DERMATOLOGY SERVICES OF KINGSTON, P.C.

KINGSTON MEDICAL ARTS BUILDING—SUITE 105
368 BROADWAY, KINGSTON, NY 12401-5159
TEL:(845) 338-7472 FAX:(845) 338-0538

MARIE-LOUISE JOHNSON, M.D., PH.D
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ABIGAIL BRENKACH, P.A.

Dear Patient

The physicians and staff would like to welcome you to the practice. We thank you for giving us the opportunity to participate in your healthcare.

There are several forms enclosed with this letter which we would ask you to fill out before your first visit with us. Please bring the paperwork, your insurance card, a photo ID, your copay (if applicable) and any insurance referral from your primary doctor. Referrals are the responsibility of the patient and we will have to reschedule your appointment if a referral is not provided.

Please be aware that obtaining a referral is the responsibility of the patient. If your insurance plan requires a referral, please contact our office to ensure that the proper referral has been received prior to your visit. If a referral has not been received you will be asked to reschedule your appointment or pay for the visit out-of-pocket.

We have a long waiting list of patients needing care. If you need to reschedule or cancel your appointment, kindly give 24 hours notice by calling 845-338-7472.

Patient registration is located at the main reception desk located in Suite 105. Please be aware that there is free parking at our facility. We look forward to seeing you.

Sincerely,

Dermatology Services of Kingston, P.C.

368 Broadway, Suites 104 & 105, Kingston, NY 12401

Date: _____

Name: _____Date of Birth: _____

Address: _____
Street/P.O. Box City State Zip Code

Home Telephone #: _____ Work Telephone #: _____ Cell #: _____

Email Address: _____

Parent/Guardian Name (if patient is a minor): _____ Telephone #: _____

Emergency Contact: _____ Telephone #: _____

How did you hear about us? _____

INSURANCE INFORMATION

Full Name of Insured: _____ Relationship to Patient: _____

Insured's Address: _____
Street/P.O. Box City State Zip Code

Home Telephone #: _____ Work Telephone #: _____ Cell #: _____

Insured's Date of Birth: _____

MEDICAL INFORMATION

Primary Physician: _____ Telephone #: _____

Primary Physician's Address: _____
Street/P.O. Box City State Zip Code

Referring Physician: _____ Telephone #: _____

Pharmacy: _____ Telephone #: _____

Prescription Coverage Company: _____ Telephone #: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Dermatology Services of Kingston, PC to release medical information concerning my condition and treatment to my insurance carrier and/or the Health Care Financing Administration. I hereby request that payment of authorized insurance and/or Medicare benefits be made on my behalf to Dermatology Services of Kingston and/or its physicians for services rendered. I understand that I am responsible for any amount not covered.

Patient or Parent/Guardian Signature: _____ Date: _____
(If patient is a minor.)

DERMATOLOGY SERVICES OF KINGSTON, PC
MEDICAL HISTORY FORM

Name: _____ D.O.B. _____ Date: _____

Why are you here today? _____

_____

Medical/Dermatology History: _____

_____

Surgical History: _____

_____

Hospitalizations: _____

_____

Medications: _____

_____

Allergies: _____

_____

Do you have a Pacemaker? (Yes) (No)

FAMILY HISTORY:

Any family member with a history of melanoma? (Yes) (No)

If yes, who? _____

Parents: **Father:** Age: _____ History of acne (Yes) (No) (Living) (Deceased)

Chronic medical conditions: _____

Cause of death: _____

Mother: Age: _____ History of acne (Yes) (No) (Living) (Deceased)

Chronic medical conditions: _____

Cause of death: _____

Siblings: How many? _____ Rank: _____ Male: _____ Ages: _____

(NOT INCLUDING SELF) Female: _____ Ages: _____

Chronic medical conditions: _____ Any

siblings with acne: _____Cause of death: _____

Children: How many? _____ Male: _____ Ages: _____

Female: _____ Ages: _____

Chronic medical conditions: _____

Cause of death: _____

(Complete Back Page)

Pets: (Yes) (No) **What?** _____

Patient's Occupation: _____

Retired: (Yes) (No) **Former Occupation:** _____

Tobacco: (Yes) (No) **Quit?** (Yes) (No)

Sun Exposure: (Minimal) (Moderate) (Excessive)

Have you had a blister from the sun? (Yes) (No)

Have you ever had sunburn? (Yes) (No)

Do you use sunscreen? (Yes) (No) **What SPF?** _____

Do you use a tanning bed? (Yes) (No)

Skin Type: (circle one)	
I	always burn, never tan
II	always burn, sometimes tan
III	sometimes burn, always tan
IV	never burn, always tan
V	naturally brown skin
VI	naturally black skin

368 Broadway, Suites 104 & 105, Kingston, NY 12401

HIPAA Privacy Information/Photography Permission

Patient Name: _____ Date:_____

Please answer the following questions to ensure your privacy is upheld in communication with our office.

How may we communicate with you regarding your appointments and medical information?

Check yes or no for each question:	**Appointments**		**Medical Information**		
	YES	NO	YES	NO	
Can our office leave a message:					
On your home phone?	___	___	___	___	
On your cell phone?	___	___	___	___	Cell #: _____
On your work phone?	___	___	___	___	Office #: _____
With another person?	___	___	___	___	
Can we send correspondence via mail?	___	___	___	___	
Can we send correspondence via e-mail?	___	___	___	___	Email: _____

If we can contact another person on your behalf:

Contact Name: _____

Telephone number: (____) _____ Relationship to patient: _____

We want to make sure that all our patients get the best care possible. We would like you to tell us your racial/ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. This information is confidential and for our internal records.

Ethnicity:
___ Spanish or Hispanic Origin
___ Not of Spanish/ Hispanic Origin
___ Prefer not to answer

What is your primary language: _____

Race:
___ White
___ Black/African American
___ Asian
___ Native Hawaiian/Pacific Islander
___ Other
___ Unknown
___ Prefer not to answer

Photography Permission:
This grants permission for Dermatology Services of Kingston, PC and its authorized personnel to take photographs for use in your medical treatment. DSOK will keep these photographs on premises in your medical chart for future treatment.

_____ _____
Signature or Representative *Date*

OR

I would like to **decline** use of photography for my medical treatment.

_____ _____
Signature or Representative *Date*

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Written Financial Policy

Thank you for choosing Dermatology Services of Kingston. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Insurance Co-pays:

We are contractually obligated by the insurance companies to collect copays at the time of service. If you are unable to pay your copay, we will reschedule your appointment.

Payment Options:

You can choose from:

- Cash, Personal Check, MasterCard®, American Express®, Discover Card® , Visa®
  or CareCredit® Healthcare Credit Card

No-Show Policy:

A fee of $50 is charged for patients who miss or cancel an appointment without 24-hour notice. Insurance does not cover charges for no-show appointment fees; therefore, the patient is responsible for payment.

Returned Checks:

In the event that your check is returned by your bank you will be rebilled by Dermatology Services of Kingston for the original charges as well as a $20 bank service charge.

If you have any questions, please do not hesitate to ask. We are here to help you get the quality care you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

**Subject to credit approval.