PARK AVENUE DERMATOLOGY (PAD) Dominick Ligresti, MD

Patient Registration Form

□ New Patient □ Name Change □ Address Change □ Insurance Change

IMPORTANT: Please present ALL Insurance cards to the receptionist. If patient is a minor and you are not the legal guardian, speak with the receptionist immediately

Would you like a complementary COSMETIC CONSULTATION during your visit today? Yes____ No____

Patient Information: **Please Complete All Fields Using Legal Names of the Parties Involved.**

Name: First________________________**MI**____ **Last** ____

Date of Birth:________ **Age:**___ **Social Security #:** ___-___-___ **Occupation:** ____________**Sex:** □ **Male** □ **Female**

Mailing Address: ____________________________ **Apt #:** ___ **City:**______________ **State:**____ **Zip:**________

Cell Phone: _____________ **Work:**_____________ **Home:** _____________ **E-mail:** ________________________

Marital Status (Please Circle): Single Married Separated Divorced Widowed

Pharmacy Name: ____________________ Address/Town: ___________________________Phone______________

Referring Physician or Primary Doctor Name: ____
Address/Town: ____ Phone #: _______________________________

How did you hear about us (Please Circle): Internet/Website | Advertising | Ins.Co. | Friend/Relative (Name________)

Insurance Information:

PATIENT IS RESPONSIBLE FOR INFORMING OUR OFFICE OF PARTICIPATING LAB:__________________________

Primary Insurance Carrier Name: ____
Name: First_____________________MI___ Last____
Date of Birth:________ SS#: ________ - ________-_______ Relationship to the Patient:__________________________
Mailing Address:____
Cell Phone: ________________________Home:_______________Work:_____________________________________

Secondary Insurance Carrier Name: ____
Annual Deductible: **$**_________ **Co-pay: $**_____________
Does this insurance require a referral? ***Yes*** ____ ***No***____

EMERGENCY Contact Person:

Name________________________________ **Phone #:**___________________________________

Patient Release: Must be signed by patient if over 18 or by legal guardian of patient under 18.
I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process Insurance claims to insurance companies or their agencies (including Medicare) for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider.
I certify that I hereby authorize Ligresti Dermatology Associates, its providers and staff to provide my minor child in my absence with examinations and basic treatments for which additional consents are not required. I understand as the legal guardian of this child I am required to be physically present to consult with the provider on any procedures which required separate consent such as surgery, biopsy, or ward destructions. I understand additional written consent maybe necessary for these types of procedures and the legal guardian must be present for such consent.

Signature:________________________ **Date:**______________________

PARK AVENUE DERMATOLOGY (PAD) Dominick Ligresti, MD
PATIENT ACKNOWEDGEMENT OF OFFICE POLICIES

APPOINTMENT CANCELLATIONS:

If I am unable to keep my scheduled appointment, I will call the office (PAD) to cancel or re-schedule my medical appointment at least 24 hours in advance. If I do NOT call PAD as outlined above, I understand I will be required to pay **a $50 no-show fee.** You can call or e-mail us at parkavederm@hotmail.com

CO-PAYMENTS:

Co-payments are due and collected on the day of my or my family's appointment. It is my responsibility to know my co-payment amount. Returned Checks (NSF) or stopped payment on credit card --ALL FEES WOULD BE PAID BY THE PATIENTS $35 to $50 depending on bank. Due to Obamacare there are very high deductibles and co-insurance payments required to be paid by patients as a result we are collecting nominal amounts for patients whose high deductibles were not met. After both patients and practice will receive balanced bill (EOB) we would reimburse patient any amount we owe to them.

INSURANCE REFERRALS:

If my insurance plan requires a referral, I understand it is my responsibility to obtain an updated referral from my Primary Care Provider and to make sure that PAD has the referral before my visit. I understand it is my responsibility to keep track of the number of visits I have used on the referral and the expiration date and obtain new ones as needed. I understand should I fail to have a valid referral for my visit, PAD is not authorized to see me. It will be my decision to either re-schedule my visit or be seen that day and be considered a self-paid patient and will be responsible for all charges incurred. I understand my insurance company will not over any visit where a valid referral is not in place. Also it is patients responsibility to call their insurance to make sure that doctor is in network as insurance can drop coverage at any time

INSURANCE CARDS:

We require you to confirm your insurance is current at each office visit and that doctor is in network (if you don't want to pay higher out of network deductibles). New patients or existing patients with a change in their insurance information must provide a valid insurance card or temporary print out at the time of the visit. Should you be unable to produce this documentation, you may pay in full at the time of the service and submit the claim to your insurance company yourself. I understand that in signing below, I am responsible for notifying PAD of any changes to my insurance or contact information and if my plan requires a referral. If the insurance information or referral information I present at my visit is not correct, I understand I am responsible for all charges. None of the above-mentioned requirements causing patients to pay their bill are considered to be a "surprise bill". It is a contractual agreement among insurance, patient and doctor.

ACCOUNT BALANCES:

I am responsible for the timely payment of my account balances, co-insurance and deductibles. All balances are due within 30 days of my first billing. Any balance left unpaid after 90 days without attempt at resolution will be considered for collections and may be submitted to a collection agency with will make reports to agencies that will affect my credit. If I am having financial difficulty, I understand I may contact the billing office to discuss a reasonable payment plan. If my account is sent to collections, I understand there will be an additional 15% of the total charges added to the principle balance for administrative fees as well as attorney and court charges. There is no guarantee of payment until claim is submitted and processed. If the claim is denied for any reason or if I have a deductible I will be fully responsible for the balance due at the contracted rate according to agreement with my insurance company.

COLLEGE STUDENTS:

If you are a college student on your parents' insurance plan, your insurance company will require a form to be completed confirming your student status. These forms are mailed to your home and must be completed and returned within 30 days. If these forms are not returned within the time frame, your claims will be denied and the policy holder will be responsible for all charges incurred.

HIPAA PRIVACY POLICY:

Patients are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of PAD from discussing appointments, medication, test results or treatment pans with anyone other than the patient. Often, this causes difficulty for some patients who would like family member or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below.

Name of Individual (please print)	Relationship to Patient	Phone Number
1		
2		

I acknowledge I understand the above policies and I have received a copy of the practice' Notice of Privacy Practices (if requested) related to Health Insurance Portability and Accountability Act of 1996.

Patient or Guardian Signature: X________________________ Date:__________

PARK AVENUE DERMATOLOGY (PAD) Dominick Ligresti, MD

Health History Questionnaire

Patient's Name: ________________ **Date of Birth:** ____________ **Age:**______

Height: ______________________ **Weight:**_________________ **Today' Day:** ________

Have you had any of the following conditions in the PAST and/or PRESENT:

Medical Conditions	Check if YES	Condition	Check if YES
Acne		Numbness/Tingling	
Actinic Keratosis		Poor Healing of Wounds	
AIDS		Psoriasis	
Anemia		Sarcoid	
Anxiety		Seizure/Epilepsy	
Atrial Flutter/Fibrillation		Skin Bruises Easily	
Atpical Moles		Squarmous Cell Carcinoma	
Basal Cell Carcinoma		Stroke/TIA	
Bleeding/Clotting disorder		Sun sensitivity and swelling	
Breast lumps or masses		Sweats	
Bumps under the skin		T-Cell Lymphoma	
Changes in skin lesion		Thyroid Disease	
Cold Sores		Warts	
Dermatitis		Weight Gain	
Diabetes		Weight Loss	
Dry eyes		Wheezing	
Dry skin		**Other (please list)**	
Eczema			
Fever		Frequency Buring	
Glaucoma		Nausea, vomiting, diarrhea when taking antibiotics	
Hair Loss		Yeast Infection when taking anibiotics	
Heart Arrhythmia		Gastrointestinal/Stomach absortive disorder	
Heart Murmur		Arthritix/Join Deformity	
Heart Palpitations		Arthralgia	
Heat Disease		Limited Motion	
Hepatitis		Artificial Join	
Herpes Simplex		Convulsions or Epilepsy	
Hirsutism			
HIV Infection			
Inflamed Skin			
Itching eyes			
Itchy skin			
Keloid			
Kidney Disease			
Lupus			
Melanoma			
Mitral Valve Prolapse			

Have you had any of the following Surgeries in the PAST:

Medical Conditions	Check if YES
Cataracts	
Endoscopy	
Heart Bypass Surgery	
Heart Valve Replacement	
Hernia Repair	
Join Replacement	
PACEMAKER	
Other (please list)	
Personal Habits:	
Do you use a tanning bed?	
Have you had sunburn or sunburn blisers?	
Do you smoke?	
Do you drink alcohol?	
Do you use drugs?	
Medications:	
Are you taking Coumadin?	
Are you taking Aspirin?	
Are you taking Vitamin E?	
Family Medical History:	
Acne	
Allergies (Seasonal)	
Atypical Moles	
Basal Cell Carcinoma	
Eczema	
Lupus	
Melanoma	
Psoriasis	
Sarcoid	
Squmous Cell Carcinoma	
Other:	
Are you pregnant?	
Are you nursing?	
Do you plan on becoming pregnant?	

List any allergies to medications: ____

Current Medications including Prescription, Over the Counter, Herbal and Vitamins:

1. ______________________________ Dosage__________ Directions______________________
2. ______________________________ Dosage__________ Directions______________________
3. ______________________________ Dosage__________ Directions______________________
4. ______________________________ Dosage__________ Directions______________________
5. ______________________________ Dosage__________ Directions______________________
6. ______________________________ Dosage__________ Directions______________________
7. ______________________________ Dosage__________ Directions______________________
8. ______________________________ Dosage__________ Directions______________________
9. ______________________________ Dosage__________ Directions______________________

Are you currently receiving any treatment for any specific skin diseases? If yes please list name of the physician and medications:

____

____

Patient's Signature ______________________ **Date** ______________________

Park Avenue Dermatology
Dominick Ligresti, MD
Steve Sekiya, DO
Certified American Board of Dermatology
Clinical Assistant Professor of Medicine in Dermatology at Mount Sinai School of Medicine
Fellow, American Academy of Dermatology
Cosmetic, Adult & Pediatric Dermatology & Laser Surgery
Office Ph: 718-981-5040; Fax: 718-981-3331; www.ParkAvenueDermatologyOFFICE.com

Quality of Life Questionnaire- ALLERGIES

Patient's Name: ______________________________ DOB: ____________________

1. Have you ever been diagnosed Allergies? YES __ NO __
2. Are you currently taking or have you within the last year or have been prescribed an over-the-counter or prescription strength medication for allergies, hay fever, or nasal congestion? YES __ NO __

If yes, please list all that apply:

____

3. Have you ever been diagnosed with asthma? YES __ NO ___
4. Is our doctor currently treating your asthma with medications? YES __NO__

If yes, please list all that apply:

____

5. Please check any/all of the following symptoms that you experience more than three times in a month or for more than three consecutive months. Please note that in the case of seasonal allergies, you may not be experiencing those now, but may experience those now, but may experience them regularly during a different season of the year.
   Please check all that apply:

- ☐ Stuff Nose
- ☐ Runny Nose
- ☐ Nasal Congestion
- ☐ Itchy Eyes
- ☐ Water Eyes
- ☐ Itchy Throat
- ☐ Sore Throat
- ☐ Cough
- ☐ Post Nasal Drip
- ☐ Headache
- ☐Trouble Sleeping
- ☐ Fatigue

Park Avenue Dermatology

Dr. Dominick Ligresti, MD

Dr. Steve Sekiya, DO

Certified American Board of Dermatology
Clinical Assistant Professor of Dermatology at Mount Sinai School of Medicine
Fellow, American Academy of Dermatology
Cosmetic, Adult & Pediatric Dermatology & Laser Surgery
31 Tioga Street, Staten Island, NY 10301
Office Ph: 718-981-5040; Fax: 718-981-3331; www.ParkAvenueDermatologyOFFICE.com

FOR ALL PATIENTS/GUARDIANS PARTIES

As you are aware, most of the new and renewed insurance plans with the passage of the OBAMACARE have extremely high office and hospital deductibles, in addition to co-payments and or co-insurances. All patients with commercial insurances will receive from their insurance company balanced bill which they are required to pay via check, cash or credit card.

OUR OFFICE POLICY mandates that all insured patients leave a valid credit card or equivalent on file with our office so that we can bill such card only if there is unpaid balance by your insurance company. We would charge your card once we receive explanations of benefits detailing your personal responsibility from the carrier, only after the claim is processed, this may take 3 days to 3 months or in some cases even longer. We would call you first and WILL ONLY bill your credit card what the insurer indicated to us is YOUR PERSONAL FAMILY RESPONSIBILITY as you wouldn't book a hotel or rent a car without leaving your credit card/debit card info in advance. Your information is safe with us.

THEREFORE:

AS PER OFFICE POLICY OF LIGRESTI DERMATOLOGY ASSOCIATES AND PARK AVENUE DERMATOLOGY, I ALLOW THIS OFFICE TO HOLD AND STORE MY CREDIT CARD ON FILE, AND ALLOW HIS OFFICE TO BILL TO MY CREDIT CARD ANY UNPAID CO-PAYS, CO-INSURANCE AND/OR DEDUCTIBLE AS DOCUMENTED BY NJ OR NY INSURANCE COMPANY FOR ALL DATES OF SERVICES. I WOULD RECEIVE INSURANCE EXPLANATION OF BENEFITS AND A RECEIPTS OF PAYMENT.

Name on card ______________________

Billing Address ______________________

____

Credit Card Type/ Debit Card Type
( ) Visa
( ) Master Card
( ) American Express

Credit Card Number ________________________________ **Expiration Date** ______________
CVC Number ________________ **(Last 3 digits on the back of card or 4 digits on face of AmX Card)**

____ ________________________________

NAME/SIGNATURE DATE