Medical History

Patient Name:________________________________ Date of birth:________________ M/ F Other________

Referring MD:________________________________ Primary MD:________________________________

Reason for today's visit:____

List all medications you are currently taking: (include over-the-counter medications and vitamins)________
____
____

Are you allergic to any medications: ◯ Yes ◯ No If yes, list:________________________________

Do you suffer from seasonal allergies: ◯ Yes ◯ No

Do you have, or have you ever had any of the following conditions or diseases: (Please circle Yes or No)

Condition			Condition		
Abnormal Bleeding/Hemophilia	Yes	No	Heart Disease	Yes	No
Asthma	Yes	No	Heart Murmur	Yes	No
Arthritis	Yes	No	Hepatitis or Yellow Skin	Yes	No
Artificial Joints	Yes	No	High Blood Pressure	Yes	No
Bronchitis	Yes	No	HIV/AIDS	Yes	No
Cancer	Yes	No	Irregular Heartbeat	Yes	No
If Yes, what type:			Liver Disease	Yes	No
Chest Pain	Yes	No	Mitral Valve Prolapse	Yes	No
Diabetes	Yes	No	Pacemaker	Yes	No
Drug Dependency	Yes	No	Rheumatic Fever	Yes	No
Alcohol Dependency	Yes	No	Personal History of Skin Cancer	Yes	No
Epilepsy, Seizures, Fainting Spells	Yes	No	If Yes, what type:		
(Circle which condition)			Specific Skin Diseases	Yes	No
Glaucoma	Yes	No	If Yes, what type:		
Kidney Disease	Yes	No	Thyroid Disease	Yes	No
Heart Attack	Yes	No	Emphysema/COPD	Yes	No

Family History of skin cancer	Yes	No	Family History of atypical moles	Yes	No
If yes, what type:			If yes, what type:		
which relative:			Which relative:		

Please answer the following:

Do you smoke	Yes	No	**Do you drink alcohol**	Yes	No
Number of packs per day:			Number of drinks per day:		
Have you ever had a bad reaction to an Anesthetic	Yes	No	(Women) Are you pregnant	Yes	No
			Are you nursing	Yes	No
			Are you trying to become pregnant	Yes	No
Do you need antibiotics before dental procedures	Yes	No			

Skin:

Have you ever had blistering sunburns	Yes	No	**Do you frequent tanning salons**	Yes	No
Do you regularly use sunscreen	Yes	No	Do you, or have you ever had an outdoor occupation	Yes	No
Acne patient's only:			When you are exposed to the sun, do you: (circle one)		
Have you taken Accutane (oral acne medicine) in the last year	Yes	No	Tan only Tan and burn Burn N/A		

Marital Status: ________________________________ **Occupation:**________________________

Race: White/ African American/ Native American/Asian /Hispanic/ other_______ /Decline to answer

List any surgical procedures you have had in the last six months:________________________________
____

List any other disease or condition we should know about:____
____

PATIENT INFORMATION *All Fields Required

*Name: ______________________________________ *Date of Birth: ____________

Last First M.I.

*Mailing Address: ____

Number, Street, Apartment Number

____

*City *State *Zip

*Home Phone: _______________ Work: ________________ Cell: _________________

*Email:____

*Preferred Pharmacy: ____

*May Pittsford Dermatology contact and reconcile a list of all your current Medications directly from your pharmacy?

Yes ___ No ___

*Name of your insurance company: __________________________________

*Policy Holder: ________________________________ *DOB: ____________________

*Primary Care Doctor: ____

Referring Doctor: ____

(If different from your Primary Care Doctor)

****

If patient is a minor, please enter responsible party information.

Name: ____

Last First M.I.

Mailing Address (if different from above): ________________________________

Number, Street, Apartment Number

____

City State Zip

Home Phone: _______________ Work: ________________ Cell: _________________

Pittsford Dermatology PLLC

Helen Strapko MD Board Certified Dermatologist (585) 389-1960 • Fax (585) 389-1947

PATIENT FINANCIAL POLICY
Pittsford Dermatology

Patient Name: ____

Date of Birth: ________________

Address: ____

This office has contracts with many managed care plans. Please check with our reception staff to determine whether your plan is one of these.

Please be aware that verification of a contract, benefits or a referral authorization does not guarantee payment. Reimbursement for services rendered is determined once the claim is submitted and can be denied. If we have a contract with your plan, we will file a claim with your insurance company. The amount for which you are responsible **(any deductibles, copays, percentages or non-covered services) is required at the time of the service.**

If you do not have one of the plans with which the practice is contracted, the total cost of your visit is required at the time of service. If at any time you are concerned about the cost of a procedure proposed by the doctor, you may ask for someone from the business office who will be happy to discuss the cost with you.

48 hours' notice is required to cancel or reschedule an appointment. Failure to give 48 hours' notice may result in a $25 fine for a regular appointment, and a $50 fine for a surgical appointment. Such fees must be paid before another appointment will be scheduled. In the event that you do not pay when fees are due, you will be responsible for all collections costs and or any attorney's fees until the balance is paid in full. For your convenience in paying, this office accepts Master Card and Visa in addition to cash and checks. A $25 fee will be levied for returned checks.

I certify that I have read the financial policy of Pittsford Dermatology, and agree to abide by the policy.

____ ______________________

Signature Date

Pittsford Dermatology, PLLC
Helen Strapko, MD
Board Certified Dermatologist
(585) 389-1960 • Fax (585) 389-1947

Specializing in Dermatology and Dermatologic Surgery for patients of all ages

HIPAA Authorization

Pittsford Dermatology is committed to protecting the privacy of our patients' personal health information. Part of that commitment is complying with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires us to take additional measures to protect personal information and to inform our patients' about those measures.

Please complete the section below on how Pittsford Dermatology may use and disclose your protected health information.

You may authorize any of the following:

May we contact or leave a message pertaining to medical/appointment information:

Home Phone?	○ Yes	○ No	
Cell Phone?	○ Yes	○ No	
Work phone?	○ Yes	○ No	○ N/A
By mail?	○ Yes	○ No	
With another person?	○ Yes	○ No	

If yes, whom:____

Relationship:____

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ASSIGNMENTS OF BENEFITS

All Insurances except Medicare

I authorize my insurance company to pay benefits on my behalf directly to Pittsford Dermatology. I authorized Pittsford Dermatology to provide to my insurance company, any information necessary to process claims for services rendered to me.

Signature: ________________________________ **Date:** ________________

Medicare

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid or its intermediaries or carrier 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.

Signature as it appears on Medicare Card: ________________________ **Date:** ________________

MEDIGAP

If you have a supplemental policy and it is a MEDIGAP policy or other policy to which your Medicare Carrier automatically "crosses over"; we are required to keep a separate signature on file:

Signature as it appears on MEDIGAP Card; _______________________ **Date:** __________________

Do you or your spouse work in a company which has more than 20 employees and have coverage through insurance at that job? ◯ **Yes** ◯ **No**

Are you covered by any other insurance that makes Medicare Secondary? ◯ **Yes** ◯ **No**

Updated 10/13/2022 RG

Pittsford Dermatology PLLC

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NYS Surprise Bill (Out-of-Network Provider)

Pittsford Dermatology does not participate in the network of your health care plan. You are required to understand what your health care plan covers if you obtain services from an out-of-network provider.

- Your plan may not cover out-of-network services at all, leaving you to pay the full cost
- If your plan covers out-of-network services, your plan may require higher co-pays, deductibles and co-insurance for out-of-network care.

Summary of visit:

- Date:
- Services performed:
- Estimated amount of today's visit:

I acknowledge that Pittsford Dermatology is out-of-network, but elect to obtain services from Helen Strapko, MD.

Name (Printed): ______________________________

Signature: ____________________________________ Date: ____________________

We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. However, if we do agree, we will comply with your request unless that information is needed for emergency treatment.

An Accounting of Disclosures. You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation) nor for a period of time greater than six years (our legal obligation to retain information).

Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how we communicate with you to preserve your privacy. *For example* – you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

File a Complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice manager or directly to the Secretary of Health and Human Services.

To file a complaint with our manager, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to Sandra Scheerens, Pittsford Dermatology, PLLC, 1050 B Pittsford Victor Rd., Pittsford, NY. You should know that there would be no retaliation for your filing a complaint.

Uses or Disclosures Not Covered

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

For More Information

If you have questions or would like additional information, you may contact our practice manager at 585-389-1960

Effective Date: April 14, 2003

PITTSFORD DERMATOLOGY

115 Sully's Trail, Suite 2

PITTSFORD, NY 14534

585-389-1960

PITTSFORD DERMATOLOGY, PLLC

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

Effective Date: April 14, 2003

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

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

Ways in Which We May Use and Disclose Your Protected Health Information:

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to another physician who we have requested to be involved in your care. For example – we would disclose your health information to a special-

ist to whom we have referred you for a diagnosis to help in your treatment.

Payment. We will use and disclose your protected health information to obtain payment for the health care services we provide you. For example – we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations. We will use and disclose your protected health information to support the business activities of our practice. For example – we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription services for our practice.

Other Ways We May Use and Disclose Your Protected Health Information:

Appointment Reminders. We will use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment.

Treatment Alternatives. We will use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to you.

Others Involved in Your Care. We will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.

Research. We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

As Required by Law. We will use and disclose your protected health information when required to by federal, state, or local law. You will be notified of any such disclosures.

To Avert a Serious Threat to Public Health or Safety. We will use and disclose your protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Worker's Compensation. We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates. We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

A Paper Copy of This Notice. You have the right to receive an additional copy of this notice upon request. You may obtain a copy by asking our receptionist or by calling and asking us to mail you a copy.

Inspect and Copy. You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our practice manager, Sandra Scheerens, Pittsford Dermatology, PLLC, 1050 B Pittsford Victor Rd., Pittsford, NY 14534. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

Request Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and your reasoning that supports your request.

We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:

- the information was not created by us, or the person who created it is no longer available to make the amendment;
- the information is not part of the record which you are permitted to inspect and copy;
- the information is not part of the designated record set kept by this practice;
- it is the opinion of the health care provider that the information is accurate and complete.

Request Restrictions. You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operations. *For example* – you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to our practice manager.