Department of Dermatology

Mount Sinai Doctors *Faculty Practice*

Mount Sinai Dermatology Associates

5 East 98th Street – 5th Floor
New York, NY 10029-6574

638 Columbus Avenue @ 91st Street
New York, NY 10024

Welcome!

Thank you for choosing **Mount Sinai Dermatology Associates** for your care. Enclosed is our Mission Statement and a list of our faculty.

For your convenience we are pleased to send you copies of the **Welcome Packet** and **Patient Medical History Questionnaire**. You will be receiving a reminder call from our automated service prior to your appointment.

Please make sure your completed forms include your primary *and* referring physicians' names, addresses and phone numbers so we can communicate with your providers.

In addition, to care for you efficiently and to avoid delays in evaluating your condition, it is essential that you bring the following with you to your office visit:

1. Your **insurance card**
2. A **picture ID**
3. **Applicable medical records**

If a referral is required by your insurance carrier, please make certain to contact your primary physician to have a fax sent to us at **212.241.1197** or, alternatively, submit the referral electronically.

Please contact us at **212.241.9728** with any questions regarding your appointment or directions to our office

We look forward to seeing you!

The Faculty and Staff
Department of Dermatology
The Mount Sinai Medical Center

Mount Sinai Doctors *Faculty Practice*

MOUNT SINAI DERMATOLOGY

5 East 98 Street, 5 Floor, Box 1048
New York, NY 10029
(212) 241-9728

OUR MISSION STATEMENT

The mission of the Mount Sinai Dermatology Department is to provide superior comprehensive dermatologic care to our patients and to exceed their expectations in service and satisfaction, as well as to advance the science of dermatology through research and education.
Our Department is at the forefront of research and care in ***skin cancer****,* ***psoriasis****,* ***mycosis fungoides*** *(cutaneous T cell lymphoma),* ***eczema, acne, vitiligo****, and in* ***medical****,* ***surgical****, &* ***cosmetic dermatology****.*

E-mail: Sinaidermatology@aol.com
Website: mountsinaidermatology.com

Mark Lebwohl, MD
Professor & Chairman
Department of Dermatology

Susan Bershad, MD
Associate Clinical Professor
Director, Division
Adolescent Dermatology

Julide Tok Celebi, MD
Professor, Dermatology & Pathology
Vice Chair, Dermatology

Annette Czernik, MD
Assistant Professor
Clinical Director of Dermatology

Lauren Geller, MD
Assistant Professor
Dermatology & Pediatrics
Director, Pediatric Dermatology

Gary Goldenberg, MD
Assistant Professor
Dermatology & Pathology
Medical Director, FPA Dermatology

Norman Goldstein, MD
Professor
Dir. Rockland County Dermatology Training Program

Emma Guttman, MD, PhD
Associate Professor,
Dermatology & Immunology
Dir, Center for Excellence in Eczema
Director, Occupational & Contact Dermatitis Clinic
Director, Laboratory for Investigation of Inflammatory Diseases

Suhail M. Hadi, MBChB., M.Phil.
Director, Visiting Fellowship Program
Department of Dermatology

Hooman Khorasani, MD
Assistant Clinical Professor
Chief, Division of Mohs, Reconstructive & Cosmetic Surgery

Soo Jung Kim, MD
Co-Director, Consultation Service
Dermatology

David A. Kriegel, MD
Associate Clinical Professor
Director, Dermatologic & Mohs Surgery

Angela J. Lamb, MD
Assistant Professor
Director, Westside Dermatology

Jacob O. Levitt, MD
Associate Clinical Professor
Vice Chair, Dermatology
Residency Director

Orit Markowitz, MD
Assistant Professor
Director, Pigmented Lesions and Skin Cancer

Robert G. Phelps, MD
Professor of Dermatology
Professor of Dermatopathology
Director, Dermatopathology

Helen Shim-Chang, MD
Assistant Professor
Dermatology & Dermatopathology
Director, Photodynamic Therapy

Heidi A. Waldorf, MD
Associate Clinical Professor
Director, Laser & Cosmetic Dermatology

Joshua A. Zeichner, MD
Assistant Professor
Director, Cosmetic & Clinical Research

Mount Sinai Doctors *Faculty Practice*

Department of Dermatology

Physician you are seeing:	**Appointment date**:

PATIENT INFORMATION

Last name:	**First**:	**Middle Initial**:	
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed		**Birth Date**:	**Sex**: ❑ M ❑ F
Street Address/PO Box:	**City**:	**State & Zip Code**:	
Email address:		**Social Security** #:	
Cell/Mobile phone: ( )	**Home Phone**: ( )	**Work Phone**: ( )	**Ext**:
Employer Name:	**Employer Address**:	**Occupation**:	
***Pharmacy Name**:	**Pharmacy Address**:		
Pharmacy Phone: ( )	**Pharmacy Fax**: ( )		

REFFERAL SOURCE

Referring Source (Please check all that apply): ❑ Physician/Clinic ❑ Family/friend ❑ Clergy ❑ Employer/Coworker ❑ 800-MD-SINAI ❑ Mount Sinai Website ❑ Insurance ❑ No Referring MD ❑Self ❑Radio ❑ **Other**:

❑ Check if this is a second opinion

Referring Physician's Name:

Referring Physician's Address:

Referring Physician's Phone: ( )	**Referring Physician's Fax**: ( )

INSURANCE INFORMATION

(Please present your insurance card to the receptionist.)

Person responsible for bill: ❑ Self	**Birth Date**: / /	**Address** (if different):	**Home Phone**: ( )
Occupation:	**Employer**:	**Employer Address**:	**Employer Phone**: ( )

Name of primary insurance:

Subscriber's Name: ❑ Self	**Birth Date**:	**Group #**:	**Policy #**:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

SECONDARY INSURANCE (IF APPLICABLE)

Name of secondary insurance:	**Subscriber's Name**:	**Group #**:	**Policy #**:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Please notify in case of emergency:	**Relationship to Patient**:	
❑ Check if address is the same as in patient information		
Address:	**City, State**:	**Zip**:
Home Phone: ( )	**Work Phone:** ( )	**Cell Phone:** ( )

Icahn School of Medicine at Mount Sinai
Department of Dermatology

Financial Agreement

We are committed to providing you with the best possible care and are pleased to explain our professional fees with you at any time. Your clear understanding of our Financial Agreement is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL ALSO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it *prior to* your appointment and to have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER and will be personally responsible for that day's services.
- **CO-PAYMENTS** – By law we MUST collect your carrier's designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit.
- **OUT OF NETWORK PLANS** – Since we do not 'participate with your plan, payment is expected at the time of service *unless* prior arrangements have been made with our financial staff including co-insurance, deductible and non-covered amount. We will send a courtesy bill to the carrier on your behalf.

Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Department of Dermatology for any services furnished. I understand I am financially responsible for any amount not covered by my health insurance contract. I also authorize any holder of medical information about me to be released to my insurance company (or their agent) concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MEDICARE** – We will submit claims to Medicare. You will be responsible for the deductible and the 20% co-insurance which can be billed to a secondary insurance if you have one.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to the Department of Dermatology for any services furnished to me. I authorize any holder of medical information about me to release it to the CMS (and its agents) to determine the benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** – The guarantor is responsible for payment of services rendered. The Mount Sinai Department of Dermatology cannot be involved with separation or divorce disputes.

You are responsible for the timely payment of your account. Our financial staff will work closely with you and your carrier to avoid sending any account to an outside agency to collect payment. We reserve the right to send delinquent accounts to an outside collection agency.

We accept CREDIT CARDS (MASTERCARD, VISA, or AMERICAN EXPRESS), CASH, or CHECKS. **Our preferred method of payment is by credit or debit card**.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share any special concerns you may have with a member of our staff.

Patient Name:	**Patient Signature**:	**Date of Birth**:
Patient Address:	**City, State**:	**Zip**:
Today's Date:	**Appointment Date**:	

Personal Representative Name:	**Personal Representative Authority**:	**Responsible Party Signature**:

Mount Sinai Doctors Fac

AUTHORIZATIONS AND ASSIGNMENTS

PLACE LABEL HERE

1. FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT (All Patients) ☐ Yes ☐ No (Please initial) _____

In consideration of services, assignment of benefits and care rendered; I agree that I am responsible for any and all charges billed by Mount Sinai Dermatology Associates with respect to such services and care unless the contract between the Physicians and my insurance company provides otherwise. In the event that the requested services are not specifically authorized by my insurance company, I agree to pay for all services as agreed upon, unless otherwise provided by law.

I authorize payment of medical benefits to which I am entitled directly to the Physicians, to cover the cost of the care and treatment rendered to myself or my dependents in the office.

Upon receipt of a medical bill, I agree to immediately pay all amounts not covered by insurance. If any insurance I have rejects my claim or pays part of the claim, I shall be responsible for payment of any balance as determined by Mount Sinai immediately upon learning of such coverage, unless otherwise provided by law.

2. RELEASE OF INFORMATION ☐ Yes ☐ No (Please initial) _____

In the event my insurer denies payment to the Physicians for services rendered to me, I hereby give my consent to have an authorized representative of the Physician to contact my insurer and to provide to my insurer all information and documentation regarding the services rendered to me by the Physicians which may be required in order for my insurer to reevaluate its decision to deny payment for such services.

I authorize this practice, my treating physician, and their respective designees to use and disclose my health information for all necessary treatment, payment and health care operations purposes. I acknowledge that my health information may include information relating to mental illness and/or AIDS/ARC/HIV and that any such information may be disclosed (including examination and copying in either hard copy or digital format) to insurers, various credit agencies and guarantors solely if needed for payment of the professional charges (no clinical information will be disclosed to any credit agency).

3. MEDICARE-RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS (Medicare only - Part B providers)

☐ Yes ☐ No (Please initial) _____

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information (including information relating to mental illness and/or AIDS/ARC/HIV) needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable to physician (s) and/or the (s) or organizations providing the service (s)

4. INSURANCE NETWORK/PROVIDER NOTICE PURSUANT TO NYS "OUT-OF-NETWORK" LAW

I understand that the Physicians may be participating providers in certain health plan networks, and that a list of the plans that the Physicians participate in can be found on their website or can be provided to me upon request.

I understand that the Physicians may not participate in the same health plans and networks as the hospitals and facilities in the Mount Sinai Health System even though the Physicians may be employed by or affiliated with hospitals or facilities in the Mount Sinai Health System. I understand that I can determine the health plans participated in by physicians who are employed or contracted by Mount Sinai to provide hospital services by visiting http://www.mountsinai.org/patient-care/find-a-doctor ; I also understand that I can also determine the health plans accepted by hospitals and facilities in the Mount Sinai Health System by visiting the facility's web portal.

I understand that the Physicians charge for their services separately from the hospitals and facilities in the Mount Sinai Health System, and that any bills from hospitals or facilities in the Mount Sinai Health System for so-called "facilities" or "technical" fees will be sent separately from the Physicians bills for their "professional" services.

I understand that it is my responsibility to check with the "physician" arranging for my services regarding: (1) whether the services of any other physicians will be required for my care; and (2) whether the services of any other physicians (including but not limited to anesthesiologists, pathologists, and/or radiologists) may be reasonably anticipated to be provided in connection with my care. I further understand that I can check with the "physician" arranging for my services to obtain the contact information and/or health plan participation information for any physicians or facility whose services may be needed in connection with my care, and that I can also contact those physicians directly to obtain information regarding their health plan participation.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE ITEMS.

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATED

_____ _____

RELATIONSHIP TO PATIENT WITNESS TO SIGNATURE

CONSENT FOR COMMUNICATION VIA E-MAIL (Provider-Patient)

I,

Patient's last name:	**First**:
E-mail Address:	

, hereby consent to have my physician,

Physician name:

, communicate with me or members of his staff, where appropriate or other physicians, nurse practitioners and pharmacists via e-mail regarding the following aspects of my medical care and treatment: [test results, prescriptions, appointments, billing, etc.]. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mails communications between my physician and me or members of my physician's office staff or between my physician and other physicians, nurse practitioners and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail communications between my physician and me or members of his office staff or between my physician and other physicians, nurse practitioners or pharmacists regarding my medical care and treatment will be printed out and made a part of my medical record. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail.

Patient Name:	**Patient Signature**:
Today's Date:	**Appointment Date**:

Personal Representative Name:	Personal Representative Authority:	Responsible Party Signature:

PATIENT HEALTH HISTORY

To help us give you the best possible care, please carefully complete all questions on this form. If you do not know the answer to a particular question, leave it blank. Thank you.

Patient's name

_____

1. **Have you ever had or been treated for any of the following**?

Duodenal or peptic ulcer …….	Yes	No
Other intestinal disease or colitis	Yes	No
Liver or gall bladder disease	Yes	No
Lung disease (TB, pleurisy, etc.)	Yes	No
Heart disease (rheumatic fever, pacemaker, etc.)	Yes	No
High blood pressure	Yes	No
Stroke	Yes	No
Kidney disease	Yes	No
Urinary or bladder problem or infection	Yes	No
Venereal disease	Yes	No
Blood or lymph gland disorder	Yes	No
Eye disease (cataract, cataract surgery)	Yes	No
Arthritis, joint problems or bone disease	Yes	No
Thrombophlebitis	Yes	No
Cancer	Yes	No
Frequent infections of the skin or other areas	Yes	No
Neurological disorder	Yes	No
Emotional or psychiatric problem	Yes	No

2. **Have you or any members of your family had any of the following**? **Please specify whom**.

Asthma …….	Yes	No	Self	Other _____
Hay fever	Yes	No	Self	Other _____
Eczema	Yes	No	Self	Other _____
Hives	Yes	No	Self	Other _____
Diabetes	Yes	No	Self	Other _____
Psoriasis	Yes	No	Self	Other _____
Skin cancer	Yes	No	Self	Other _____
Glaucoma	Yes	No	Self	Other _____
Other skin conditions	Yes	No	Self	Other _____

Please specify _____

3. **Have you or any members of your family had any of the following**? **Please specify whom**.

Excessive bleeding when cut	Yes	No	Self	Other _____
Difficulty with the healing of wounds	Yes	No	Self	Other _____
Overgrown scars or keloids	Yes	No	Self	Other _____
Allergy to local anesthetics	Yes	No	Self	Other _____

4. **Have you previously had a skin problem or been under the care of a dermatologist? If yes, please describe.**

_____

_____

_____

_____

5. **Social History**

Have you ever had a venereal disease? Yes No

Do you smoke? Yes No

If yes, how many cigarettes or packs per week? (Specify which) _____

Do you drink alcohol? Yes No

If yes, how many drinks do you consume on a weekly basis? _____

Are you married single other ? If other, please elaborate _____

_____

6. Have you ever been given X-ray or Grenz treatments for your skin? Yes No

7. Do you take any medicine, drugs or over-the-counter preparations or remedies? Yes No
(These might include medicines for sleep, constipation, headaches, birth control or "nerves.")

_____

_____

8. Are you allergic to any medicines, drugs or over-the-counter preparations or remedies? Yes No

9. Please provide details of any prior hospitalizations or surgeries:

Reason for **Hospitalization/Surgery**	**Dates of Hospitalization/Surgery**	**Outcome**

10. **For Women** Only

Have you ever had vaginal yeast infections? ..... Yes No

Are you pregnant? ..... Yes No

Are you currently planning a pregnancy? ..... Yes No

Are you nursing? ..... Yes No

NOTE The dermatologic examination which you are about to receive is NOT a complete physical exam. Therefore, we suggest you have a complete physical examination periodically by your family physician or internist.

Patient's Signature _____ **Date** _____

Physician Comments _____

_____

_____

_____ **Date** _____

Physician's Signature

THIS SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES (NOTICE), REVISED AS OF SEPTEMBER 2013, DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. MORE DETAINED INFORMATION IS CONTAINED IN OUR COMPLETE NOTICE. PLEASE REVIEW THIS INFORAMTION CAREFULLY.

Our Pledge to Protect Your Privacy

The Mount Sinai Hospital (MSH), including Mount Sinai Queens (MSQ); Icahn School of Medicine at Mount Sinai (ISM), including its Mount Sinai Doctors Faculty Practice (DEP), its owned off-site physician practices such as North Shore Medical Group (NSMG) and Mount Sinai Brooklyn Heights Medical Group (BHMG); and Mount Sinai Cares (collectively, "Mount Sinai" for purposes of this Notice) are required by law to protect the privacy of your health information. The privacy practices described will be followed by

- Any healthcare professional who treats you at any Mount Sinai location;
- All employees, medical staff, trainees, students or Volunteers at any Mount Sinai location;
- Any business associates of Mount Sinai and their subcontractors.

These privacy practices will be followed at sites of care associated with the Mount Sinai entities listed above. A list of current locations is included as Attachment E to the complete Notice and will be updated on our website (www.mssm.edu/HIPPA) as new locations are added or deleted

Only to the extent necessary, we will use and share your Medical information (PHI) to treat you, to conduct our Business operations, to collect payment for the services we Provided to you and to comply with applicable laws. (See Notice pp 6-8)

- For fund raising, although you will always have the right to opt out of receiving these communications at anytime by emailing us at philanthropyoptout@mountsinai.org, calling us at 212-659-8500 or writing us at One Gustave L. Levy Place, New York, NY 10029, Box 1049
- To support our research mission as an academic medical center with approval of Mount Sinai's Privacy Board
- For workers' compensation or similar programs;
- For required public health activities (e.g., Reporting abuse or adverse reactions to medications);
- For healthcare oversight (e.g., to the New York State Department of Health
- For law enforcement in certain limited circumstances
- To a coroner, medical examiner or funeral director as required by law
- For organ procurement or transplantation, if you are a potential donor.

We will not use or disclose your information for any other purpose without your permission.

You have the following rights to access and control Your PHI: (See Notice pp. 2-5)

- To inspect and obtain a copy in either electronic or paper form of your PHI. We will produce the records in the specific electric format that you request if it is feasible to do so.
- To request restrictions on certain uses or disclosures of your PHI. [For example, you may direct us not to share specific PHI with your insurance company if you plan to pay for a service personally without submitting a claim to your insurer. It is your responsibility to inform other providers who may receive copies of your record that they may not share this information with your insurance company.
- To request an accounting of Mount Sinai's Disclosures of your PHI
- To add an addendum or make an amendment to your medical record if you believe it is inaccurate or incomplete
- To request that we communicate with you in a certain way or at a certain location
- To receive a copy of the full version of our Notice
- To be notified within 60 days if your PHI has been disclosed to or accessed by a person who was not authorized to receive the information.

For more information about this Summary or the full Notice, please contact our Privacy Office at 212.241.4669.

Mount Sinai

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NOPP)

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospitals and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information.

Patient Name

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

I was not able to obtain the patient's acknowledgement of receipt of the NOPP upon registration because:

- ☐ *The patient refused to sign despite good faith efforts.*
- ☐ *The patient was unaccompanied and not alert and oriented.*
- ☐ *The patient was unaccompanied and needed emergency care.*
- ☐ *Other, (explain)*: _____

Employee Signature: _____ Employee Title: _____

Print Name: _____ Date: _____

- ☐ Acknowledgement subsequently obtained (see above)

Locations & Directions – 5 East 98th Street Office

The Mount Sinai Medical Center is located between 98th and 102nd Streets and between Madison and 5th Avenues.

By Subway

East Side: Take #6 train to 96th Street and Lexington Avenue. Walk west on 96th Street to Madison Avenue. Turn right and walk to 98th Street. Turn left to find the address.

West Side: Change for the B or C train to 96th Street Exit at 96th Street and take the cross town bus M96 or M106 one stop through Central Park to 96th Street and 5th Avenue. Walk N to 98th Street (From Downtown: Take the A train to 59th Street. Transfer to B or C train.)

By Public Bus

Take M1, M2, M3 or M4 Bus (5th Avenue Buses) traveling South to 99th Street stop. Take M1, M2, M3.or M4 Bus (Madison Avenue Buses) traveling North to 98th Street stop.

By Taxicab

Taxi northbound to Madison Avenue and 98th Street or southbound to 5th Avenue and 98th Street

By PATH Train

Take PATH Train (from NJ) to 33rd St. Transfer to N or R subway lines, 34th St. station. Take Uptown N or R to Lexington Ave. Transfer to #6 train at 59th St. station. Follow #6 train directions above.

By Car

- From **Brooklyn**

Take BQE to Brooklyn Bridge Exit or Brooklyn Battery Tunnel. Follow signs to FDR Drive North. Exit FDR Drive at East 96th Street. Follow traffic onto East 96th Street to Madison Avenue. Turn right on Madison Avenue.

- From **Staten Island**

Take Verrazano Bridge (Staten Island only) onto BQE North to Grand Central Parkway West and the Triboro Bridge to the FDR Drive. Exit at 96t Street and turn right on Madison Avenue.

- From **Queens**, **Long Island** and **parts of Brooklyn** (Triboro Bridge)

Take Grand Central Parkway (West) to Triboro Bridge to the FDR Drive. Exit at East 96th Street and turn right onto East 96th Street and continue to Madison Avenue. Turn right on Madison Avenue.

- From **Westchester** and **New England**

Take New England Thruway (**95 S**) to Triboro Bridge to the FDR Drive. Exit at East 96th Street. Turn right onto East 96th Street and continue to Madison Avenue. Turn right on Madison Avenue.

- From **Upstate New York**

Take NYS Thruway (**87 S**) to Major Deegan Highway (**same road**). Exit at Willis Avenue Bridge and bear right. Follow signs to FDR Drive. Exit at East 96th Street Turn right onto East 96th Street and continue to Madison Avenue. Turn right on Madison Avenue.

- From **New Jersey**

Lincoln Tunnel: Henry Hudson Parkway North (West Side Highway). Exit at 95th/ 96th Streets and travel across 96th Street through Central Park to Madison Avenue. Turn left on Madison Avenue.
GW Bridge: Henry Hudson Parkway South (West Side Highway). See Directions from Lincoln Tunnel.

By Train

- From **Penn Station** and **Port Authority Terminals**

Take the A train to 59th St. Transfer to the B or C train to 96th St. station. Exit at 96th St. and take the cross town bus M96 or M106 one stop through Central Park to 96th St. and 5th Ave. Walk north to 98th St.

- From **Grand Central Station** (East 42nd Street and Lexington Avenue)

Take #6 train to 96th St. and Lexington Ave. Walk west on 96th St. to Madison Ave. Turn right and walk to 98th St. Turn left to find the address.

- From **Metro North**

Take the Metro North to Grand Central Station. Follow Directions above.

PARKING: The Parking Garage is located on 99th Street between Madison and Park Avenues.