GATEWAY DERMATOLOGY, PC

Main Office:
1 SOUTH WESTERN AVE.
GLENS FALLS, NY 12801
PH (518)745-5280
FAX(518)745-5284
info@gatewaydermatology.net

Satellite Office:
2691 Route 9
Malta, NY 12020
PH (518)682-5555
FAX (518)745-5284
info@gatewaydermatology.net

Dear Patient:

Please fill out the attached forms. We must receive the forms prior to your appointment. The completed forms can be emailed, faxed or mailed. Due to current health guidelines we ask that if brought to the office they are left in the locked, outdoor drop box at our Glens Falls location. Please bring the following items to your appointment:

1. **Insurance Card - also bring to every visit**
2. If your Insurance requires an insurance referral, please make arrangements through your Primary care physician.
3. Photo Identification, if you have one.
4. If the patient is a minor, **parent MUST** come to the first visit.
5. **Co-Pay** (as required by your insurance company to be paid at the **time of service**).
5. If you are unable to keep your appointment, please give us 24 hours notice (**48 hours notice for cosmetic appointments) so that we may fill your spot, and to avoid a $40 no show fee.**
6. As of June 1st, 2015 there will be a $5 billing fee per statement on all personal balances over 30 days old.

We are looking forward to your visit. If there is anything we can do to make things easier for you please contact our office at **518-745-5280 or 518-682-5555.**

DIRECTIONS to MAIN OFFICE IN GLENS FALLS:
1 SOUTH WESTERN AVE, GLENS FALLS, NY 12801
FROM EXIT 18:
- From exit 18 off the Northway, head towards downtown
- Approximately 3/4 of a mile from the exit, turn left onto South Western Ave. (this is the big intersection just before the Hannaford plaza on Broad St.)
- We are located 1/4 mile down South Western on the right. There is a Gateway Dermatology sign on the lawn.

FROM DOWNTOWN GLENS FALLS:
- Head west on Broad St. (from downtown towards the Northway).
- Next red light after Hannaford, turn right onto South Western Ave.
- We are located 1/4 mile down South Western on the right. There is a Gateway Dermatology sign on the lawn.

DIRECTIONS TO SATELLITE OFFICE IN MALTA:
2691 ROUTE 9, MALTA, NY 12020
FROM SOUTH OF MALTA:
- Travel north on I-87 to exit 12
- Head east towards state route 9.
- Go north on State Route 9.
- Office is on the right just past the Albany-Malta Speedway and before the Ripe Tomato

FROM NORTH OF MALTA:
- Travel south on I-87 to exit 13S
- Head south on State Route 9.
- Office will be on your left just past the Ripe Tomato and before the Albany-Malta Speedway.

*****Please Keep This Page for Your Records*****

PLEASE COMPLETE ALL SECTIONS
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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

NAME: _____ **DOB:** _____

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature below, I provide this practice with my authorization and consent to use and disclose my protected health information for the purpose of treatment, payment and healthcare operations (TPO) as described in the Privacy Notice.

CONTACT INFORMATION
With this consent, Gateway Dermatology may communicate through the portal, call my home or other alternative locations and leave a message on voicemail or in person, through the mail or e-mail 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 test results, amongst others.

My contact information will be used in the following default order:

(1) Portal, if I have signed up
(2) Home Phone or 1st # listed,
(3) Cell phone or 2nd # listed, TEXT MESSAGES
(4) Work Number if urgent that we reach you (such as office is closing and appointment is canceled)
(5) US postal service.

Any specific changes to this must be requested in writing. This is a separate form, "Contact Information Request", that I can request.

AUTHORIZATION FOR FRIENDS OR FAMILY:
In addition to the use of my health information for treatment, payment or healthcare operations, I understand that I may request to designate a representative who can have access to my protected health information. **If I wish to do this, I can request the authorization form "Limited Patient Authorization for Disclosure of Protected Health Information". (NOTE: Primary Care Physician and Minor's parents are automatic.)**

RESTRICTIONS:
I further understand that I have the right to request restriction on the use or disclosure of my health information. Any specific restrictions and to whom I want the restriction to apply must be requested in writing. This is a separate form, "Patient Request for Restriction of Protected Health Information" that I can request.

If the office does not agree to the specific restriction, then I will be notified and then have the right to use another healthcare professional.

_____

(Signature of Patient or Parent/Guardian/ Patient's Representative) (Date)

_____

(Printed name of Patient or Parent/Guardian / Patient's Representative) (Relationship)

NOTE: (TPO - treatment, payment, and health care operations

*You have the right to receive a copy of signed authorizations upon request.

3/30/21

PLEASE COMPLETE ALL SECTIONS
PATIENT MEDICAL HISTORY

NAME: _____ **DOB:** _____

PERSONAL MEDICAL HISTORY: **Do you have now, or have you ever had:**

Acne	Yes	No
Allergies, Seasonal	Yes	No
Arthritis	Yes	No
Asthma	Yes	No
Autoimmune disease	Yes	No
Eczema	Yes	No
Emphysema	Yes	No
Diabetes	Yes	No
Heart Disease	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Kidney Disease	Yes	No
Psoriasis	Yes	No
Rosacea	Yes	No
Seizure Disorder	Yes	No
Stomach Disorder	Yes	No
Thyroid Disorder	Yes	No
Vitiligo	Yes	No
Cancer: (pls list)_____	Yes	No

Other Skin Conditions:

Actinic Keratosis	Yes	No
Abnormal / Dysplastic Moles	Yes	No
Skin Cancer:		
-Melanoma Skin Cancer	Yes	No
-Basal Cell Carcinoma	Yes	No
-Squamous Cell Carcinoma	Yes	No
Have you had Staph infection/MRSA	Yes	No

Surgery:

Heart Bypass	Yes	No
Hip Replacement	Yes	No
Knee Replacement	Yes	No
Organ Transplant	Yes	No
Pacemaker/Defibrillator	Yes	No

List other Surgery: _____
_____
_____

CURRENT MEDICATIONS:
AUTHORIZATION FOR SURESCRIPTS:
The office is connected to the SureScripts information system for medications. In order to improve accuracy of your medication information the office would like your permission to share information through this system.

☐ I AUTHORIZE the practice to share medication information through SureScripts.
☐ I DO NOT authorize the practice to share medication information through SureScripts.
If you have not authorized this, please list your medications:

_____

_____

ALLERGIES TO MEDICATIONS(PLEASE LIST ALL)
_____

FAMILY MEDICAL HISTORY: (1ST DEGREE RELATIVES: MOTHER, FATHER, SIBLINGS, CHILDREN)

			Family Member:				Family Member:
Allergies, seasonal	Yes	No	_____	Eczema	Yes	No	_____
Asthma	Yes	No	_____	Heart Disease	Yes	No	_____
Skin Cancer	Yes	No	_____	Psoriasis	Yes	No	_____
- Melanoma	Yes	No	_____	Autoimmune dx.	Yes	No	_____
- Basal Cell Carcinoma	Yes	No	_____	(such as Lupus, Arthritis, MS, Crohn's, Colitis, Thyroid)			
- Squamous Cell	Yes	No	_____	Other Cancer	Yes	No	_____
Diabetes	Yes	No	_____	(list) _____			

SOCIAL HISTORY: (circle one)
Smoking: Never Smoked Previous Smoker Date Quit: _____ Current Smoker: # cigarettes/day: _____
Alcohol: Denies Alcohol Use Occasional Use # of Drinks/Day: _____

Do you use Sunscreen?	Yes	No	Do you work outdoors?	Yes	No
Do you use Tanning Booths?	Never	Currently uses	Have you had blistering sunburns?	Yes	No
	History of tanning booth use				

_____
(Signature of Patient or Patient's Representative) (Date)

_____
(Printed name of Patient's Representative) (Relationship)

PLEASE COMPLETE ALL SECTIONS
PATIENT INFORMATION SHEET

NAME: First: _____MI _____Last: _____

DOB: _____Sex: Male ___ Female ___ Other___ SS#: _____

ADDRESS: (Mailing)

Street: _____City: _____State: ____ Zip Code: _____

Physical Address if Different than above: _____

PLEASE LIST PHONE ORDER OF PREFERENCE:

PHONE #'S: 1st: _____ HOME OR CELL (PLEASE CIRCLE)
2nd:_____ HOME OR CELL (PLEASE CIRCLE)
3rd: _____Work phone, **used only if we need to speak to someone urgently and all else has failed.**
E-Mail: _____ **(Currently not used, possibly future use for reminder messages, etc.)**

Employer: _____

If Patient is a minor, Parents' Names: _____ _____
(Father) (Mother)

Emergency Contact Information:
HIPAA Documentation to be signed at first visit
First and Last Name: _____

Relationship to Patient: _____

Address: _____Phone #:_____
- At your first office visit signature will be requested of patient/ guardian in order for this to be in compliance with current HIPAA guidelines

RACE: ☐White, ☐Black/African American, ☐ American Indian/Alaskan Native,
☐Asian, Native Hawaiian/Other Pacific Islander, ☐Patient Declined or Unknown

ETHNICITY: ☐Spanish/Hispanic Origin, ☐Not Spanish/Hispanic,
☐Patient Declined/Unknown)

LANGUAGE: ☐English, ☐Spanish, ☐Patient Declined/Unknown

☐Other -list _____

Reason for visit:_____

Referring Physician: _____Phone #: _____

Primary Care Physician: _____Phone #: _____

Pharmacy: (local): _____Phone #: _____

Prescription Plan/Mail Order: _____

_____
(Signature of Patient or Patient's Representative) (Date)

_____
(Printed name of Patient's Representative) (Relationship)

PLEASE COMPLETE ALL SECTIONS
INSURANCE
WE REQUIRE A COPY OF INSURANCE CARD WITH ALL PAPERWORK

NAME: _____ **DOB:** _____

PRIMARY INSURANCE: _____

ID#: _____SUFFIX: _____ GROUP #: _____

Primary Card Holder**(Guarantor for billing Name as it appears on the card)**:
_____ DOB: _____
(Name)/(Relationship) **address if different from home address**

SECONDARY INSURANCE: _____

ID#: _____SUFFIX: _____ GROUP #: _____

Primary Card Holder **(Guarantor for billing Name as it appears on the card**):
_____ DOB: _____
(Name)/(Relationship) **address if different from home address**

TERTIERY INSURANCE (3RD): _____

ID#: _____SUFFIX: _____ GROUP #: _____

Primary Card Holder: _____ DOB: _____
(Name)/(Relationship)

PLEASE NOTE:
- We ask that you bring your current **insurance card to every visit.**
- **All copays are expected at time of service**.
- It is your responsibility to know if your insurance requires an insurance referral, and to verify that we have one for you before your visit. If you arrive for a visit without a current referral in the system you may be required to reschedule your appointment.
- Do you have a Medicare Advantage policy such as MVP Gold, BS Senior Blue, etc? These are Medicare Replacement policies and take over for Medicare.
- Do you have a supplemental insurance policy - These are second to Medicare.

Is Medicare Primary?
Do you have Medicare based on age? - If so:
- Do you also have any coverage (group health plan) through employment of yourself or your spouse?
  - How many employees work for the sponsor of the group health plan?
    If less than 20 employees - Medicare is primary.
    If more than 20 employees - The group health coverage is primary.

Do you have Medicare based on disability? If so:
- Do you also have any coverage (group health plan) through employment of yourself or a spouse:
  - How many employees work for the sponsor of the group health plan?
    If less than 100 employees - Medicare is primary.
    If more than 100 employees - The group health coverage is primary.

Financial Policy:
Your insurance policy is a contract between you and your insurance company. Professional care is provided to you, our patient and not an insurance company. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. We gladly process your claim, but request your estimated portion be paid at the time of service. To do so, we require your complete insurance information. In the event we do accept assignment of benefits, please know that the balance of your bill is still your responsibility whether your insurance company pays or not. If your insurance company has not paid your account in full within 30 days, you will have 30 days to arrange payment of the balance due. Regarding insurance plans in which we are a participating provider, please understand that we may require payment of co-pays and deductibles prior to treatment.

_____
(Signature of Patient or Patient's Representative) (Date)

_____