VANGUARD DERMATOLOGY

Patient Information

Name ______________________________________ Date of Birth: ____________________

Address ____

City, State and Zip ____

Social Security No ____________________________ Male · Female ·

Home Tel #: _________________________ Mobile Tel#____________________________

E-mail Address____

Race _________________ Ethnicity________________ Language________________

Emergency Contact _________________________________ Relationship ______________

Home #: ________________ Mobile # _________________ Work # _________________

Payment Agreement

Medicare Patients: I request that payment of authorized Medicare benefits be made on my behalf for any services furnished by the physicians and staff of vanguard Dermatology. I authorize any holder of my medical information to release to the Centers of Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

All Patients: PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED FOR "YOUR PART" OF THE CHARGES INCURRED. I agree to pay my deductibles, co-payments, and payments at the time services are rendered. We accept cash, checks, and Visa/MasterCard Your signature below indicates that you understand and accept this policy. Furthermore, your signature authorizes your Doctor to release such medical information necessary to process your insurance claims (if any). I herein authorize payment of medical benefits to Vanguard Dermatology when an assigned claim is submitted.

Signature of Patient / Legal Guardian - X ____

Date ________________ Patient Relationship to Policy Owner: · Self · Child · Spouse

Should my account fall into arrears greater than 60 days, I authorize that the unpaid balance be charged to my major credit card: Card #____ Exp. Date ____________________

Name on Card______________________________ Signature___________________________

Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of Vanguard Dermatology's Notice of Private Practices (effective July 1, 2005) detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction (if any) concerning the use of my personal information:

X Signature ____ Date _____________

VANGUARD DERMATOLOGY

Medical Information

Name ____ Date: ______________

Reason for visit ____

Referred by ____

Primary Care Physician / Tel # / Address ____

____

Pharmacy Name and Tel # ____

Medications

(List all current medications including prescriptions, over-the counter meds, vitamins, and herbal supplements):

1 ______________________ 2 _______________________ 3 ______________________

4 ______________________ 5 _______________________ 6 ______________________

Medical History

Basal Cell Carcinoma	· Yes	· No	Asthma	· Yes	· No
Squamous Cell Carcinoma	· Yes	· No	Atopic dermatitis (eczema)	· Yes	· No
Melanoma	· Yes	· No	Seasonal allergies	· Yes	· No

Other: ____

No drug allergies □ Allergies (List all medication allergies): ___________________

Surgical History: ____

Hospitalization: ____

Family History

Basal Cell Carcinoma	· Yes	· No	Asthma	· Yes	· No
Squamous Cell Carcinoma	· Yes	· No	Atopic dermatitis (eczema)	· Yes	· No
Melanoma	· Yes	· No	Seasonal allergies	· Yes	· No

Other: ____

Social History

Occupation: ____

Tobacco: · Yes · No · Occasionally Alcohol: · Yes · No · Occasionally

Difficulty swallowing	· Yes	· No	Wheezing / difficulty breathing	· Yes	· No
Musculoskeletal/joint pain	· Yes	· No	Fever	· Yes	· No
Lower leg edema/swelling	· Yes	· No	Chest pain/angina	· Yes	· No
Weight loss	· Yes	· No	Special diet	· Yes	· No
Stomach pain or heartburn	· Yes	· No	Currently pregnant	· Yes	· No

X Signature: ____ Date: ___________

Consent for Treatment / Authorization for Release of Medical Information

I authorize Vanguard Dermatology to treat me and/or provide medical services for me, or for the minor in my care. I authorize Vanguard Dermatology to release information requested by my insurance company or any of its agents. I also authorize Vanguard Dermatology to furnish my primary care physician, referring physician or other treating medical professional any and all information that may be requested regarding my physical or mental condition, treatment rendered by my physician at Vanguard Dermatology, or any records or results. This authorization shall remain in force until revoked in writing by the undersigned.

Signed (Patient or Responsible Party)

X ____ Date________________

Staff Witness Name and Signature

____ Date________________

Consent for Communication of Information

In addition to release of information as authorized above (Authorization for Release of Medical Information), and in the interest of confidentiality and compliance with HIPAA (Health Insurance Portability and Accountability Act), I authorize the release of information as it pertains to my care to the following individuals:

Name _____________________________Relationship __________________Tel#__________

Name _____________________________Relationship __________________Tel#__________

For the purpose of communicating test results, prescription refill requests, and other information, please provide us with acceptable ways of reaching you: Vanguard Dermatology may leave messages only: (please check all that apply)

- On my home answering machine #__________________________________
- On my cell phone voicemail #__________________________________

I have the right to revoke and change my consent options as listed above. When circumstances change regarding me response, In order to make changes to my communication options, I will submit written changes, revocations, limitations, and restrictions to Vanguard Dermatology, at main office address. Without a written letter that makes changes to the acceptable methods of communicating information, Vanguard Dermatology Doctors nor Staff will not be held liable for leaving messages or test results on the methods of communication listed above.

Signed (Patient or Responsible Party)

____ Date________________

Internal use only: If the Patient or Responsible Party refused to sign any of the above acknowledgements, please document the date and time the patient was presented with the above material and sign below: Information presented on (date) ___________________________ Time ________________

Staff Name _________________________ Signature____________________________

Informed Consent for Biopsy

Patient_ X ____

I hereby authorize the physicians of Vanguard Dermatology, PC to perform the following procedure on me:

Biopsy

I recognize that, during the course of the biopsy, unforeseen conditions may necessitate additional or different procedures than those set forth above. I further authorize that the above named doctor or his assistant perform such procedures that are, in his or her professional judgment, necessary and desirable.

I consent to administration of local anesthesia to be given by or under the direction of the above doctor. I am aware of the risks of this procedure include the following:

> **-**bleeding, infection, scarring (including keloid formation) **-**darkening or lightening of pigmentation which can be temporary or permanent **-**temporary (rarely permanent) loss of sensation / numbness to the area **-**pain or discomfort **-**possible need for additional procedures

I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of the operation of procedure.

After this procedure, I agree to cooperate with the above doctor in my own care until completely discharged.

By signing below, I understand and agree that laboratory and pathology services are covered by Vanguard Dermatology's INSURANCE INFORMATION AND FINANCIAL POLICY and that I am entitled to a copy of this policy upon request.

Patient Signature X ____ Date: ____________

Physician's or Medical Assistant's Signature ____

2408 Ocean Avenue
Brooklyn, NY 11229
718 332 2999

TEL 718 332 2999
FAX 718 332 3454

11045 Queens Blvd No. 116
Forest Hills, NY 11375
718 261 1411

146 Norman Avenue
Brooklyn, NY 11222
718 609 0310

1855 Richmond Ave No. 5
Staten Island, NY 10314
718 697 2212

161 6th Ave No. 1304
New York, NY 10013
212 242 1023

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Rahat Azfar, MD, FAAD
Lina Plantilla, MD, FAAD
Gilberto Alvarez del Manzano, MD, FAAD
Susan Bard, MD, FAAD

I, ________________________________, authorize Vanguard Dermatology to provide medical services. I do understand and accept the payment/billing issues described below:

- I understand that if my primary insurance only covers a portion of my services, I, the patient will be responsible for the remaining balance.

- If I do not have a secondary insurance plan, I will be held responsible for the balance.

Signed (Patient or Responsible Party)

_______________________________ Date_______________________

Staff Witness Signature

_______________________________ Date_______________________