CLINTON CROSSINGS DERMATOLOGY

Mark H. Goldgeier, M.D. 2275 South Clinton Avenue, Rochester, NY 14618 Phone #: 585-244-4240 Tax ID # 16-1208468

PATIENT INFORMATION

Acct #_____

Patient's Name (Mr,Miss,Ms,Mrs)_____ Date of Birth___/___/_____

Address_____

Home Phone _____ Cell Phone_____

Employer_____ Occupation_____

Employer's Address _____ Work Phone _____

Spouse's Name _____ Work Phone _____

Emergency Contact _____ Relation to Patient _____ Phone _____

Referring Physician _____ Primary Care Physician_____

Reason for visit _____ Is it work related? _____

E-mail _____

INSURANCE INFORMATION

First Insurance Company_____ Effective Date_____

Address_____ Phone _____

Subscriber's Name_____ Date of Birth_____ Relation to Patient_____

Subscriber ID#_____

Second Insurance Company_____ Effective Date_____

Address_____ Phone _____

Subscriber's Name_____ Date of Birth_____ Relation to Patient_____

Subscriber ID#_____

Third Insurance Company_____ Effective Date_____

Address_____ Phone_____

Subscriber's Name_____ Date of Birth_____ Relation to Patient_____

Subscriber ID#_____

PATIENT CONSENT, AGREEMENT OF FINANCIAL RESPONSIBILITY

I, the undersigned, consent to the use and disclosure of my protected health information for treatment, payment and operations and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act without a written authorization. I understand that Clinton Crossings Dermatology does not accept medical insurance, will not bill my insurance company and is a self pay office. I accept that I am financially responsible for all services and collections by Mark H. Goldgeier, MD. A copy of this agreement may be used in place of the original. I certify that the information stated on this form is correct.

_____ _____

Signature Of Patient or Representative Date

The following persons are authorized to discuss my care and treatment:

Name	Relationship to patient
Name	Relationship to patient
Name	Relationship to patient

I, the undersigned, consent to the use and disclosure of my Protected Health Information (PHI) for treatment, payment and operations (TPO) and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act (HIPAA) without a written authorization. (Dr. Goldgeier's Notice of Privacy Practices, available to me and posted in this office, provides a more complete description of such uses and disclosures.)

Signature of Patient or Representative	Date

Rx THERAPEUTIC RECORD

CLINTON CROSSINGS DERMATOLOGY

NAME [M] [F] D.O.B. HT WT BMI

PHARMACY PHONE

ALLERGIES - (PRINT IN RED INK)

MEDICATION	DOSAGE/FREQ. AMOUNT	PATIENT DIRECTION	START DATE	REFILL DATES WITH CHANGES IN DOSAGE / FREQ.					STOP DATE

MARK H. GOLDGEIER, M.D.
Diplomate, American Academy of Dermatology
Diplomate, American Board of Internal Medicine
Fellow, American College of Physicians

CLINTON CROSSINGS DERMATOLOGY

Our office practices according to the following guidelines

Payment at time of Service	Full patient responsibilities are due on the date of service.
Payment for cosmetic services	Fees for cosmetic procedures are due on the day the service is provided. These charges are non-refundable.
Fees for failure to cancel appointments	$200 for the 1st procedure/office visit up to $400 for missed appointments if not cancelled at least 24 hours in advance are subject to a graduated fee.
Billing Fees	Personal balances are due upon receipt of a billing statement. There is a $15.00 subsequent billing fee. Our billing system has a set fee of $15.00 per additional bill forwarded to the patient if the balance remains unpaid for 30 days after the previous billing transmission.
Returned Checks	There is a $40.00 charge for all payments returned to our office. We then accept cash, money order or credit card to repay the balance.
Collection Fees	All fees incurred for services from collection agencies or attorneys to recover payment become the responsibility of the patient or responsible party.
Products Sold	All products purchased are returnable within 30 days of receipt.
Refunds	Refunds will first be applied to any outstanding personal balances; then applied to your next office visit, your next purchase or returned by check.

I have read and acknowledge the above terms:

Date Patient Name

To our patients who pay the charges for their visits on time and who keep their scheduled appointments; we extend our sincerest thanks!