Dermatology of Lower Manhattan

Alan H. Greenspan, M.D.
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New York, New York 10006
(212) 509-5200 F(212) 425-0235

Patient Registration Information

Today's Date ___________________

Last Name _______________________________________ First Name _______________________ MI ___

Address ____ City ________________ State _____ Zip _______

Date of Birth: ___________________ Soc. Sec. # _____________________

Home Phone ___________________ Cell Phone _____________________

Work Phone ___________________ Email Address ____________________________

Occupation and Employer __________________________ Employer Address __________________________

Insurance Information

Insurance Company Name

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Group Number ________________________________ Policy Number ________________________

***For TRICARE patients, sponsor's social security number____

Emergency Contact

In case of an emergency, who should we contact?

Name ___________________________ Relationship _______________ Phone Number _______________

Address ____

Referral Information

How did you hear about our practice?

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Insurance Authorization Form

I authorize the use of this form on all my insurance submissions.

I authorize release of information to all my insurance carriers.

I understand that I am responsible for my bill, including the deductible and/or copayment, if any.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.

I authorize payment directly to my doctor.

I permit a copy of this authorization to be used in place of the original.

I have read and agreed to the above.

Name ___________________________

Soc. Sec. # _______________________

Signature ________________________

Legal Guardian Signature ________________________________

Date ____________________________

Receipt of Notice of Privacy Practices
Written Acknowledgement Form
Dermatology of Lower Manhattan
Alan H. Greenspan, M.D.
Zoe Veritas, M.D.

I hereby acknowledge receipt of Dermatology of Lower Manhattan's Notice of Privacy Practices

I hereby give my consent for Dermatology of Lower Manhattan, to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Dermatology of Lower Manhattan's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dermatology of Lower Manhattan reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dermatology of Lower Manhattan at 39 Broadway, Suite 3005, New York, NY 10006.

With this consent, Dermatology of Lower Manhattan may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Dermatology of Lower Manhattan may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as patient statements as long as they are marked Personal and Confidential.

With this consent, Dermatology of Lower Manhattan may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO.

By signing this form, I am consenting to Dermatology of Lower Manhattan's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

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Signature of Patient or Legal Guardian

____ ______________________________________
Patient's Name Date

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Print Name of Legal Guardian