Department of Dermatology

Mount Sinai Faculty Practice
Doctors

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 98th Street, 5th 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****.*

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Director, Occupational & Contact
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Department of Dermatology

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Associate Clinical Professor
Director, Laser & Cosmetic
Dermatology

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

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:		
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 ❑ **Other**:

❑ *Check if this is a **second opinion***

Referring Physician's Name:	
Referring Physician's E-mail:	
Referring Physician's Address:	
Referring Physician's Phone: ( )	**Referring Physician's Fax**: ( )

OTHER TREATING PHYSICIANS

Primary Care Physician:	
Address:	Phone: ( )
Fax: ( )	
Specialist Physician(s):	
Physician Name:	Address:
Phone: ( )	Fax: ( )
Physician Name:	Address:
Phone: ( )	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 *Faculty Practice*

AUTHORIZATIONS AND ASSIGNMENTS

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

Mount Sinai Doctors *Faculty Practice*

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 _____

Occupation _____ **Hobbies** _____

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

_____

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

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 (specify)	☐ Yes	☐ No	☐ Self	☐ Other	_____

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

Please list _____ _____ _____

4. 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."

Please list _____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

5. 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	_____

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

Reason for Hospitalization/Surgery	Dates of Hospitalization/Surgery	Outcome

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

Gastrointestinal	☐ Yes	☐ No
Duodenal or peptic ulcer	☐ Yes	☐ No
Colitis	☐ Yes	☐ No
Stomach absorptive disorder	☐ Yes	☐ No
Nausea, vomiting, diarrhea when taking antibiotics	☐ Yes	☐ No
Liver or gall bladder disease	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
Lung disease	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Chronic cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
TB	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No

Stents	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Chest pain, heart murmur, irregular heart beat	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Kidney disease	☐ Yes	☐ No
Dialysis	☐ Yes	☐ No
Urinary or bladder problem or infection	☐ Yes	☐ No
Venereal disease	☐ Yes	☐ No
Have you had or ever been exposed to HIV or Hep C	☐ Yes	☐ No
Blood or lymph gland disorder	☐ Yes	☐ No
Eye disease (cataract, cataract surgery)	☐ Yes	☐ No
Arthritis, joint problems or bone disease	☐ Yes	☐ No
Artificial joint	☐ Yes	☐ No
Thrombophlebitis/ blood clots/vein inflammation	☐ Yes	☐ No
Cancer, other than skin cancer _____	☐ Yes	☐ No
Frequent infections of the skin or other areas	☐ Yes	☐ No
Neurological disorder/migraines	☐ Yes	☐ No
Epilepsy/seizures	☐ Yes	☐ No
Fainting	☐ Yes	☐ No
Psychiatric problems: Depression, anxiety, OCD, other _____	☐ Yes	☐ No

8. Social History - Marital Status Single ☐ Married ☐ Divorced ☐ Other ☐

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? _____

9. 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

Is there anything else you would like me to know? If so, use the space provided below.

_____

_____

_____

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, as well as your dentist and ophthalmologist (eye doctor). Women should be seen by a gynecologist on a yearly basis.

Patient's Signature _____ **Date** _____

Physician Comments _____

_____

_____

Physician's Signature _____ **Date** _____

Insert **Summary of Notice of Privacy Practice Page** here

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 5 East 98th Street.

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 north 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 Street. Transfer to N or R subway lines, 34th Street station. Take Uptown N or R to Lexington Avenue. Transfer to #6 train at 59th Street 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 Street Transfer to the B or C train to 96th Street station. 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 north to 98th Street

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

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 locate 5 East 98th Street.

- 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.