your written authorization. And, in the event that you authorize one of more of the above mentioned uses or disclosures, you have the right to revoke your authorization at any time by writing to us at the address below. We will honor the revocation unless we have already used or disclosed the information. Revocation will in no case affect your care at WCMC.

Right to be Notified in the Event of a Breach
In the event of a breach of your Protected Health Information as defined by the Department of Health and Human Services (HHS), you will be notified by us in a manner specified by HHS.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may obtain a copy from any of our Weill Cornell locations or by contacting the Privacy Officer. You may also obtain a copy of this Notice electronically at our website address noted below.

Changes To This Notice. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information about you we already have as well as any information we receive in the future. The current Notice in effect at any time will be posted on our website address listed below and will be available from the Privacy Officer as well as at any of our practice locations.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with Weill Cornell or with the Secretary of the Department of Health and Human Services. To file a complaint with Weill Cornell, please call or write to the Privacy Officer at the address listed at the end of this Notice. You will not be penalized or retaliated against for filing a complaint regarding your privacy rights.

Questions. If you have a question about this Privacy Notice, please contact:

Privacy Office
Weill Cornell Medical College
1300 York Avenue, Box 303
New York, N.Y. 10021

Tel: (646) 962 – 6930

Email: privacy@med.cornell.edu

Website: http://www.weillcornell.org/privacy