PATIENT_____

(LAST) (FIRST) (MIDDLE INITIAL)

ADDRESS_____

_____

HOME PHONE #_____ **CELL PHONE #**_____

BUSINESS PHONE #_____ **E-MAIL**_____

(PLEASE GET MORE THAN ONE WAY OF CONTACTING THE PATIENT!)

DATE OF BIRTH_____

REFERRING MD_____

REASON FOR VISIT_____

WAS LESION BIOPSIED?_____

(PLEASE GET A COPY OF THE BX ASAP)

IS LESION ON/NEAR EYELID?_____

IS THE PATIENT ON COUMADIN?_____

IF ON COUMADIN, GET A RECENT INR FROM PRESCRIBING PROVIDER

Do you take Ibuprofen (Motrin/Advil) yes/no ***Do you take Naproxen***(Naprosyn/Aleve) yes/no

(If patient takes any of the above, they need to stop taking it **2 days** before surgery, and resume 2 days after)

Do you take any of the following:

Vitamins yes/no Fish Oil yes/no Garlic yes/no Ginko yes/no Ginseng yes/no

(If patient is on any of the above, they need to stop taking it **1 week** before surgery, and resume 2 days after)

PRIMARY INSURANCE

COMPANY NAME_____

INSURED"S NAME & DOB_____

POLICY #_____

GROUP #_____

SECONDARY INSURANCE

COMPANY NAME_____

INSURED'S NAME & DOB_____

POLICY #_____

GROUP #_____

Certification of Active and Valid Insurance
& Assignment of Benefits

Patient: _____

Primary Insurance: _____ ID #: _____

Secondary Insurance: _____ ID #: _____

I (patient or guardian), _____, Social Security #: _____
voluntarily declare that I have the following valid and active health insurance for today's doctor visit. I fully understand that I will be responsible for payment of the services rendered if my insurance is not valid and active at the time of service.

I, _____ , do hereby request and instruct the above insurance company to pay by check made payable and sent directly to:

SKIN CANCER CENTER OF FAIRFIELD COUNTY PC
6 Business Park Drive, Suite 204
Branford, CT 06405

If current policy prohibits direct payment to the above named doctor and/or diagnostic firm, then I hereby also direct and instruct you to make out the check to me and mail it as follows:

SKIN CANCER CENTER OF FAIRFIELD COUNTY PC
6 Business Park Drive, Suite 204
Branford, CT 06405

This is for professional services rendered to me, and as payable under my policy benefits. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed to the above-mentioned assignee, and I have agreed to pay in a current manner, any balance of said professional service charge over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorny involved in this case.

_____ _____
Patient/Responsible Party Signature Date

Address: _____

Driver's License #: _____ State Issued: _____

The Skin Cancer Center of Fairfield County

PRIVACY NOTICE WRITTEN ACKNOWLEDGEMENT

Name:_____
(Last) (First) (Middle)

I understand that the Skin Cancer Center of Fairfield County (the "Center") may use my health information for treatment, payment and health care operations. I have been shown a copy of the Center's Notice of Privacy Practices that describes how my information is used and disclosed. I understand that the Center has the right to change this Notice at any time. I may obtain a current copy of the Notice by contacting the Center's Privacy Officer at (203) 957-3535.

_____ _____
Signature of Client/Parent/Legal Guardian or Personal Representative — **Date**

_____ April 1, 2013
If signed by Personal Representative, relationship to client — Privacy Notice Effective Date

DOCUMENTATION OF GOOD FAITH EFFORT (TO BE COMPLETED BY CENTER STAFF)

Notice of Privacy Practices and Written Acknowledgement provided to the client/parent/ legal guardian or other personal representative, by:

- ☐ Hand delivery,
- ☐ Sent to the client/parent/legal guardian at the address of record, or
- ☐ Sent to the client/parent/legal guardian at the Email address of record

Client/parent/legal guardian or other personal representative:

- ☐ Expressly states they decline to sign Written Acknowledgement of receipt of Notice because _____
- ☐ Has not expressly declined, but has failed to return the signed Written Acknowledgement, despite the following good faith efforts to obtain the return of the Acknowledgement:

Signature Date

Andrew M. Herbst MD
Fellow American Academy of Dermatology
Fellow American College of Mohs Surgery

6 Business Park Drive, Suite 204, Branford, CT 06405
P: 203.957.3535 F: 203.957.3536
www.skincancercenterct.com

The Skin Cancer Center of Fairfield County

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

Name: _____
Last *First* *MI*

Account No: _____ Date of Birth: _____

I authorize the disclosure and use of my protected health information by The Skin Cancer Center of Fairfield County (Center) as described below:

1. Who may receive and use this information?
(Print their name, address, phone number and relationship to you.)

_____

_____

2. List any restrictions on the information to be released

_____

_____

I understand that:
• I may revoke this authorization at any time by notifying, in writing, the Center at the address below.
• Revoking this authorization does not apply to information that has already been released under this authorization.
• I have the right to inspect or copy the health information to be disclosed.
• If the disclosed information goes to a health care provider or a health plan covered by federal privacy laws, it will be protected by federal privacy laws.
• Information that goes to other persons or entities may not be protected by state or federal privacy laws and may be re-disclosed.
• I do not have to sign this form. Treatment will still be provided to me if I do not sign this form. Payment for services is not contingent upon me signing this form, unless those services are for the sole purpose of creating personal information for a third party, such as life insurance companies.

_____ _____
Signature of Patient or Patient's Representative Date

Andrew M. Herbst MD
Fellow American Academy of Dermatology
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