Dear Patient:

You have an appointment at one of our offices on _______________________.
Please be sure you know which location your appointment has been scheduled at.

Please fill out the attached forms and bring them with you to the appointment along with the following items:

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).
6. 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.

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.
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 Patient's Representative)  (Date)

_________________________________________________________________________________________________
(Printed name of 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.

3/20/14
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  
Ecema  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:  
-Basal Cell Carcinoma  Yes  No  
-Melanoma Skin Cancer  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)

<table>
<thead>
<tr>
<th>Family Member:</th>
<th>Allergies, seasonal</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>Yes  No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin Cancer</td>
<td>Yes  No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Melanoma</td>
<td>Yes  No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Basal Cell Carcinoma</td>
<td>Yes  No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Squamous Cell</td>
<td>Yes  No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>Yes  No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Member:</th>
<th>Eczema</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>Yes  No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin Cancer</td>
<td>Yes  No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Melanoma</td>
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<td>- Squamous Cell</td>
<td>Yes  No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>Yes  No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Member:</th>
<th>Heart Disease</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psoriasis</td>
<td>Yes  No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autoimmune dis.</td>
<td>Yes  No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Member:</th>
<th>Other Cancer</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

SOCIAL HISTORY: (circle one)

Smoking:  Never Smoked  Previous Smoker  Current Smoker: # ciggarettes/day:__________

Alcohol:  Denies Alcohol Use  Occassional Use  # of Drinks/Day:__________

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

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

(Printed name of Patient's Representative) (Relationship)
PATIENT INFORMATION SHEET

NAME: First: ___________________________ MI ______ Last: __________________________________________
DOB: _____________________________ Sex: Male ___ Female ___ SS#: _____________________________

ADDRESS: (Mailing)
Street: ___________________________________ City: _______________________ State: _____ Zip Code: _________

Physical Address if Different than above: ______________________________________________________________

PLEASE LIST PHONE ORDER OF PREFERENCE:
We will use your cell for text confirmations
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:
Name: ___________________________________ Relationship: ________________________________
Address: ___________________________________________________________ Phone #: __________________________

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 _________________________________________________

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) __________________________
INSURANCE

NAME: _____________________________________________ DOB: _______________________

PRIMARY INSURANCE: ________________________________________________________________________
ID#: ________________________________________________ SUFFIX: _____ GROUP #: ________________
Primary Card Holder (Guarantor for billing): _____________________________________________ DOB: _______________________
(Name)/(Relationship) address if different from home address

SECONDARY INSURANCE: ________________________________________________________________________
ID#: ________________________________________________ SUFFIX: _____ GROUP #: ________________
Primary Card Holder (Guarantor for billing): _____________________________________________ DOB: _______________________
(Name)/(Relationship) address if different from home address

TERTIARY 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)