CENTER FOR LASER AND DERMATOLOGIC SURGERY

PATIENT INFORMATION

Date: _____

Name:_____ Gender _____

Date of Birth: _____ Social Security **#:** _____

Address: _____
street city state zip

Home phone: _____ Cell phone: _____

For Patient Portal Access: Email Address _____

❋ **FEDERAL GOVERNMENT REQUIREMENT** Race: _____ Ethnicity: _____ Decline ☐

Emergency Contact: _____ **Phone Number:**_____

Referring Doctor: _____

Primary Care Physician: _____

Pharmacy, Name and Location:_____

INSURANCE INFORMATION

	Primary Insurance	**Secondary Insurance**
Health Insurance Co:	_____	_____
Policy #::	_____	_____
Group #:	_____	_____
Subscriber's Name.:	_____	_____
Relationship to Patient:	_____	_____

(HAVE YOU COMPLETED BOTH SIDES?)

Name:_____ Date of Birth: _____

PLEASE FILL OUT BOTH SIDES

Past Medical History: (please circle ALL that apply)

Anxiety	Depression	Lymphoma
Arthritis	Diabetes	Radiation Treatment
Asthma	Hepatitis	Renal Disease
Atrial Fibrillation	High Blood Pressure	Seizures
Bacterial Endocarditis	HIV/AIDS	Stroke
Coronary Artery Disease	Leukemia	**NONE**

Other: _____

Past Surgical History: (please circle ALL that apply)

Coronary Artery Bypass	Kidney Transplant
Mechanical Valve Replacement	Liver Transplant
Biological Valve Replacement	Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)	
Joint Replacement, Hip, (Right, Left, Bilateral)	**NONE**

Other: _____

Skin Disease History: (please circle ALL that apply)

Actinic Keratoses	Basal Cell Skin Cancer	Squamous Cell Skin Cancer
Precancerous Moles	Melanoma	Blistering Sunburns

Other: _____

Do you have a family history of melanoma? YES NO

If YES, circle who - Mother Father Sister Brother

Medications: (please enter ALL current medication, dosage and frequency)

Medication	**Dosage**	**Frequency**

Medications continued **Dosage** **Frequency**

_____

_____

_____

Allergies (please list all allergies) _____

_____

Cigarette Smoking: ☐ Currently Smokes ☐ Former Smoker ☐ Never Smoked

If current smoker, # of packs per day _____ Number of Years Smoking _____

Alcohol Use: ☐ None ☐ 1-2 drinks per day ☐ Less than 1 drink per day ☐ 3 or more drinks per day

Other: _____

For what are you being seen today? _____

Where on your body is it? _____

How is it bothering you? _____

How severe do you think it is: Mild Moderate Severe

How long has it been there? _____

How has it been treated? ☐ Biopsy ☐ Excision ☐ Frozen ☐ Scraped ☐ Other _____

Do you have:

☐ Problems with Bleeding ☐ Problems with Healing ☐ Problems with Scarring

☐ Unintentional Weight Loss ☐ Pacemaker and/or Defibrillator ☐ Artificial Heart Valve

Have you received a Flu shot this year? YES NO

Have you ever received the Pneumonia Vaccine? YES NO

Do you have a health care proxy? YES NO

If Yes, designated agent name: _____ **Phone Number:** _____

Insured's or Authorized Person's Signature

I authorize the release of any medical or other information necessary to process this claim to my insurance company.

_____

I authorize payment of medical benefits and/or government benefits to Yehuda D. Eliezri, M.D./ Edward B. Desciak, M.D. for services rendered.

_____

I have been notified that should it become necessary to send any outstanding balances to a collection agency, the patient will be responsible for any fees incurred by this office.

_____

IF the Drs. DO NOT participate in your health insurance plan, please sign.

I have been notified that Dr. Eliezri and Dr. Desciak do not participate in my health insurance plan.

I understand that I am responsible for any fees that are incurred at this office.

_____

Center for Laser and Dermatologic Surgery
Yehuda D. Eliezri, M.D. Edward B. Desciak, M.D.
7A Medical Park Drive ❖ Pomona, New York 10970
845-354-1169

NOTICE OF PRIVACY PRACTICES

(MEDICAL)

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

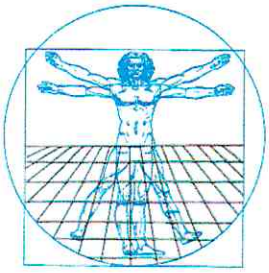
We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

Center for Laser & Dermatologic Surgery
Yehuda D. Eliezri, M.D.
Edward B. Desciak, M.D.
7A Medical Park Drive, Pomona, New York 10970
phone: 845-354-1169 fax: 845-362-5126



RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy

of The Center for Laser and Dermatologic Surgery's Notice of Privacy Practices.

_____ _____

Signature of Patient Date

Center for Laser & Dermatologic Surgery
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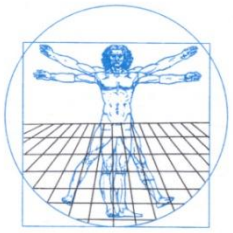

ABOUT YOUR INSURANCE BENEFITS

In the past few years, the number of different health insurance programs has increased at an amazing rate. Even within one insurance company, there may be several programs with varying benefits, referral policies, and requirements. There is no way that we can possibly know or keep up with each program's specifications.

It is **YOUR RESPONSIBILITY** to know and advise us of your insurance company's requirements in advance each and every time we schedule an appointment or provide a service to you.

Please understand that if we have not been advised in advance of your plan's terms or conditions and we provide a service that is not covered by your plan, you will be responsible for the appropriate fees.

These are not our regulations, they are your insurance company's regulations. Unless you follow them carefully the insurance company may decline all or part of your claim. You should contact your insurance company with any questions prior to your appointment with us and discuss your coverage.

As a courtesy our office will bill your insurance for the services you receive. We cannot bill your insurance company unless you provide us with the correct insurance information. **It is your responsibility to inform us if your insurance has changed at any time.** Please understand that the balance of your bill, after your insurance company has paid and notified us of any ***"Patient Responsibility"***, is your responsibility. Please be aware of your guidelines as to co-pays, co-insurance and deductibles. We accept cash, check, American Express, Discover, Visa and Mastercard. All co-pays are due at the time of visit.

I UNDERSTAND AND ACKNOWLEDFGE RECEIPT OF THIS INFORMATION.

_____ _____
Signature Date

_____
Please print your name

Pre-Operative Instructions
For Mohs Micrographic Surgery

- Plan to spend the day with us (between 3-5 hours average).
- Patients and anyone walking into our office, must wear a face mask.
- You may be accompanied by ONE person only.
- Wear comfortable clothing that does not pull up over your head, (e.g. a top that buttons, V-neck sweater).
- You can eat a normal breakfast or lunch the day of your surgery. You may bring snacks, lunch and drinks with you.
- Refrain from all alcohol seven days prior to surgery.
- You may require sutures after surgery and therefore, you will need to return to the office 7-14 days after surgery to have the sutures removed.

Your co-pay is expected the day of your surgery. If you require a referral, YOU are responsible to speak with your primary care physician and either fax it to us or bring it with you the day of your appointment. If you DO NOT have your required referral, your appointment will be rescheduled.

Please bring your insurance cards with you.

What is Mohs surgery?

Mohs surgery is performed by doctors who are specially trained to fulfill three roles:

1. As the surgeon who removes the cancerous tissue
2. As the pathologist who analyzes the lab specimens
3. As the surgeon who closes or reconstructs the wound

The procedure is done in stages, all in one visit, while the patient waits between each stage. After removing a layer of tissue, the surgeon examines it under a microscope in an on-site lab. If any cancer cells remain, the surgeon knows the exact area where they are and removes another layer of tissue from that precise location, while sparing as much healthy tissue as possible. The doctor repeats this process until no cancer cells remain.

Mohs surgery is the gold standard for treating many basal cell carcinomas (BCCs) and squamous cell carcinomas (SCCs), including those in cosmetically and functionally important areas. Mohs is also recommended for BCCs or SCCs that are large, aggressive or growing rapidly, that have indistinct edges, or have recurred after previous treatment.

Advantages of Mohs Surgery

Efficient, cost-effective treatment:

- Single-visit outpatient surgery
- Local anesthesia
- Lab work done on-site

Precise results:

- Physician examines 100% of tumor margins
- Spares heathy tissue
- Leaves the smallest scar possible

The highest cure rate:

- Up to 99% for a skin cancer that has not been treated before
- Up to 94% for a skin cancer that has recurred after previous treatment