

WELCOME TO OUR OFFICE

Your Appointment is _____ at _____ with Dr. _____

(You will be receiving an automated appointment reminder call 2 days prior to your appointment. Please be sure we have the correct telephone number to contact you and or leave a message.)

Our medical staff and office personal want to take this opportunity to acquaint with our office policies in order to make your visit with us as pleasant as possible. We are committed to providing you with the finest in personal service and healthcare.

NEW PATIENT VISIT FORM:

Please complete the enclosed new patient visit forms (4 pages) and bring the completed forms with you on the day of your appointment. If it is more convenient you can mail in the completed forms. *Please answer all questions.*

OFFICE HOURS:

Office hours are by appointment only. Appointments can be scheduled from 8:00 AM to 4:30 PM Monday through Thursday and Friday 7:30 AM to 1:30 PM. We ask all New Patients to arrive 15 minutes prior to your scheduled appointment to facilitate the registration process. Our goal is to allow the appropriate amount of time for each patient. However, sometimes a particular case is more complex than anticipated and more time may be required. We ask your patience in understanding that scheduled appointment times are approximate. If you are unable to keep your appointment please call **203-789-1249** at least 36 hours in advance to reschedule. There will be a fee of \$50.00 for appointments not cancelled with appropriate notice.

REFERRALS and COPAYMENTS (for HMO and Managed Care Patients):

If your insurance is an HMO or other managed care plan which requires a referral for a specialist visit, it is your responsibility to get the referral from your primary care physician. Please have the referral made out to the physician you are scheduled to see. Co-payments are due at the time of visit. We do not bill for co-payments. For your convenience we accept credit cards, checks and cash.

LATENESS:

We strive to see patients on time. Arriving late for an appointment may require rescheduling. Every effort will be made to accommodate you with a rescheduled appointment.

PRESCRIPTION REFILLS:

Prescriptions are filled at the time of your appointment. If a refill is required at another time please have your pharmacy fax us a written request to 203-776-6188. Please allow 72 hours call back time for refills. Prescriptions requested after hours will be reviewed on the next business day and be processed as stated above. If you have not been seen in a year or more, your prescription will not be filled. You will need to make a follow up appointment.

Yale Dermatology Associates, PC ~ 2 Church St South ~ New Haven CT 06519

PATIENT REGISTRATION FORM- Please print

Patient Information

Name _____
Last First Middle Initial

Address _____
Street City State Zip

Phone # _____ Phone # _____
home cell

Date of Birth _____ Sex _____ SS# _____

Parent or responsible party (if different from patient)

Name _____
Last First Middle Initial

Address _____
Street City State Zip

Phone # _____ Phone # _____
home cell

Date of birth _____ Sex _____ SS# _____

Insurance Information (please present insurance card at time of visit)

****Insured is the name of the person who carries the insurance, not always the patient****

Primary Insurance Carrier: _____

Relationship of patient to insured: self spouse child other

Name of Insured _____

Insured DOB _____ ID # _____

Group Number _____

Secondary Insurance Carrier: _____

Relationship of patient to insured self spouse child other

Name of Insured _____

Insured DOB _____ ID# _____

Group Number _____

Referring Physician:

Name address telephone

Primary Care Physician:

Name address telephone

Emergency Contact: _____ relation _____ Phone # _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _____ **Date** _____

Copy of insurance card (both sides) attached

Updated By: _____

MEDICAL HISTORY

1. Do you have or have you had any of the following conditions?

	Yes	No		Yes	No		Yes	No
Diabetes			High Blood Pressure			Chest Pain		
Asthma			Artificial Joint/ Valve			Pneumonia		
Rheumatic Fever			Immunosuppression			Kidney Disease		
Hepatitis			Emphysema			Cancer		
Glaucoma			Organ Transplant			Stroke		
Seizures			Heart Disease					

Other:

2. List any past illness or surgery for which you were hospitalized.

Operation/Illness	Year
.....
.....
.....

3. List and describe any Allergies to medications and other substances.

.....

4. List any current medications (include prescription and non prescription drugs).

Medication	Dosage
.....
.....
.....

5. Do you use tobacco? Yes No If yes, how much?

6. Do you use alcohol? Yes No If yes, how much?

7. Have you received a blood transfusion? Yes No If yes, when?.....

8. Have you had a recent weight loss? Yes No If yes, how much?

9. What is the reason for today's visit?

10. Have you received any treatment for skin cancer in the past? Yes No

If yes, type and treatment date.....

**Yale Dermatology Associates, PC
No Show Policy**

Patient Name: _____ Account: _____

We are committed to meeting our patients' health care needs. No-show and late cancellations waste precious time that other patients could use.
Please be advised of our office policy.

All appointments must be cancelled by noon of the previous day (or by 10:00 AM Friday for a Monday appointment) to avoid charges for a no-show or late cancellation. PLEASE NOTE: Insurance does not cover charges for no-show/late cancellation fees; therefore, the patient is responsible for payment

~ A NO SHOW fee of \$50.00 will be charged to the patient ~

Billing Questions:

If you have any questions regarding billing, please call our office at 203-789-1249 x 103 during regular office hours.

I have received a copy of this document and understand that I will be financially responsible for the following:

- All missed scheduled appointments that are not cancelled as described in the policy above.

Patient/parent/legal guardian signature

Date

Thank you for your continued support of our practice

If you believe we have made an error in scheduling or you believe you deserve special consideration, please call or provide an appeal in writing for consideration

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. If you have any questions, please contact our Practice Manager at the address or phone number at the end of this notice.

Our pledge to you:

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of care and services you receive to provide quality care and to comply with the legal requirements. This notice applies to all records of your care generated by Yale Dermatology Associates, P.C. We are required by law to:

- Keep medical information about you private,
- Give you this notice of our legal duties and privacy practices with respect to medical information about you, and
- Follow the terms of this notice that are currently in effect.

How we may use and disclose medical information about you:

- We may use and disclose medical information about you without your prior authorization for treatment (such as sending medical information about you to a specialist as part of a referral) and this may include psychiatric or HIV information needed for the purpose of your diagnosis and treatment), to obtain payment for treatment (such as sending billing information to your insurance company or Medicare), and to support our healthcare operations (such as comparing patient data to improve treatment methods or for professional education purposes). (Note: only limited psychiatric or HIV information may be disclosed for billing purposes **without your authorization**).
- Other examples of such uses and disclosures include contacting you **for appointment reminders** and telling you about or recommending **possible treatment options, alternatives, health-related benefits or services** that may be of interest to you.
- We may use or disclose medical information about you **without** your prior authorization for several other reasons. Subject to certain requirements, we may give our medical information about you (without prior authorization) **for public health purposes, abuse or neglect reporting, health oversight audits or inspections, medical examiners, funeral arrangements and organ donation, workers' compensation purposes, emergencies, national security and other specialized government functions, and for members of the Armed Forces as required by Military Command Authorities**. We also disclose medical information when **required by law**, such as in response to a request from **law enforcement** in specific circumstances, or in response to valid judicial or administrative orders or other **legal process**.
- We may disclose medical information about you to a friend or family member whom you designate or in appropriate circumstances, unless you request a restriction. We may also disclose information to disaster relief authorities so that your family can be notified of your location and condition.
- Under certain circumstances, we may use and disclose health information about you for research purposes, subject to an approval process.
- In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize or disclose, you can later revoke that authorization by notifying us in writing about your decision.

Right to Access and or Amend Your Records:

- In most cases, you have the right to look at or get a copy of medical information that we may use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.
- If you believe that information in your record is incorrect or that important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides the reason for requesting the amendment. We could deny you request to amend a record if the information is not maintained by us; or if we determine that your record is accurate. You may submit a written statement of disagreement with a decision by us not to amend a record.

Right to an Accounting:

- You have the right to request a list accounting any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and healthcare operations, circumstances in which you have specifically authorized such disclosure, and certain other exceptions.
- To request this list of disclosures, indicate the relevant period, which must be after April 13, 2003, but in no event for more than the last six years. You must submit your request in writing to the Practice Manager listed below.

Request for Confidential Communications:

You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

Changes to this Notice:

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. Before we make significant changes in our policies, we will change our notice and post the new notice in the waiting area. You can receive a copy of the current notice at any time. The effective date is listed at the end. Copies of the current notice will be available each time you come to our facility for treatment. You will be asked to acknowledge in writing your receipt of this notice.

Complaints:

- If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact the Practice Manger listed below.
- If you are not satisfied with our response, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Practice Manager can provide you the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Practice Manager
Karen Piscitelli
2 Church Street South Suite 305
New Haven CT 06519
(203)789-1249 x 103

Yale Dermatology Associates, P.C.

Print name of patient: _____

Relationship to Patient: _____
example: self, mother, father, legal guardian, other (specify)

Do you give our office permission to discuss your medical information with family members? Yes No

If yes, please provide us with their names and phone numbers below:

Name/relationship	phone number
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Name/relationship	phone number
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May we leave personal medical information on your:

Answering Machine? Yes No

Cell Phone voice mail? Yes No

May we e-mail personal medical information to you? Yes No

E-Mail address: _____

My signature below indicates I have received and/or reviewed a copy of the Privacy Practice Policy of this office and have agreed to the release of my health information as indicated above.

Patient or Responsible Party Signature	Date
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