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****.*

E-mail: Sinaidermatology@aol.com
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Mark Lebwohl, MD
Professor & Chairman
Department of Dermatology

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Annette Czernik, MD
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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

Marsha Gordon, MD
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Emma Guttman, MD, PhD
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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, PhD
Co-Director, Consultation Service
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David A. Kriegel, MD
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Director, Dermatologic & Mohs Surgery

Angela J. Lamb, MD
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Director, Westside Dermatology

Jacob O. Levitt, MD
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Vice Chair, Dermatology
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Orit Markowitz, MD
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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*

PEDIATRIC AND ADOLESCENT DERMATOLOGY INTAKE FORM

Department of Dermatology

PATIENT INFORMATION

Patient Name _____ Date of Birth _____ Today's Date _____
Age _____ Gender – Male / Female
Address _____
Hone Phone Number _____ Cell Phone Number _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian 1 _____
Address _____
_____
Home Phone Number _____
Work Phone Number _____
Cell Phone Number _____

Parent/Guardian 2 _____
Address _____
_____
Home Phone Number _____
Work Phone Number _____
Cell Phone Number _____

Is it permissible to leave a message on voicemail on above provided numbers (it may contain personal health information)? Home: Yes / No Mobile: Yes /No

PEDIATRICIAN

Name _____ Phone Number _____
Address _____

REFERRING PHYSICIAN

[] check here if same as pediatrician listed above
Name _____ Phone Number _____
Address _____

PHARMACY INFORMATION

Name _____ Phone Number _____
Address _____

INSURANCE INFORMATION

Please have insurance identification card(s) available for office staff.

Primary Insurance _____
Claims Mailing Address _____
_____
ID Number _____
Group Number _____
Name of Insured _____
Relationship to Patient _____
Insured's Birth Date _____
Insured's Employer _____
Insured's Address _____
_____
Insured's Phone Number _____

Secondary Insurance _____
Claims Mailing Address _____
_____
ID Number _____
Group Number _____
Name of Insured _____
Relationship to Patient _____
Insured's Birth Date _____
Insured's Employer _____
Insured's Address _____
_____
Insured's Phone Number _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance, (see financial agreement). I also authorize the ***Department of Dermatology*** and/or insurance company to release any information required to process my claims.

Patient/Guardian signature	**Date**:

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

Patient Name _____ Date of Birth _____ Today's Date _____

BIRTH HISTORY (For patients under age 8)

Weeks gestation at birth _____ Birth weight _____

Vaginal delivery or C-section _____ If C-section, reason _____

Please list any problems with pregnancy, delivery or after birth _____

_____

MEDICAL HISTORY

Has your child ever had or been treated for any of the following? If yes, please describe.

Anemia	Yes / No	_____
Asthma	Yes / No	_____
Allergies / Hay Fever	Yes / No	_____
Arthritis	Yes / No	_____
Behavioral Problems	Yes / No	_____
Bleeding tendency	Yes / No	_____
Bowel Problems	Yes / No	_____
Cancer/Leukemia	Yes / No	_____
Chicken Pox/Shingles	Yes / No	_____
Developmental Disorder	Yes / No	_____
Diabetes	Yes / No	_____
Ear/Nose/Throat (ENT) Disorder	Yes / No	_____
Eczema/Skin Disorder	Yes / No	_____
Eye Disorder	Yes / No	_____
Growth Disorder	Yes / No	_____
Heart Disorder/Defect	Yes / No	_____
High Blood Pressure	Yes / No	_____
High Cholesterol	Yes / No	_____
Immune Deficiency Disorder	Yes / No	_____
Kidney/Urinary Disorder	Yes / No	_____
Liver Disease	Yes / No	_____
Seizures	Yes / No	_____
Thyroid Disorder	Yes / No	_____
Any Other?	Yes / No	_____

SURGICAL HISTORY

Has your child had any surgeries? Yes / No

If yes, please list surgeries and approximate dates _____

_____

MEDICATIONS

Does your child take any medications? Yes / No

If yes, please list current medications _____

_____

Does your child take non-prescription medications (vitamins, herbal supplements, etc.)? Yes / No _____

If yes, please list _____

ALLERGIES

Does your child have any allergies to medications? Yes / No

If yes, please list medications and reactions _____

_____

Does your child have any other allergies (environmental, food, latex, etc.)? Yes / No

If yes, please list allergies and reactions _____

Patient Name _____ Date of Birth _____ Today's Date _____

FAMILY HISTORY

Does your child have a family member with any of the following? Please specify family member's relationship to patient.

Asthma	Yes / No	_____
Allergies/Hay Fever	Yes / No	_____
Atopic Dermatitis (eczema)	Yes / No	_____
Psoriasis	Yes / No	_____
Skin Cancer	Yes / No	_____
Melanoma	Yes / No	_____
Dysplastic Nevi	Yes / No	_____
Thyroid Disorder	Yes / No	_____
Autoimmune Disorder (lupus)	Yes / No	_____
Inflammatory Bowel Disease	Yes / No	_____
Celiac Disease	Yes / No	_____
Vascular birthmarks	Yes / No	_____
Diabetes (If yes, specify Type 1 or 2)	Yes / No	_____

SOCIAL HISTORY

Parent 1 _____ Marital Status _____ Occupation _____

Parent 2 _____ Marital Status _____ Occupation _____

Does your child or anyone in your home smoke? Yes / No

Do you have any pets in your home? Yes / No _____

Do you have other children? Yes / No If yes, how many? _____ Ages _____

REVIEW OF SYSTEMS

Has your child had any of the following in the past month? Please circle all that apply or NONE.

Constitutional	Fever, Chills, Feeling Tired, Recent Weight Gain, Overweight, Recent Weight Loss	NONE
Eyes	Dry Eyes, Red Eyes, Itchy Eyes, Discharge from Eyes, Vision Problems	NONE
ENT	Ear Ache, Hearing Loss, Nosebleeds, Sore Throat, Hoarseness	NONE
Cardiovascular	Chest Pain, Palpitations, Fast/Slow Heart Rate, Leg Claudication, Leg Swelling	NONE
Respiratory	Shortness of Breath, Wheezing, Cough, Trouble Breathing with Exertion	NONE
Gastrointestinal	Nausea, Vomiting, Diarrhea, Constipation, Heartburn, Blood in Stool, Abdominal Pain	NONE
Genitourinary	Pain with Urination, Trouble Urinating, Genital Discharge, Abnormal Vaginal Bleeding	NONE
Musculoskeletal	Joint Pain, Joint Stiffness, Joint Swelling, Limb Pain, Limb Swelling	NONE
Integumentary	Skin Lesions, Skin Wound, Itching, Change in a Mole, Breast Pain, Breast Lump	NONE
Neurological	Headaches, Seizures, Dizziness, Fainting, Limb Weakness, Difficulty Walking	NONE
Psychiatric	Sleep Disturbance, Anxiety, Depression, Emotional Problems, Suicidal	NONE
Endocrine	Muscle Weakness, Feelings of Weakness, Hot Flashes, Deepening of the Voice	NONE
Heme/Lymph	Easy Bruising, Easy Bleeding, Swollen Glands	NONE

Other (Please Explain) _____

Female patients only: Age of first menses _____ Last menstrual period _____ Menses regular? Yes / No

NOTE: *The dermatologic examination your child is about to receive is NOT a complete physical exam. Therefore, we recommend that your child have a complete physical examination periodically by his / her pediatrician.*

Parent / Guardian Signature: _____ **Date**: _____

Finally, please indicate how you heard about Pediatric Dermatology at Mount Sinai. Check all that apply.

❑ Physician/Clinic ❑ Family/friend ❑ Clergy ❑ Employer/Coworker ❑ 800-MD-SINAI ❑ Mount Sinai Website ❑ Insurance ❑ No Referring MD ❑Self ❑Radio ❑ **Other**:

_____

For office use only:

I have reviewed all sections of the intake form.

Physician Signature: _____ **Date**: _____

Mount Sinai Doctors *Faculty Practice*

Lauren Geller, M.D.
Instructor, Dermatology and Pediatrics
Director, Pediatric Dermatology

Department of Dermatology
5 East 98th Street – 5th Floor
New York, NY 10029
T 212.241.9728 **F** 212.987.1197

PEDIATRIC AND ADOLESCENT DERMATOLOGY
CONSENT FOR TREATMENT OF A MINOR WITHOUT PARENT PRESENT

I give permission for my child to be medically evaluated and treated by **Dr. Lauren Geller** in my absence. My child will be accompanied by:

Name _____

Relationship to child _____

I give permission for Dr. Geller to share any relevant health information with the person who is accompanying my child.

Date _____

Patient's Name _____

Parent/Guardian's Name _____

Parent/Guardian's Signature_____

Phone number where parent/guardian can be reached _____
(Area Code)

03/11/14

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:

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)