

Ariel Ostad, MD PC  
897 Lexington Avenue New York, N.Y. 10065 Phone: 212-517-7900

## Patient Registration Information

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_  
STREET: \_\_\_\_\_ APT #: \_\_\_\_\_ Male  Female   
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ WORK PHONE : \_\_\_\_\_ CELL PHONE: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_-\_\_\_\_-\_\_\_\_ MARITAL STATUS: Married  Single  Other   
IN CASE OF EMERGENCY, PLEASE CONTACT: \_\_\_\_\_  
RELATIONSHIP TO YOU: \_\_\_\_\_ PHONE: \_\_\_\_\_  
EMAIL \*\*: \_\_\_\_\_ @ \_\_\_\_\_ \*\* May we send you educational information? YES  NO   
ARE YOU EMPLOYED? Yes  No  If yes, employer name: \_\_\_\_\_

Were You Referred By a Doctor? Yes  No  If Yes, please give us the contact information of your doctor below:

REFERRING MD NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

If no, how did you find out about us? Website  Family/Friend  Newsletter  Insurance Resources  Google Search

City Search  Magazine  If referred by a friend, please tell us who we can thank? \_\_\_\_\_

**PRIMARY INSURANCE NAME / CLAIMS ADDRESS:** \_\_\_\_\_

PHONE: \_\_\_\_\_

ID#: \_\_\_\_\_ GROUP #: \_\_\_\_\_

**ARE YOU THE POLICYHOLDER?** Yes  No  If not, please complete the information below on the policy holder.

INSURED'S NAME: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_-\_\_\_\_-\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ EMPLOYER PHONE: \_\_\_\_\_

**SECONDARY INSURANCE NAME/CLAIMS ADDRESS:** \_\_\_\_\_

PHONE: \_\_\_\_\_ ID#: \_\_\_\_\_ GROUP #: \_\_\_\_\_

INSURED'S NAME: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS # \_\_\_\_-\_\_\_\_-\_\_\_\_

### **AUTHORIZATION TO RELEASE INFORMATION:**

I hereby authorize Ariel Ostad, MD, PC, and its associate physicians and para-professionals, to bill the above referenced health insurance companies on my behalf for any/all services performed. I hereby assign all insurance payment benefits directly to this physician group should they accept assignment to my insurance carriers. I understand that any payments that I may receive directly, for services which were billed on my behalf by the physicians, must be turned over to the physician. I understand that I am financially responsible for any/all charges not payable by my insurance carriers. I hereby authorize the release of any information necessary to secure payment of benefits. I affirm that I have been offered a copy of the patient bill of rights and provider information and may ask for a personal copy to take with me.

\_\_\_\_\_  
PATIENT / LEGAL GUARDIAN SIGNATURE

\_\_\_\_/\_\_\_\_/\_\_\_\_  
DATE

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## Medical History Assessment

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Male  Female

Reason for today's visit: \_\_\_\_\_ Total Body Skin Check   
Other: \_\_\_\_\_  
(Please describe)

History of problem that brings you in today:

Site (skin area (s) involved): \_\_\_\_\_

Duration (how long has problem been present?): \_\_\_\_ Day(s) \_\_\_\_ Week(s) \_\_\_\_ Month(s) \_\_\_\_ Year(s)

Timing (has this been treated previously?): Yes  No  If yes, when? \_\_\_\_/\_\_\_\_/\_\_\_\_ (approx. if unknown)

Context (was a Biopsy done)? Yes  No  If yes, by whom? \_\_\_\_\_

Please check all that apply regarding the problem you are coming in for today:

**Quality (Change in):**

Size

Color

Elevation

Hardness

**Modifying Factors (History of):**

X-ray treatment

Ultraviolet light treatment

Arsenic exposure

Chronic scar

Immunosuppression

**Associated Symptom(s):**

Bleeding

Tingling/Pain

Ulceration

Infection

Itching

**Severity:**

No symptoms  Occasional symptoms  Constant symptoms

**Are you allergic to any medications?** Yes  No  If yes, please list:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**List all medications you are currently taking:**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

**Did you use indoor tanning during childhood or adolescence?** \_\_\_\_\_

Check all that apply to your overall health and add important information not mentioned:

**Please circle all that apply regarding your overall health and add other pertinent information:**

Skin	Hematologic	Lymphatic	Constitutional Symptoms	Eyes/Ears/Nose/Throat	Cardiovascular	Respiratory
Normal	Normal		None	Normal	Normal	Normal
Keloids	Anemia		Weight loss	Glaucoma	Angina	Asthma
Poor healing	Bleeding problem		Fever	Hearing Aid	Artificial heart valve	Emphysema
Skin problems	Enlarged lymph nodes		Other _____	Plastic surgery	Pacemaker	Other _____
					Hypertension	
					Heart attack	When: ____/____/____

Name: \_\_\_\_\_

Gastro-intestinal	Musculoskeletal	Neurological	Psychiatric	Endocrine	Infections
Normal	Normal	Normal	Normal	Normal	None
Stomach ulcer	Arthritis	Stroke	Depression	Diabetes	Hepatitis
Colitis	Artificial joint	Seizures	Anxiety attacks	Thyroid problems	HIV/AIDS
Other GI problems	Other _____				T.B. (Tuberculosis)

Other important medical information:

\_\_\_\_\_  
\_\_\_\_\_

**Past Medical History:**

Previous Skin Cancer? Yes  No  If yes, what type if known? \_\_\_\_\_

Any major illnesses not prior stated or Hospitalizations? Yes  No

If yes, please list \_\_\_\_\_

**Family History Skin Cancer:** Melanoma  Basal cell or squamous cell  None

**Social History:**

Do you wear glasses? Yes  No  Dentures? Yes  No  Contact Lenses? Yes  No

Do you smoke? Yes  No  If yes, how many packs/ day? \_\_\_ If you were a smoker, when stopped: \_\_\_/\_\_\_

Do you consume alcohol? Yes  Socially or Regularly (circle one) No  Never

History of alcohol or drug abuse? Yes  No  Addictions? Yes  No   
If yes, please describe: \_\_\_\_\_



Fine Lines & Wrinkles	
Lines around the Lips & Mouth	
Rough Texture of Skin	
Tired-looking or Uneven Skin Tone	
Dark Circles/Puffiness	
Sagging Skin	
Brown Spots/Freckles	
Excess Skin Eyelids/Neck	
Skin Hyperpigmentation	
Eyelashes: Fuller, darker, longer	
Unwanted Hair	
Acne Scars	
Unwanted Skin Veins	
Blood Vessels around Nose or Face	
Other:	

**Are you interested in receiving "skin celebration" gift certificates?**

Yes  No

**Please verify delivery preference:**

Email (address): \_\_\_\_\_@\_\_\_\_\_

Regular Mail

**Patient Signature:** x \_\_\_\_\_

**(Office use only)** Reviewed by: \_\_\_\_\_ (Personnel)

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## **Patient Financial Obligation**

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

### **In Network and Medicare Patients :**

If we participate with your insurance plan you will be responsible to pay for your co-pay, deductibles and/or co-insurance at time of service. You may also be responsible for payment of services related to conditions that are not covered by your Plan. If you have not met your deductible, you will be responsible for the amount of the deductible and whatever amounts the insurance company does not pay. If your insurance company denies payment or will only pay a portion of your medical bill, you, the patient is responsible for payment of services rendered and will be billed accordingly. Please be aware that your insurance carrier does not guarantee accuracy of its confirmation of coverage and benefits. In order to expedite this responsibility we request that you leave a credit card on file.

If you should undergo a biopsy in our office, your insurance carrier will be billed separately by the Lab. You will receive a separate bill from the Lab for any uncovered charges.

### **Out of Network and Self Pay Patients:**

Payment is due at time of service. As a courtesy to our patients, we will submit your paid claim to your insurance carrier; it is your responsibility to follow up with your carrier regarding your reimbursement. Patients should contact their insurance companies directly for any coverage questions they may have.

If you should undergo a biopsy in our office, your insurance carrier will be billed separately by the Lab. You will receive a separate bill from the Lab for any uncovered charges.

### **Payment Methods:**

For your convenience, we accept the following forms of payment: Cash, Check, Visa, MasterCard, Discover or American Express.

- It is office policy that a credit card is left on file as most insurance policies have deductible, co-insurance, and surgical co-insurance in addition to co-pays. Your ins company determines the exact amount after we have submitted your claim for payment. We will only charge your card for the amount which is your responsibility and your ins co will also send you a copy of the explanation of benefits.
- Your signature below provides authorization for our office to process payment (s) to this card for reasons as outlined above.

Please be advised that billing statements are sent out bi-monthly for your convenience. Any unpaid balance that exceeds 30 days will be sent to a collection attorney and will incur interest charges of 2% compounded monthly, as well as 20% collection cost. The patient/or guarantor will be held responsible for all associated costs including interest from the date of service.

I, \_\_\_\_\_ **have read the above disclaimer and fully understand my financial responsibilities to Dr. Ariel Ostad:**

Patient/Guardian Signature: x \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Credit Card# \_\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_

<p><b>AUTHORIZATION TO RELEASE INFORMATION:</b></p> <p>I hereby authorize Dr. Ariel Ostad to release to the insurance company named above any information acquired in the course of my examination or treatment</p> <p>SIGNED _____</p> <p>(if patient is a minor, signed by parent or guardian)</p>	<p><b>ASSIGNMENT OF INSURANCE BENEFITS:</b></p> <p>I hereby agree to full responsibility for all expenses incurred by or on account of this patient and hereby assign to Dr. Ariel Ostad any and all insurance benefits due me to the fullest extent of my financial obligation to said office.</p> <p>SIGNED _____</p> <p>(if patient is a minor, signed by parent or guardian)</p>
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## Notice of Privacy Practices

This notice describes how information about you as a patient of our practice may be used and disclosed as well as how you can access your health information. This is stipulated by the Privacy Regulation created by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We are committed to maintaining the privacy of your health information and we are required by law to ensure the confidentiality of your health information. These laws are complex therefore we have provided below the important information we are required to provide for your understanding. The following circumstances may require us to use or disclose your health information:

**To Provide Treatment:**

We will use your PHI (private health information) within our office to impart the highest quality healthcare possible. This may include administrative & clinical office procedures to schedule & coordinate care between physician, technician, nurse, medical assistant and business office staff. This also includes pathology laboratories, pharmacies or other healthcare personnel involved in your treatment and care. It may be necessary to release your test results to authorize healthcare providers treating patients even when the provider requesting results did not originally order the tests.

**To Obtain Payment:**

We may include your health information with an invoice in order to collect payment for treatment you received in our office. This may include insurance forms filed for you by mail or electronically. Our office makes a concerted effort to work only with companies that maintain similar standards to protect and maintain the security of your health information.

**To Conduct Healthcare Operations:**

Your health information may be used during staff performance evaluations, during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews i.e. JCAHO. Your PHI may be reviewed during the routine processes of certification, licensing or credentialing activities.

**Communications:**

As regular follow-up is essential to your health, we customarily remind patients of scheduled appointments as well as make contact to communicate to you that it is time for you to contact us to schedule an appointment. Methods of communication consist of postcards, letters, emails and phone. We may share your PHI with those individuals you inform us will be assisting you with your home needs, medications or financial responsibilities. You are welcome to request specific limitations and or restrictions with regard to the manner in which this information is shared and with whom it can be shared i.e. contact to be made at home rather than at work etc. We will make every attempt to comply with and honor your wishes.

\_\_\_\_ (Initial) **RELEASE OF MEDICAL INFORMATION I do / do not** (circle one) authorize Dr. Ariel Ostad and its designated representatives to release medical information to (print name) \_\_\_\_\_ Relationship \_\_\_\_\_

**Required by Law:**

We may disclose your PHI to public health authorities and health oversight agencies that are authorized by law to collect information when required to do so by law enforcement officials, lawsuits and similar proceedings in response to a court or administrative order. This oftentimes occurs when it becomes necessary to reduce or prevent a serious threat to your health & safety, that of another individual, the public or for Worker's Compensation and similar programs.

Our patient medical records are kept confidential, secure and out of reach by unauthorized persons. All reports, consultations and correspondence are reviewed by Dr. Ariel Ostad prior to being filed in the medical record. A written release signed and dated by the patient/guardian must be obtained prior to the release of medical record information to comply with Privacy Regulations.

I have read and understand the content of this Notice of Privacy Practices. My signature below serves as my consent for your office to use and disclose my PHI as outlined above to facilitate and orchestrate my treatment and care at the highest standard.

Patient/Guardian Signature: x \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\*\*Specific Restrictions: \_\_\_\_\_  
\_\_\_\_\_

**Interpreted by:** \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name

**E-Prescribing Consent Form**

Patient's Name \_\_\_\_\_

Patients Account# \_\_\_\_\_

Ariel Ostad, M.D., P.C. is in the process of implementing ePrescribing:

- \* ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011
- \* ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.
- \* ePrescribing software also lets your doctor see important information - like drug interactions and your prescription history.

**Patient benefits:**

- Less confusion over handwritten prescriptions or unclear phone calls
- Reduced possibility of medical errors
- Less chance of adverse drug reactions
- Fewer trips to drop off at the pharmacy
- A safer, faster, easier way to get your prescription filled

**Patient Consent:**

I agree that Ariel Ostad, M.D. P.C. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. This consent form will be updated on an annual basis.

Please provide our office with your **pharmacy name (s)**, address, phone number/ fax number.

Pharmacy Name: _____
Address: _____ _____
Ph#: _____ - _____ - _____
Fax#: _____ - _____ - _____

Pharmacy Name: _____
Address: _____ _____
Ph#: _____ - _____ - _____
Fax#: _____ - _____ - _____

x \_\_\_\_\_

(Patient Signature)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Date