DERMATOLOGY
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The Trokhan Group

ORTHOPAEDIC SURGERY
SHAWN TROKHAN, M.D.
JOHN PARRON, M.D.

NEW PATIENT REGISTRATION

LAST NAME:_____ SSN:___ - ___ - _____ DOB:___ / ___ / _____

FIRST NAME:_____ HOME ADDRESS:_____

MIDDLE:_____ CITY, STATE, ZIP _____

GENDER: ☐ FEMALE ☐ MALE HOME PHONE: (___) _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED CELL PHONE: (___) _____

WORK PHONE: (___) _____

RACE:_____ LANGUAGE:_____ WHICH SHOULD WE CALL FIRST? ☐ HOME ☐ CELL ☐ WORK

EMAIL ADDRESS:_____

REFERRED HERE BY:_____

DRUGSTORE NAME:_____ PRIMARY CARE PHYSICIAN:_____

PHONE OR TOWN:_____ PHONE OR TOWN:_____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY:_____

POLICY HOLDER'S NAME:_____

POLICY HOLDER'S DOB:_____

RELATIONSHIP TO PATIENT:_____

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

INSURANCE COMPANY:_____

POLICY HOLDER'S NAME:_____

POLICY HOLDER'S DOB:_____

RELATIONSHIP TO PATIENT:_____

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY:_____

RELATIONSHIP TO PATIENT:_____ PHONE NUMBER:(___) _____

PLEASE PRESENT YOUR INSURANCE CARD(S) AND PHOTO ID TO THE RECEPTIONIST. THE RECEPTIONIST WILL SCAN AND RETURN THEM TO YOU AT THE END OF YOUR VISIT.

SIGNATURE OF RESPONSIBLE PARTY:_____ DATE:_____
(MUST BE 18 YEARS OF AGE OR OLDER)

PLEASE TURN THIS PAGE OVER. SIGNATURE IS NEEDED ON BACK

Office Policy Regarding Patient Financial Responsibility

Providing quality medical care for our patients is our primary concern. The following is a summary of our financial policy. We would be happy to provide further clarification if necessary. We ask that you read and sign the following to acknowledge that you have been advised of your financial responsibility for medical services provided here.

Please initial each numbered item and sign below

1.____ Prior to seeing a medical professional at this office I can request that a staff member can discuss the likely costs involved in my procedure(s) and review my financial responsibility.

2.____ This office participates with some insurance plans. It is my responsibility to provide this office with an up-to-date insurance card, and to notify this office of any changes to my insurance plan.

3.____ I understand that insurance may not cover all fees. I am responsible for understanding my specific insurance plan and for payment of all co-pays and/or deductible charges at the time of service. (A billing form can be supplied to you for out of network insurance submission if requested.)

4.____ I understand that some procedures performed at Trokhan Dermatology, LLC are considered cosmetic and will not be covered by insurance. (You will be notified before any procedure is performed if this is the case.)

5.____ Any laboratory analysis that is required can be sent to an external laboratory of my choice and/or as required by my insurance.

6.____ **This office does accept Medicare** and will file all claims for patients with Medicare. (Please give us your secondary insurance card and we will also file it.)

7.____ This office accepts payment in the form of **CASH, MASTERCARD, VISA, DISCOVER or AMERICAN EXPRESS.** Personal checks are only accepted for billing statements that we send out to you from the office. I understand that any checks returned due to insufficient funds will result in a fee of **$25.00** each.

8.____ I understand that any reimbursement sent by the insurance company directly to the patient/insured for services rendered by our doctors will be remitted to this office within 2 weeks of receipt or extra fees will be incurred.

9.____ I understand that I have financial responsibility for payment of medical services provided by this office, and hereby assume and guarantee payment of all expenses incurred during my office visit. Should legal action be required to secure payment of this account, I agree to pay the legal expenses incurred by this office.

I have read and understand this financial policy and agree to accept responsibility as described.

Signature of responsible party:_____Date:_____
(Must be 18 years of age or older)

Did you know there is a dentist, orthodontist, endodontist, periodontist, and oral surgeon in our Closter office building, right upstairs?

(Well, now you do. Ask the front desk for more information)

DERMATOLOGY ORTHOPAEDIC SURGERY

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed by Trokhan Dermatology, LLC and how you can get access to this information. Please review it carefully.

As required by HIPAA, this notice explains how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for the following purposes: treatment, payment, and health care operations.

* Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be contacting a previous therapist to discuss your case.
* Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
* Health care operations include the business aspects of running our practice such as conducting quality assessment and improvement activities, auditing functions, cost- management analysis, and customer service.

We may also create and distribute "de-identified" health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to our office:

*The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to your immediate family members, other relatives, close personal friends or other individuals you identify. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
*The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
*The right to inspect and copy your protected health information.
*The right to amend your protected health information.
*The right to receive an accounting of disclosures of protected health information.
*The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

Please note that there is no violation of privacy when you are called by name for your examination or if you should overhear part of a telephone conversation while checking out. These types of incidental disclosures are acknowledged by HIPAA as being an inevitable consequence of the practical limitations of space. The office makes every attempt to protect your personal health information as the act requires by being careful that it is not available to those who should not have access to it.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

I have been notified of the updated Notice of Privacy rights and understand I can request of copy of them.

Signature of responsible party:_____Date:_____
(Must be 18 years of age or older)

Please turn this page over. Signature is needed on back

Dermatology Patients Only:

I understand that Dermatologists often perform biopsies, liquid nitrogen treatments or minor skin surgeries.

I also understand that any time my skin is cut (for a biopsy or minor skin surgery) there is a risk of scarring, bleeding, infection, allergic reactions, swelling, recurrence and if the biopsy or surgery is near the eyes or forehead, bruising around my eyes.

I also understand that any time liquid nitrogen is used to treat my skin, a blister may form and the treatment may result in a lighter or darker discoloration of the area treated.

By my signature below, I hereby give the physicians at Trokhan Dermatology, LLC authorization to treat my skin with a
biopsy, liquid nitrogen or minor skin surgery.

Signature of responsible party:_____ **Date:**_____
(Must be 18 years of age or older)

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I understand that I can revoke this authorization in writing at any time.

Signature of responsible party:_____ **Date:**_____
(Must be 18 years of age or older)

ALL PATIENTS:

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation, or evaluation of any claim submitted to my insurer. I also authorize my insurer to disclose to a hospital or health care service plan, self-insurer, or any insurer, any medical information obtained if such disclosure is necessary to allow the processing of any claim.

If my coverage is under a Group Contract held by an employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with my insurer, including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon, me, my dependents, and our heirs, executors, and administrators.

Signature of responsible party:_____ **Date:**_____
(Must be 18 years of age or older)

Visit www.TROKHAN.com for more information about our doctors

Past Medical History

Do you have a history of or are currently being treated for any of the following?

Asthma	O Yes	O No
High Blood Pressure	O Yes	O No
Diabetes	O Yes	O No
High cholesterol	O Yes	O No
Arthritis	O Yes	O No
Urinary tract infections	O Yes	O No
Depression	O Yes	O No
Hepatitis C	O Yes	O No
Seizures	O Yes	O No
Tuberculosis	O Yes	O No
Environmental allergies	O Yes	O No
Eczema	O Yes	O No
Psoriasis	O Yes	O No
History of stroke	O Yes	O No
Gall stones	O Yes	O No
Mitral valve prolapse	O Yes	O No
Lupus	O Yes	O No
Blood clots	O Yes	O No
HIV	O Yes	O No
Pregnant (currently)	O Yes	O No
Problems with healing	O Yes	O No
Melanoma	O Yes	O No
Cancer, basal cell	O Yes	O No
Cancer, squamous cell	O Yes	O No
Heart disease	O Yes	O No
Peptic ulcer disease	O Yes	O No
Thyroid disease	O Yes	O No
Bowel disorders	O Yes	O No
Cancer	O Yes	O No

If you answered “yes” to any of the last 5 questions, or have a medical condition that is not listed, please specify below:

_____

Do you take any medications? Please list them here:

_____

_____

Do you have any allergies to any medications, drugs or over the counter preparations? If yes, please list them here:

_____

Family History

Have you or any members of your family had any of the following?

Skin Cancer	O Yes	O No
Eczema	O Yes	O No
Psoriasis	O Yes	O No
Diabetes	O Yes	O No
Asthma	O Yes	O No

Social History

Do you drink alcohol?	O Yes	O No	O sometimes
Do you smoke?	O Yes	O No	
Do you have a history of venereal diseases?	O Yes	O No	
Have you travelled outside US in the past three months?	O Yes	O No	

Please list and date any prior surgeries or hospitalizations:

_____

_____

Areas of Aesthetic Concern: (please check all that apply):

__ Fine lines
__ Lines around nose and mouth
__ Brown spots
__ Uneven skin tone
__ Dry skin
__ Unwanted hair
__ Rough skin texture
__ Short eyelashes
__ Broken blood vessels