Gateway Dermatology, PC

Website: www.gatewaydermatology.net
Email: Info@gatewaydermatology.net

Main Office
1 South Western Ave
Glens Falls, NY 12801
Ph: (518)-745-5280
Fax: (518)-745-5284

Malta Office
2691 State Route 9
Malta, NY 12020
Ph: (518)-682-5555
Fax: (518)-745-5284

New Patient Paperwork

Patient:

- Please Attach copies of your current insurance cards (**Front and Back)** including medicaid, medicare or a supplemental if you have one.
- The Completed Forms can be Emailed, Faxed, Mailed, or Dropped off to either office. **(See office information above)**
- Once Paperwork is received, we will enter into our system and get you established. **We will then call you to schedule an appointment**.

Please Bring to Your Appointment:

- **Insurance Card(s) (Including medicare/medicaid/prescription cards)**-Bring to every appointment
- If your insurance requires an **Insurance Referral**, Please make arrangements through your primary care physician before scheduling the office visit.
- **Photo Identification**, if you have one.
- **If the patient is a minor, Parent/Guardian MUST come to the first visit. After 1st visit, a note or permission from parent/guardian must accompany the minor for the office visit in order for the patient to be treated.**
- **Co-Pay** (As required by your insurance company to be paid at the time of service)

Patient Information Sheet

Name: First:_____MI:_____LAST:_____

DOB:_____/_____/_____ Sex: Male or Female or Other SSN: _____-_____-_____

If the patient is minor, parent names? _____ _____

Parent 1/Legal Guardian Parent 2/Legal Guardian

Address:

Mailing:_____City/State:_____Zip Code:_____

Physical (if Different)_____City/State:_____Zip Code:_____

Employer:_:_____ Email:_____

Phone #:

Home: _____-_____-_____ Cell: _____-_____-_____

Preferred # to call for appointments: Home or Cell

Emergency Contact: ***HIPAA Documentation to be signed at first visit***

Name:_____ Contact #____-_____-_____ Relationship:_____

Mailing**:**_____ City/State:_____ Zip Code:_____

Race: (Circle) White Black/African American American Indian/Alaskan Native

Asian, Native Hawaian Unknown/Declined to specify
OtherPacific Islander

Ethnicity: (Circle) Spanish/Hispanic Not Spanish/Hispanic Unknown/Declined to specify

Language: (Circle) English Spanish Other

Reason For Visit: _____

Referring Physician: _____Phone #: _____-_____-_____

Primary Care Physician:_____Phone #:_____-_____-_____

Pharmacy (Local):_____Address:_____Phone #:_____-_____-_____

Pharmacy (Mail):_____Address:_____Phone:_____-_____-_____

_____

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

PATIENT MEDICAL HISTORY

NAME: _____ **DOB:** _____

Do you have *now* or *have you ever had*: (*Please CHECK Yes or No to each*)

	Yes	No	Other Diagnosed Skin Cancer	Yes	No
Acne			ACTINIC KERATOSIS		
ALLERGIES, SEASONAL			DYSPLASTIC MOLES		
ARTHRITIS			SKIN CANCER		
ECZEMA			-MELANOMA SKIN		
HEART DISEASE			-BASAL CELL CARCINOMA		
HIGH BLOOD PRESSURE			-SQUAMOUS CELL CARCINOMA		
KIDNEY DISEASE			**SURGERY:**		
PSORIASIS			ORGAN TRANSPLANT		
THYROID DISEASE			PACEMAKER/DEFIBRILLATOR		
			OTHER _____		

AUTHORIZATION FOR SURESCRIPTS

Do you give us permission to access prescription information through your pharmacy? (Please Circle One:)

I AUTHORIZE OR **I DO NOT AUTHORIZE**

List of Medications (If Not Authorized) _____

_____

Allergies to Medications: _____

_____

FAMILY MEDICAL HISTORY: (*Please CHECK Yes or No to each*)

1st Degree Relatives ONLY- (Mother, Father, Siblings, or Children

	YES	NO		YES	NO
ALLERGIES, SEASONAL			DIABETES		
ASTHMA			ECZEMA		
SKIN CANCER			HEART DISEASE		
-MELANOMA SKIN			PSORIASIS		
-BASAL CELL CARCINOMA			AUTOIMMUNE DISEASE		
-SQUAMOUS CELL CARCINOMA			OTHER CANCER: _____		

SOCIAL HISTORY:

	YES	NO		YES	NO
SMOKING: *If Previous, Date Quit*:_____			HISTORY OF TANNING BOOTH		
SUNSCREEN			CURRENT USE OF TANNING BOOTH		
HISTORY OF SUNBURNS			WORK OUTDOORS		

_____

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

Insurance Sheet

We Require A Copy of your INSURANCE CARD(s) (Front+ Back) With All Paperwork

Patients Name: First: _____MI:_____Last:_____ DOB: ___-___-____

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Primary Insurance: _____

Id #: _____**Suffix:**(ie: 00,01,02)(If Applicable)_____**Group #:**_____

Name of Guarantor For Billing: (Primary Card Holder / As it appears on Insurance Card):

First:_____ MI:___ Last:_____ DOB:___-___-____ Relationship:_____

Secondary Insurance: _____

Id #: _____**Suffix:**(ie: 00,01,02)(If Applicable)_____**Group #:**_____

Name of Guarantor For Billing: (Primary Card Holder / As it appears on Insurance Card):

First:_____ MI:___ Last:_____ DOB:___-___-____ Relationship:_____

Pharmacy Card:_____

Id #: _____**Suffix:**(ie: 00,01,02)(If Applicable)_____**Group #:**_____

Name of Guarantor For Billing: (Primary Card Holder / As it appears on Insurance Card):

First:_____ MI:___ Last:_____ DOB:___-___-____ Relationship:_____

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 copays and deductibles prior to treatment.

_____

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

Gateway Dermatology, PC

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 mail or email 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 closing and appointment is canceled)
5. U.S. Postal Service

Any specific changes to this must be requested in writing. This is separate from, "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 (PHI). **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 restrictions 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 have the right to use another healthcare professional.*

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

Note: **(TPO)- **T**reatment, **P**ayment, and **H**ealth **C**are **O**perations.
You have the right to receive a copy of the signed authorizations upon request.

Directions to Main Office in Glens Falls:

1 South Western Avenue, 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 Avenue (This is the big intersection just before the Hannaford Plaza on Broad Street.)
- We are located 1/4 mile down South Western Avenue on the right. There is a Gateway Dermatology Sign on the Lawn.

Directions to Satellite Office in Malta: .

2691 State Route 9, Malta, NY 12020

From South of Malta:

- Travel North on I-87 to Exit 12
- Head East towards State Rt 9
- Go North on State Rt 9
- Office is on the right just before the Ripe Tomato Restaurant and after the Albany-Malta Speedway

From North of Malta:

- Travel South on I-87 to Exit 13S
- Head south on State Rt 9
- Office will be on the left just past the Ripe Tomato Restaurant and before the Albany-Malta Speedway

Billing/Insurance Notes:

- We ask that you bring your current **insurance card(s) to every visit.**
- **All Copays are expected at time of visit**
- 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 we don't have this, we will have 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 secondary 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 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

*If you are unable to keep your appointment, please give 24 hours notice **(48 hours notice for cosmetic appointments) so that we may fill your spot, and to avoid a $40 no show fee.***
As of June 1st, 2015 there will be a $5 billing fee per statement on all personal balances over 30 days old.