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
148 East Ave, Suite 3B
Norwalk, CT 06851

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
148 East Ave, Suite 3B
Norwalk, CT 06851

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

148 East Ave., Suite 3B, Norwalk, DT 06851
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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