ocean DERMATOLOGY
DERMATOLOGY • DERMATOLOGIC & COSMETIC SURGERY

STEVEN M. WEISSMAN, M.D. | ZECHARIA LIND, P.A.
MERIDIAN HEALTH VILLAGE
27 S. COOKS BRIDGE ROAD • SUITE 2-14 • JACKSON, NJ 08527
P 732.876.3376 • F 732.876.0276 • OCEANDERMATOLOGY.COM

Patient Information

Name _____

Prefer to be called_____

Social Security # _____

Birth Date _____ Age _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____

Work Phone _____

E-mail Address _____

Occupation _____

Employer _____

Pharmacy Name_____

Pharmacy Phone #_____

Gender: ☐ Female ☐ Male

Marital Status: ☐ Married ☐ Partnered

☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Primary Care Doctor

Do you have a Primary Care Doctor? ☐ No ☐ Yes

Physician's name: _____

Physician's Contact Number: _____

Person to Contact in Case of Emergency

Name _____

Relationship _____

Telephone _____

PATIENT AUTHORIZATION

I, the undersigned, hereby certify that I have insurance coverage and I assign all insurance benefits, if any, to Ocean Dermatology for services rendered. I understand that I am responsible for all copayments / coinsurance, deductibles and otherwise elective non-covered services provided to me. I authorize the use of this signature on all insurance submissions. I authorize the release of any medical information necessary to process any claim.
I hereby agree that I am financially responsible for all services provided to me by Ocean Dermatology.

Signature _____ Date _____

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Health Information

Please CHECK off anything that you **currently have** or **have recently had:**

Health Issues:	**Skin History (Cancerous):**	**Skin History (Non-Cancerous):**
□ Anxiety □ Arthritis □ Asthma □ AIDS/HIV □ Diabetes □ Hepatitis A, B or C □ Heart Disease □ High Blood Pressure □ Stroke □ Seizures □ Leukemia/Lymphoma □ Liver Disease □ Blood Clots □ Depression □ Hyperthyroidism □ Hypothyroidism □ Radiation □ Chemotherapy □ Cancer (Other than skin): _____ _____	□ Basal Cell Carcinoma Where/When:_____ _____ □ Squamous Cell Carcinoma Where/When:_____ _____ □ Melanoma Where/When:_____ _____ □ Actinic Keratosis □ Precancerous Moles **Family History of Skin Cancer:** □ Who/What Kind: _____ _____ _____ _____	□ None □ Acne □ Poison Ivy □ Eczema □ Dry Skin □ Psoriasis □ Flaking or Itchy Scalp □ Other:_____ _____ _____ _____

Surgeries (Skin)		
Year	Reason	Hospital

FOR WOMEN ONLY:		
Date of last menstruation:		
Are you pregnant? □ Yes □ No	Are you breastfeeding? □ Yes	□ No

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List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name of Drug:	Strength	Frequency Taken
NON-Prescription: □ Aspirin □ Ibuprofen (Advil, Motrin) □ Naproxen (Aleve)		
Blood Thinners: □ Coumadin (Warfarin) □ Plavix (Clopidogrel) □ Pradaxa (Dabigatran) □ Xarelto (Rivaroxaban)		
Allergies (Medications)		
Name of Drug:	Reaction:	

HEALTH HABITS AND PERSONAL SAFETY		
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.		
Alcohol	Do you drink alcohol? □Yes □No	
Tobacco	Do you use tobacco? □Yes □No	

Is there anything else you would like to inform Ocean Dermatology about your medical history that you think may be important?

_____

_____

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Patient Name: _____ DOB: _____ Date: _____

Email: _____

All Patients

Have you received the flu vaccine this year?
- ☐ Yes (G8482)
- ☐ No (Reason: _____ (G8483)

Do you have a history of Melanoma?
- ☐ Yes (3320F, G8749 & 7010F)
- ☐ No

Are you on a biologic (ex: Stelara) for psoriasis?
- ☐ Yes (G9359)
- ☐ No

Patients 65 and older

Do you have an Advance Care Plan/Directive?
- ☐ Yes (1123F) If yes, please name your Surrogate Decision Maker: _____
  Relationship: _____
  Phone Number: _____
- ☐ Decline to answer (1124F)

Have you EVER received the pneumonia vaccine?
- ☐ Yes (4040F)
- ☐ No (4040F w/ 8P)

Patients 12 and older

Tobacco Use:
- ☐ Non-Smoker (1036F – 20 and younger G9459)
- ☐ Smoker (4004F – 20 and younger G9458)

Medications:

- ❑ No current medications

_____

_____

_____

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Consent for Operative and/or Diagnostic Procedures

The risk of undergoing procedures at Ocean Dermatology may include but are not limited to scar, pigmentary changes/blemishes, infection, bleeding and numbness. Less likely risks include permanent nerve damage and deformity. Often the risks noted may be remedied by secondary procedures. Sometimes multiple procedures are required to treat a dermatological problem. The benefits of undergoing procedures include diagnosing and potentially curing a skin problem. I recognize that the practice of medicine is not an exact science, and acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures.

1. I hereby authorize Ocean Dermatology and associates to perform upon me or the named patient the following operations and/or course of treatment including such photographing, videotaping, televising or other observation of the operation(s)/ procedure(s) as may be purposeful for the advance of medical knowledge and/or education, with the understanding that my/the patient's identity will remain anonymous.

2. Ocean Dermatology or associates has fully explained to me the purpose of the operation(s)/ procedure(s) and has also informed me of expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment, including no treatment. The attendant risks of no treatment have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.

3. I understand that during the course of the operation(s)/procedure(s) unforeseen conditions may arise which necessitate procedures different from those contemplated. I, therefore, consent to the performance of additional operation(s)/procedure(s) that may consider necessary.

4. Any organs or tissues surgically removed may be examined and retained by the hospital/lab for medical, scientific or educational purposes and such tissues or parts may be disposed of in accordance with customary practices.

5. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the operation(s)/procedure(s).

6. I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above that do not pertain to me.

_____ _____ _____
Signature Print Name Date

_____
Relationship to Patient

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PATIENT BILLING & FINANCIAL INFORMATION

We offer the following information to help you understand our financial policies and encourage you to ask us any questions relating to the services you may receive. Any members of our billing department will be glad to discuss payment arrangements with you or your responsible party.

Ocean Dermatology, PC participates with many insurance companies, including HMO, PPO, POS, and several local plans. It is your responsibility to make sure that we are participating with your health plan or that you have out-of network benefits. If we do not participate in your plan, payment in full is expected at each visit. We make every effort to verify your insurance coverage prior to your appointment, in order to notify you of your financial responsibility at the time of your appointment. In the event that your coverage cannot be verified prior to your appointment, you will be responsible to pay for any services administered at the time you are seen.

Ocean Dermatology, PC will file your insurance claim for you. Therefore, at the time you check in, you will be asked to present your health insurance card so we may retain a copy for our records. If your policy requires, it will be your responsibility to make sure a referral from your primary care physician or your insurance company is obtained prior to your appointment. If you do not have a referral you may reschedule your appointment or contact your doctor from our office. However, you will not be seen until your referral has been received in our office.

If your insurance company declines to cover the services provided or pays less than the actual cost, you will be responsible for any remaining balance that your coverage deems your responsibility. All copayments and deductibles are due at the time services are rendered. A $25 surcharge will be added to your account if your payment is not paid at the time of your appointment. If you pay by check and your bank returns your check you will be charged a $25 returned check fee and/or $35 fee for any payments written on a closed account.
Summary: You may be responsible for a bill if:

- Your biopsy/pathology or lab samples are sent to labs outside of our office. These services are billed on a separate invoice from the lab, and will be your responsibility to pay them directly. This is in addition to our charge.
- You have a deductible that has not been met at the time services are rendered. Please keep in mind that some insurance plans have a separate surgical and/or pathology deductible which is not included in your annual medical deductible.
- The service is not a covered service under your plan
- Your insurance company deems the services to be not medically necessary
- Your plan requires you to pay a coinsurance on any services rendered

By signing this document you acknowledge that you have read the above information regarding our billing policies.

_____ _____ _____
Signature Print Name Date

_____
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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that the information can and will be used and disclosed to carry out treatment, payment and healthcare operations such as but not limited to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third party payers, including but not limited to health insurance and credit card issuers.

- Conduct normal healthcare operations such as quality assessments and physician certifications.

You have informed me of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my health information. I have been given the right to read and review your Notice of Privacy Practices before signing this consent. I understand that Ocean Dermatology PC has the right to change its Notice of Privacy Practices from time to time and, since revisions may apply to my health care information, that I may contact the organization's Privacy Officer to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations and I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I am entitled to a copy of this consent form after I have signed it.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Authorization and release of photographs: I authorize and release Ocean Dermatology, its employees, and its agents to take photographs and/or other photographic, electronic, or other images of me and to use them as may be medically appropriate. Such images may be used for educational or other purposes as necessary and appropriate. These images may be maintained as a permanent part of my medical record.

_____ _____ _____

Signature Print Name Date

_____

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CONTACT CONSENT FORM

In general, the HIPAA privacy rule gives individuals the right to request a restriction for uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communications of PHI be made by an alternative means, such as sending correspondence to the individual's workplace instead of the individual's home. The Privacy Rule generally requires healthcare providers to make reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. In case of an emergency, disclosures may be permitted without prior consent.

With my consent Ocean Dermatology may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminders, prescription reminders, test results, insurance items and all other PHI and return calls requesting a call back.

May leave a message: ☐ **Home phone** ☐ **Cell phone** ☐ **Work phone**

It is our policy to only speak with the patient concerning detailed medical information, unless instructed otherwise. Please list the names of any other individuals that our office staff has permission from you to release medical information, **if none, please write none.**

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

_____	_____	_____
Signature	Print Name	Date

_____
Relationship to Patient