Stony Brook Medicine

Department of Dermatology

Dear Patient,

We welcome you to Stony Brook Dermatology Associates. It is important not to rush through these forms since important (requested) data such as your medical history must be accurate and thorough. If you are unsure of any section, leave it blank and we will assist you when you arrive.

Please remember to bring your completed forms, your insurance card so that we can scan it into your electronic medical record, and your referral (if applicable). Insurance referrals authorize payment for medical services & if you are insured with a carrier that requires one, it is your responsibility to obtain it & confirm that it has either been submitted electronically by your primary care physician (PCP) and or received in the office. If you need the ID# for the dermatologist you will be seeing, we are more than happy to provide you with the information you need to ease the process. **All (paper) referrals should be sent to fax# 631-638-4220.**

We respectfully request a minimum 24hr. advance notice if you need to cancel or reschedule your appointment to avoid incurring a "No Show" fee. We understand that you may have changes to your own schedule however, our goal is to maximize appointment availability to ensure that all patients on our wait list can avail themselves of unexpected appointment openings.

If you have any questions prior to your visit, please feel free to contact us @ 631-444-4200 and we will be happy to assist you.

Sincerely,

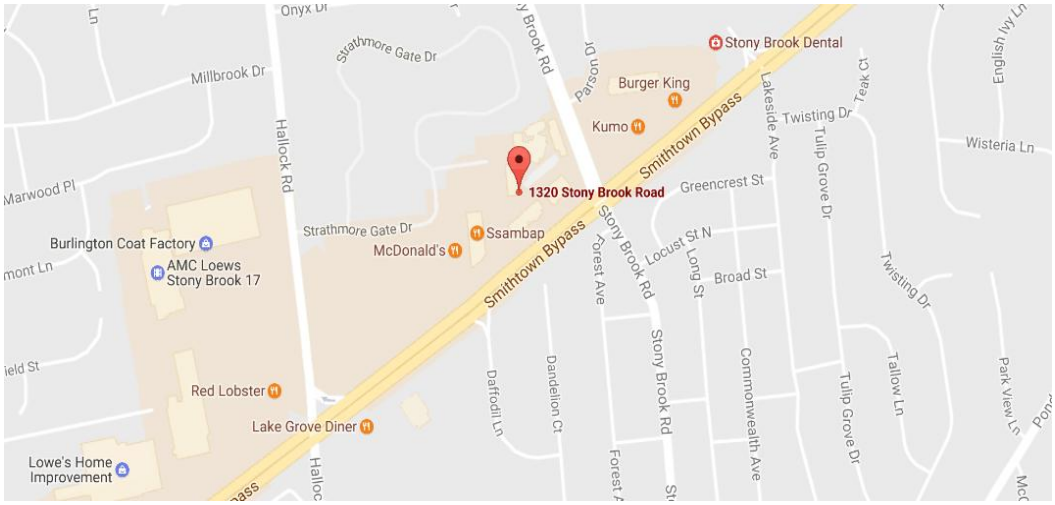
Julie Bouziotis
Practice Administrator

DIRECTIONS
1320 Stony Brook Road
Building F, Suite#200
Stony Brook, NY 11790

Directions to our office can be obtained by calling our main number @ 631-444-4200 and pressing option 5

Please note that there is another entrance on 347 Nesconset Highway (it is the 1st right turn after the traffic light at 347 Nesconset Highway & Stony Brook Rd.) traveling West. If traveling East, one would need to make a legal U-turn at this traffic light to access. Once you enter, make a right after the yield sign or go straight and loop around to access parking near Building F

- **From the LIE (Long Island Expressway)** take exit 62 North to Route 97/Nicolls Road. Stay on Nicolls Road for approximately 8 miles and turn left on Route 347/Nesconset Highway heading west. At the 2nd light turn right on Stony Brook Rd. and turn left into the shopping center either after Duane Reade or after Ralph's Italian Ices
- **From the NS (Northern State Parkway North)** take to the end & follow signs for Route 347 (Nesconset Highway) heading east for approximately 9 miles. Turn left on Stony Brook Road and turn left into the shopping center either after Duane Reade or after Ralph's Italian Ices
- **From Route 347 (Nesconset Highway) traveling West** turn right onto Stony Brook Road and turn left into the shopping center either after Duane Reade or after Ralph's Italian Ices
- **From Route 347 (Nesconset Highway) traveling East** turn left onto Stony Brook Road and turn left into the shopping center either after Duane Reade or after Ralph's Italian Ices
- **From 25A traveling East** turn right onto Stony Brook Road just before 347 (Nesconset Highway) and turn right into the shopping center either after Duane Reade or after Ralph's Italian Ices
- **From 25A traveling West** turn left onto Stony Brook Road just before 347 (Nesconset Highway) and turn right into the shopping center either after Duane Reade or after Ralph's Italian Ices



Name: _____ DOB: _____

STONY BROOK DERMATOLOGY ASSOCIATES

- REASON FOR VISIT: _____
- WEIGHT_____ HEIGHT_____
- ALLERGIES_____
- DO YOU FEEL WELL TODAY? YES ___ NO ___
  - If no what are your symptoms_____
- ARE YOU HAVING ANY PAIN? YES ___ NO ___
  - If yes, please tell us your pain level from 0-10 (0=none, 10 = worst) _____
  - What is your pain tolerance (threshold)? _____
- WHAT IS YOUR PRIMARY LANGUAGE?_____
- BARRIERS TO LEARNING: (impaired vision, hearing, reading or speaking) YES ___ NO ___
  - If yes, please explain_____
- PATIENT/PARENT LEARNING PREFERENCES

  ___ DEMONSTRATION ___ EXPLANATION ___ PRINTED MATERIALS

  ___ VIDEO ___ WEB BASED

- DO YOU PREFER SOMEONE PRESENT DURING TEACHING? YES ___ NO ___
  - If yes, who? _____
- DO YOU HAVE CULTURAL/RELIGIOUS PRACTICES THAT AFFECT PROVISION OF YOUR HEALTHCARE? YES ___ NO ___
  - If yes please explain _____
- DO YOU HAVE TROUBLE WALKING OR STANDING? YES ___ NO ___
- HAVE YOU FALLEN IN THE PAST 12 MONTHS YES ___ NO ___
- DO YOU HAVE A FEAR OF FALLING YES ___ NO ___

WHEN WAS YOUR LAST INFLUENZA VACCINE? _____

Please list your MEDICATIONS or provide a current list at the time of your appointment:

NAME	DOSE	HOW MANY TIMES A DAY TAKEN

Name: _____ DOB: _____

- DO YOU USE TOBACCO YES ___ NO ___
- HAVE YOU EVER USED TOBACCO YES ___ NO ___
- DO YOU USE ALCOHOL YES ___ NO ___
  - How much_____
- DO YOU FEEL SAFE AT HOME YES ___ NO ___

IS THERE A FAMILY HISTORY OF:

___ SKIN CANCER Who? _____

___ MELANOMA Who? _____

___ ANY CANCERS Who? _____

___ Other skin diseases & Who?_____

DO YOU HAVE A PERSONAL HISTORY OF SKIN CANCER? YES ___ NO ___

- IF YES, WAS IT A MELANOMA? YES ___ NO ___

LIST ALL MEDICAL PROBLEMS

_____

_____

_____

- Heart valve problems: Yes ___ No ___
- Artificial joints: Yes ___ No ___
- Hepatitis: Yes ___ No ___
- Pacemaker/Defibrillator: Yes ___ No ___
- Do you need antibiotics before procedures? Yes ___ No ___

LIST ANY PROCEDURES

_____

_____

_____

COMMUNICATION CONSENT

STONY BROOK DERMATOLOGY
1320 Stony Brook Road
Building F, Suite #200
Stony Brook, NY 11790

It is the policy of Stony Brook Dermatology not to release confidential information other than face to face without **authorization** to do so by alternative methods (Voice Mail/Answering Machine/Telephone). Any information that will be provided will be released only to the authorized person (s) listed below.

I authorize Stony Brook Dermatology, and/ or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes (please fill out all contact information).

Home Telephone: _____-_____-_____ YES ____ NO____
Answering Machine: YES ____ NO ____
Work Telephone: _____-_____-_____ YES ____ NO ____

Cell/ Voice Mail: _____-_____-_____ YES ____ NO ____

E-mail: _____@_____.com YES ____ NO ____

Regular Mail: YES ____ NO ____

If you would like to have information released to someone other than yourself, please complete the following list of authorized people:

Spouse: _____ Tel: _____-_____-_____

Adult Child: _____ Tel: _____-_____-_____

Other (please indicate relation): _____Tel: _____-_____-_____

Print Patient Name: _____Preferred Tel: _____-_____-_____

Patient Signature: _____

E-Prescribing Consent Form

Patient's Name _____ Date of Birth: _____

Stony Brook Dermatology Associates, UFPC is in the process of implementing e-Prescribe (electronic prescribing) in our ongoing efforts to maximize patient safety.

Total Quality in patient care is just one of our ongoing commitments…

Patient benefits:

- Less confusion over handwritten prescriptions or unclear phone calls
- Reduced possibility of medical errors
- Less chance of adverse drug reactions
- Fewer trips to drop off at the pharmacy
- A safer, faster & easier way to get your prescription filled

Please list any DRUG allergies:

_____ _____

_____ _____

_____ _____

Please provide our office with your **pharmacy name (s)**, address & phone number so that we may enter this data into your medical record.

Pharmacy Name (1st Choice):	Pharmacy Name (2nd Choice):
_____	_____
Street Name, Town OR **ZIP CODE**:	Street Name, Town OR **ZIP CODE**:
_____	_____
Ph#: _____-_____-_____ (if known)	Ph#: _____-_____-_____ (if known)

Patient Consent:

I agree that Stony Brook Dermatology Associates, UFPC may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes. This consent form will be updated on an annual basis.

_____ _____/_____/_____

Patient Signature Date

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Stony Brook Medicine

Ambulatory Care and/or Pre-Surgical Testing Consent

By signing below I consent to receive treatment and for the use and disclosure of my health information to provide treatment, arrange for my medical care, seek and receive payment for services provided to me and for the business operations of the Hospital and its staff.

I understand that with my permission, photographs/video and/or voice recordings may be taken of me and used for medical or scientific purpose such as documenting or planning my care, teaching or publication in a scientific journal. I understand that every attempt will be made to conceal my identity (name) prior to publication in a scientific journal or display of the photographs/video and/or voice recordings. I understand that the photographs/video and/or voice recordings taken to document my care may be a part of my medical record and those taken for other purposes may not be a part of my medical record.

I have been provided a copy of the SBOHCA Notice of Privacy Practices (Notice) on, or prior to this visit, and have therefore been advised of how health information about me may be used and disclosed by the Hospital and the facilities listed at the beginning of the Notice, and how I may obtain access to and control this information.

I acknowledge the receipt of the Ambulatory Care Patient Guide on, or prior to this visit.

I understand this authorization, for the use and disclosure of my health information to provide treatment, arrange for my medical care, seek and receive payment for services provided to me and for the business operations of the Hospital and its staff, may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in 12 months from the date signed.

I also understand I may refuse to sign this form and that my health care and payment will not be affected. The facility, its employees, officers and physicians are hereby relased from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I may request a copy of this form after signing.

Signature of Patient or Patient Representative	Date	Time
Print Name of Patient or Personal Representative	Date	Time
Relationship, if signed by person other than Patient	Date	Time

Signature of Witness

Print Name of Witness

Date

Time

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Stony Brook Medicine
Stony Brook, NY 11794

AGREEMENTS FOR PHYSICIAN PRACTICES

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☐ **Financial Agreement / Guarantee of Payment:** I, the undersigned patient or responsible party, agree to be fully responsible for payment to Stony Brook University Hospital / University Faculty Practice Corporations for the care and treatment of the patient whose name appears on this form.
I understand that this includes cost sharing payments to the provider (including any co-payments and deductibles) for care and treatment as required by the patient's health insurance contract and benefits.
I understand that the patient is responsible for ensuring that authorizations and approvals are obtained as required by their insurance company. If prior approval is not obtained when required or authorization has been denied, I am fully responsible for all charges that the insurance company does not pay, as may be specified under the provisions of my contract and the extent permitted by law.
I understand that I am responsible to provide accurate information to the provider regarding: contact, demographic, health insurance and other pertinent information required for hospital / professional billing and that I must promptly notify the provider of any changes in this information. I agree to provide any other information reasonably requested by the provider in order to bill for the care and treatment provided.
I understand that if I have any questions about my bills I may call:

- 631-444-4151 for Patient Accounts/ Hospital Billing.
- 631-444-4800 for Physician Services

☐ **Release of Information:** I consent to the release of all or part of my health record, including my social security number to insurance carriers, government agencies, and other third party payors as needed in order for Stony Brook University Hospital/University Faculty Practice Corporations to obtain reimbursement for my care. I also understand that my social security number may be provided to the New York Department of Health in accordance with incidence reporting and other New York State hospital regulatory requirements and to manufacturers of medical devices and the Federal Food and Drug Administration for medical device tracking purposes. I consent to the use and disclosure of my protected health information as necessary to treat my condition, obtain payment for treatment and conduct health care operations.

☐ **Release of Information to Primary Care Provider & Uniform Assignment**

Release of Information to Primary Care Provider: I authorize Stony Brook University Hospital, its Emergency Department, and University Faculty Practice Corporations staff to disclose the health care related information for this Emergency Department encounter to my Primary Care Practitioner (PCP) for the purpose of continuity of my health care. I understand that this will include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection.

Uniform Assignment: I transfer, assign and set over to Stony Brook University Hospital/University Faculty Practice Corporations, sufficient monies and or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my hospitalization and medical care to cover the costs and treatment rendered to myself or my dependent.

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Stony Brook Medicine
Stony Brook, NY 11794

AGREEMENTS FOR PHYSICIAN PRACTICES

The following section ONLY pertains to Medicare patients. Patients signing this form who have Medicare Benefits understand that this information is included for their signature.

☐

MEDICARE

Medicare Assignment of Benefits: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers, any information needed for this or any related Medicare Claim. I request that payment of authorized benefits be made on my behalf directly to physician or organization providing medical care. I assign, transfer and set over all benefits payable for physician services to the physician or organization to submit a claim to Medicare for payment to me.