Dermatology of Lower Manhattan

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39 Broadway, Suite 3005
New York, New York 10006
(212) 509-5200 F(212) 425-0235

Clear Form

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

_____

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?

_____

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.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date

_____

Print Name of Legal Guardian

SUBMIT