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

500 Commack Road Suite#102
Commack, NY 11725

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

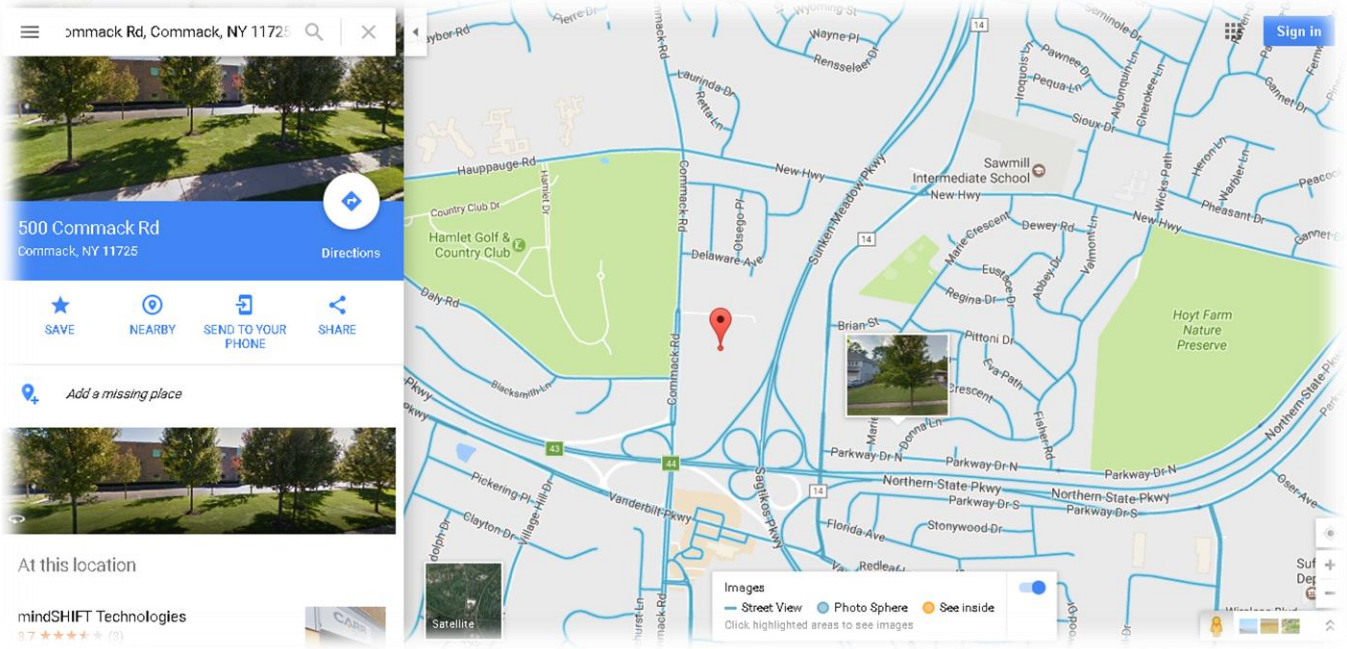
From the LIE (Long Island Expressway) take exit 53 toward Bayshore/Kings Park. Keep right to take the ramp towards Kings Park. Merge onto Sagtikos Parkway North. Take exit SM1W toward New York. Merge onto Northern State Parkway West. Take County Highway 4 exit 43 toward Commack. Turn left onto Commack Road #500 turn right into the parking lot.

From the Northern State Parkway take to County Highway 4 exit 43 toward Commack. Turn left onto Commack Road #500 turn right into the parking lot.

From 347 (Nesconset Highway) travelling West stay straight to go onto Northern State Parkway West. Take County Highway 4 exit 43 toward Commack. Turn left onto Commack Road #500 turn right into the parking lot.

From Sunrise Highway take the Robert Moses Parkway ramp North. Take the exit towards East Islip. Keep left at the fork and merge onto Southern State Parkway East. Keep left to take Sagtikos Parkway North via exit 41A toward Kings Park. Take exit SM1W toward New York. Merge onto the Northern State Parkway West. Take the County Highway 4 exit 43 toward Commack. Turn left onto Commack Road #500 turn right into the parking lot.

From Southern State Parkway take exit 41A Sagtikos Parkway North towards Kings Park. Take exit SM1W toward New York. Merge onto Northern State Parkway West. Take County Highway 4 exit 43 toward Commack. Turn left onto Commack Road #500 turn right into the parking lot.



NEW PATIENT PAPERWORK PACKAGE "CHEAT SHEET"

Page 1: **E-Prescribing Consent Form**"

- Please only list known DRUG allergies. If none known please indicate "N/A"
- Enough pharmacy information for us to identify in the database (name, town, & zip code)

Page 2: **"Communication Consent"** – Patient approval regarding private health information (HIPAA)

Page 3: "**Ambulatory Care Consent Form**"

This form is requesting your consent to receive care in our outpatient facility as well as your confirmation of receipt of our notice of privacy practices

- Please write in your name & D/O/B
- Sign on the 1st signature line IF you are the patient or patient representative
- Indicate your relationship IF you are NOT the patient who has signed
- Please write in the date

Page 4-5. **Agreement for Physician Practices** (Billing & HIPAA consents)

Page 6: **"Ambulatory Care Summary List"**

This is to be completed by the patient or patient's guardian. This provides your doctor with medical history & clinical information that becomes part of your medical record (4 separate & distinct categories)

Allergies/Medical Conditions/Past Procedures/Medications

In any section where there is no applicable information for you to enter, please write in "N/A" to indicate that this is not applicable

Remember that it's important to provide any & all information within each category that is known to you

Page 7: **Related Historical Information Sheet/Primary Care Physician & HIPAA information**

PLEASE write your name on top

- These are a series of Yes & No questions – please answer ALL
- Please complete current PCP & Referring physician information
- Don't forget to answer the permission to discuss your medical condition (HIPAA) question @ the bottom
- Do NOT forget to sign @ the bottom!

Page 8: "**Adult Patient Needs Assessment**"

It is critical that this be completed in its entirety to ensure that we plan proper accommodations if needed.

IF the patient is a ***child***, the following sections apply to his/her guardian:

- Communication
- Culture
- Learning Preference
- Domestic Concerns

Falls Risk & **Nutrition Screen** applies to the child/patient

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):

_____

Street Name, Town OR **ZIP CODE**:

_____

Ph#: _____-_____-_____ (if known)

Pharmacy Name (2nd Choice):

_____

Street Name, Town OR **ZIP CODE**:

_____

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

COMMUNICATION CONSENT

STONY BROOK DERMATOLOGY
181 BELLE MEAD ROAD
SUITE 5
SETAUKET, NY 11733

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: _____

A D 2 C 0 3 4

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

AGREEMENTS FOR PHYSICIAN PRACTICES

☐ **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.

AD2N538

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.

State University of New York
UNIVERSITY HOSPITAL
AND MEDICAL CENTER
Stony Brook, New York 11794

AMBULATORY CARE SUMMARY LIST

Service: _____

Service Phone # _____

Pt. Name: _____

M.R.#: _____

D.O.B.: _____

Phone (h)_____

(c)_____

(w)_____

Ambulatory Care Guide Given ☐ (date) _____

Advanced Directive Documents Received from Patient ☐ (date) _____

Allergies / Adverse Reactions (Describe) ☐ No Known Allergies

Allergy	Description	Allergy	Description	Allergy	Description

Diagnoses/ Medical Conditions

DATE		DATE RESOLVED	DATE		DATE RESOLVED

Heart valve problems such as MVP? Yes No
Artificial joints? Yes No
Hepatitis? Yes No
Pacemaker/Defibrillator? Yes No

Do you need antibiotic prophylaxis? Yes No
If yes, please list_____

Past Operative/Invasive Procedures

Past Operative/Invasive Procedure	Date	Past Operative/Invasive Procedure	Date

Medications (prescribed for or used by the patient)

Start Date	Medication Name	Dose	Route	Frequency	Stop Date

Stony Brook Dermatology Associates Registration Form

Name: _____
Last **First** MI □Mr. □Mrs. □Ms. □Miss □Dr

Address _____
Street # **Street Name** **Apt#**

_____
City **State** **Zip**

Home Phone: _____-_____-_____ Cell Phone#_____-_____-_____ Email: _____ _____

Social Security # _____-_____-_____ Employer: _____

Primary Insurance: _____ID# _____ Referral Required? Y N

FAMILY HISTORY: Please indicate if there is a family history of any skin conditions or cancers Y N

Relationship to you – Father/Mother/Sister/Brother/Other_____

MEDICAL HISTORY: Please circle yes or no if you **have** or **have had** any of the following:

Y N HEART DISEASE
Y N HIGH BLOOD PRESSURE
Y N BREATHING PROBLEMS
Y N DIABETES
Y N THYROID DISEASE
Y N PROSTATE DISORDER
Y N LIVER DISORDER
Y N STOMACH/INTESTINAL DISORDER
Y N EAR OR EYE DISORDER
Y N JOINT PAIN
Y N HIV/AIDS

Y N STROKE
Y N CANCER
Y N SKIN CANCER
Y N ANY SKIN DISEASE
Y N PSYCHIATRIC CONDITION
Y N SEIZURES
Y N WEIGHT LOSS
Y N BLEEDING DISORDER
Y N MIGRAINES
Y N Other _____

Please indicate:
Height: ____'____" Weight: _____ lbs.

SOCIAL HISTORY:

1. Do you use Tobacco Y N If yes, how much_____
2. Do you use Alcohol Y N Social Weekends Daily (please circle)
3. Occupation _____ 4. SINGLE MARRIED DIVORCED WIDOWED (please circle)

Females only:
5. Are you pregnant? Y N **6.** Are you breast-feeding? Y N **7.** Are you planning to become pregnant? Y N

Primary/Family Physician Name & Address

_____

_____

Phone #_____

Referring Physician Name & Address

_____

_____

Phone #_____

_____ DATE _____/_____/_____
PATIENT (OR GUARDIANS) SIGNATURE

AC2C030

STONY BROOK UNIVERSITY MEDICAL CENTER

ADULT PATIENT NEEDS ASSESSMENT

Communication:

Do any of the following apply to you?

☐ Impaired Vision
☐ Impaired Hearing
☐ Reading or Speaking Problems
☐ Pain
☐ Concerns about your illness
☐ None of the above
☐ Other _____

What is your primary language? _____

Do you have difficulty understanding English? ☐ Yes ☐ No

Can you read English? ☐ Yes ☐ No

What language do you prefer when receiving information? _____

Culture:

Do you have any Cultural/ Religious/ Spiritual Practices that are important for us to know to provide your health care?

☐ Yes ☐ No If Yes, please describe_____

_____

Learning Preference:

How do you prefer to learn?

☐ Reading ☐ Person explaining to me ☐ Seeing/pictures ☐ Demonstration ☐ Video/Television

Is there anyone you would like to have with you during your teaching? If so, whom? _____

Domestic Concerns:

Have you been a victim of mental or physical abuse? ☐ Yes ☐ No

Do you feel that you are currently in danger at home? ☐ Yes ☐ No

Falls Risk:

Do you have a fear of falling? ☐ Yes ☐ No

Have you fallen in the last 12 months? ☐ Yes ☐ No

If you answered "YES" to either of these two questions, please notify staff immediately.

Nutrition Screen:

Have you noticed a decrease in appetite within the last month? ☐ Yes ☐ No

Have you had an unexplained weight loss (over 10 lb.) over the past 3-6 months? ☐ Yes ☐ No

Please describe your appetite: ☐ Good ☐ Fair ☐ Poor ☐ Other _____

Patient/Designee Signature: _____Date: _____

Practitioner Signature:_____ ID#:_____ Date: _____Time: _____