WESTWOOD DERMATOLOGY AND DERMATOLOGIC SURGERY GROUP, P.A.
390 OLD HOOK ROAD, WESTWOOD NJ 07675
(P) 201-666-9550 (F) 201-666-1251 EMAIL: WESTDERM@AOL.COM

Office Policy

Thank you for choosing Westwood Dermatology as your healthcare provider. The following information outlines your responsibility related to insurance, payment and appointments for our professional services. Please read and initial the following to acknowledge your understanding of our appointments and financial policy. **If you are a new patient we kindly ask to arrive 15 minutes prior to your scheduled appointment. If you are 15 minutes late for your appointment we will need to ask you to reschedule your appointment.**

- Current Insurance cards, valid government photo ID and referrals MUST be present at time of appointment. All co-pays and other balances are due prior to treatment. WE ACCEPT CASH, CHECK, AND ALL MAJOR CREDIT CARDS.

- You are responsible for knowing your insurance information, including referrals, policy and group numbers. IF YOU DO NOT HAVE A VALID REFERRAL FROM YOUR PCP AT THE TIME OF YOUR APPOINTMENT YOU MUST RESCHEDULE YOUR APPOINTMENT. IT IS YOUR RESPONSIBILITY TO OBTAIN A VALID REFERRAL FROM YOUR PCP PRIOR TO YOUR APPOINTMENT.

- You are responsible for any co-pays, deductibles and non-covered services. Some procedures are considered cosmetics and will NOT be covered by insurance. Patients are responsible for all cosmetic procedure fees at time of service.

- Patients who do not have health insurance coverage are considered self-pay. Payment for services must be paid in full at time of appointment.

- If you cannot keep your scheduled appointment please notify our office 24 hours prior to your appointment time. Failure to provide 24 hours notice will result in a $25 no-show fee. If arriving 15 minutes or later past your scheduled appointment you will be asked to be rescheduled. **Cancellations for Dr. Nychay or Joanna Disalvo FNP-C must be made 48 hours in advance. Failure to provide 48 hours notice will result in a $50 no-show fee for office visits/consults, $100 for excision appts and $200 for Mohs surgery appointments.**

- You are responsible for any additional fees for lab services (biopsy, cultures, or bloodwork) that are not covered by your insurance. We always submit specimens to participating labs based on the patient's insurance. If you have identified as “self-pay”, you are responsible for all fees related to processing and interpreting your specimen.

- Patients under the age of 18 must be accompanied by a parent or legal guardian for their first appointment. For additional visits a signed authorization from the parent or guardian allowing our physicians to provide treatment is required for all visits. All co-pays due are expected to be paid at the time of each service.

I have read and understand the office policy of Westwood Dermatology and Dermatologic Surgery Group, P.A. And agree to its terms.

Print name:_____

Signature of Patient/Legal Guardian/Guarantor:

_____Date:_____

New Patient Registration

LAST NAME:_____ FIRST NAME:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

DOB:____/____/_____ SSN:____-____-_____ ZIP:_____ HEIGHT:_____ WEIGHT:____

GENDER: _____ HOME:(_____)_____

CELL:(_____)_____ WORK: (_____)_____

MARITAL STATUS: M__ S___ W___ D___ SPOUSE:_____

PHARMACY:_____ PHONE OR TOWN:_____

EMAIL:_____

PRIMARY CARE PHYSICIAN:_____PHONE:_____

PRIMARY INSURANCE COMPANY:_____

SUBSCRIBERS NAME_____ SUBSCRIBERS DOB:_____/_____/_____

SECONDARY INSURANCE COMPANY(IF APPLICABLE):_____

SUBSCRIBERS NAME_____SUBSCRIBERS DOB:_____/_____/_____

EMERGENCY CONTACT INFORMATION:_____

RELATIONSHIP TO PATIENT:_____ PHONE:(_____)_____

PLEASE PRESENT YOUR INSURANCE CARD(S) AND GOVERNMENT ISSUED PHOTO ID TO THE RECEPTIONIST.

I HEREBY AUTHORIZE WESTWOOD DERMATOLOGY GROUP TO RELEASE TO MY INSURANCE CARRIER ANY MEDICAL INFORMATION NECESSARY FOR THE COMPLETION OF MY MEDICAL CLAIM. I UNDERSTAND THAT THIS MAY INCLUDE COPIES OF MY MEDICAL RECORDS OR LAB RESULTS.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PAST MEDICAL HISTORY (please circle all that apply)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Asthma	End Stage Renal Disease	Lymphoma
Atrial Fibrillation	GERD	Prostate Cancer
Bone Marrow	Hearing Loss	Radiation Treatment
Transplantation	Hepatitis	Seizures
BPH	High Blood Pressure	Stroke
Breast Cancer	HIV/AIDS	Pacemaker
Colon Cancer	High Cholesterol	
COPD	Thyroid problems (Hyper or	NONE
Coronary Artery Disease	Hypo)	

Other:_____

PAST SURGICAL HISTORY:

_____

_____

_____

_____

SKIN DISEASE HISTORY:(please circle all that apply)

Psoriasis	Acne
Eczema	Actinic Keratosis
Flaking or itchy scalp	Asthma
Hayfever/Allergies	Basal Cell Skin Cancer
Precancerous Moles	Blistering Sunburns
Melanoma	Dry Skin
Poison Ivy	Squamous Cell Skin Cancer
Do you wear sunscreen? Yes/No	If yes, what SPF?_____ Do you tan in a tanning salon? Yes/No

MEDICATIONS: (Please enter all current medications, including dosage and frequency)

_____

_____

_____

_____

ALLERGIES: (please list all allergies)

_____

_____

_____

_____

Social History:

Cigarette Smoking:
Never Smoked
Quit:Former Smoker
Smokes Less Than a Pack Daily
Smokes Daily

Alcohol Intake:
None
Less than one drink per day
1-2 drinks per day
3 or more drinks per day

FAMILY HISTORY: (please circle all that apply)

Melanoma:	Mother	Father	Sister	Brother	Daughter	Son
Diabetes:	Mother	Father	Sister	Brother	Daughter	Son

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NOTICE OF PRIVACY PRACTICES

OUR NOTICE OF PRIVACY PRACTICES PROVIDES INFORMATION ABOUT HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU, YOU HAVE THE RIGHT TO REVIEW OUR NOTICE BEFORE SIGNING THIS CONSENT. THE TERMS OF OUR NOTICE MAY CHANGE. IF WE CHANGE OUR NOTICE, YOU MAY OBTAIN A REVISED COPY AT ANY TIME BY CONTACTING OUR OFFICE.

WE MAY USE AND DISCLOSE YOUR MEDICAL RECORDS ONLY FOR THE FOLLOWING PURPOSES: TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. WE MAY ALSO CREATE AND DISTRIBUTE "DE-IDENTIFIED" HEALTH INFORMATION BY REMOVING ALL REFERENCES TO INDIVIDUALLY IDENTIFIABLE INFORMATION.

WE MAY CONTACT YOU TO PROVIDE APPOINTMENT REMINDERS OR INFORMATION ABOUT TREATMENT ALTERNATIVES OR OTHER HEALTH-RELATED BENEFITS AND SERVICES. ANY OTHER USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION. YOU MAY REVOKE SUCH AUTHORIZATION IN WRITING, AND WE ARE REQUIRED TO HONOR AND ABIDE BY THAT WRITTEN REQUEST, EXCEPT TO THE EXTENT THAT WE HAVE ALREADY TAKEN ACTIONS RELYING ON YOUR AUTHORIZATION. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION, WHICH YOU CAN EXERCISE BY PRESENTING A WRITTEN REQUEST TO OUR OFFICE:

*THE RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION, INCLUDING THOSE RELATED TO DISCLOSURES TO YOUR IMMEDIATE FAMILY MEMBERS, OTHER RELATIVES, CLOSE PERSONAL FRIENDS OR OTHER INDIVIDUALS YOU IDENTIFY. WE ARE, HOWEVER, NOT REQUIRED TO AGREE TO A REQUESTED RESTRICTION. IF WE DO AGREE TO A RESTRICTION, WE MUST ABIDE BY IT UNLESS YOU AGREE IN WRITING TO REMOVE IT.
*THE RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION.
*THE RIGHT TO AMEND YOUR PROTECTED HEALTH INFORMATION.
*THE RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION.
*THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM US UPON REQUEST.

I HAVE BEEN NOTIFIED OF THE UPDATED NOTICE OF PRIVACY RIGHTS AND UNDERSTAND I CAN REQUEST OF COPY OF THEM,
SIGNATURE OF RESPONSIBLE PARTY: _____ DATE: _____
(MUST BE 18 YEARS OF AGE OR OLDER)

I HEREBY AUTHORIZE ANY PHYSICIAN, HEALTH CARE PRACTITIONER, HOSPITAL, CLINIC, OR OTHER MEDICAL OR MEDICALLY RELATED FACILITY TO FURNISH ANY AND ALL RECORDS, MEDICAL HISTORY, SERVICES RENDERED OR TREATMENT GIVEN TO ME OR ANY DEPENDENT FOR PURPOSES OF REVIEW, INVESTIGATION, OR EVALUATION OF ANY CLAIM SUBMITTED TO MY INSURER. I ALSO AUTHORIZE MY INSURER TO DISCLOSE TO A HOSPITAL OR HEALTH CARE SERVICE PLAN, SELF-INSURER, OR ANY INSURER, ANY MEDICAL INFORMATION OBTAINED IF SUCH DISCLOSURE IS NECESSARY TO ALLOW THE PROCESSING OF ANY CLAIM.

IF MY COVERAGE IS UNDER A GROUP CONTRACT HELD BY AN EMPLOYER, AN ASSOCIATION, TRUST FUND, UNION, OR SIMILAR ENTITY, THIS AUTHORIZATION ALSO PERMITS DISCLOSURE TO THEM FOR PURPOSES OF UTILIZATION REVIEW OR AUDIT.
SIGNATURE OF RESPONSIBLE PARTY: _____ DATE: _____
(MUST BE 18 YEARS OF AGE OR OLDER)

I UNDERSTAND THAT DERMATOLOGISTS OFTEN PERFORM BIOPSIES, LIQUID NITROGEN TREATMENTS OR MINOR SKIN SURGERIES. I UNDERSTAND THAT ANY TIME MY SKIN IS CUT (FOR A BIOPSY OR MINOR SKIN SURGERY) THERE IS A RISK OF SCARRING, BLEEDING, INFECTION, ALLERGIC REACTIONS, SWELLING, RECURRENCE AND IF THE BIOPSY OR SURGERY IS NEAR THE EYES OR FOREHEAD, BRUISING AROUND MY EYES. I ALSO UNDERSTAND THAT ANY TIME LIQUID NITROGEN IS USED TO TREAT MY SKIN, A BLISTER MAY FORM AND THE TREATMENT MAY RESULT IN A LIGHTER OR DARKER DISCOLORATION OF THE AREA TREATED.

BY MY SIGNATURE BELOW, I HEREBY GIVE THE PHYSICIANS AT WESTWOOD DERMATOLOGY AUTHORIZATION TO TREAT MY SKIN WITH A BIOPSY, LIQUID NITROGEN OR MINOR SKIN SURGERY. OUR PHYSICIANS WILL ALWAYS DISCUSS THE PROCEDURE WITH YOU AND BE GIVEN CONSENT BY YOU BEFORE ANY PROCEDURE IS PERFORMED.

SIGNATURE OF RESPONSIBLE PARTY: _____ DATE: _____
(MUST BE 18 YEARS OF AGE OR OLDER)

DATE OF LAST REVISION: 3/1/23

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PATIENTS NAME (PRINT):_____

I AUTHORIZE WESTWOOD DERMATOLOGY TO RELEASE MY LAB OR TEST RESULTS TO, OR DISCUSS MY MEDICAL CONDITION WITH (PLEASE CHECK ALL THAT APPLY):

MYSELF:____ SPOUSE:____ PARENT:____ DOCTOR:____ OTHER(PLEASE SPECIFY):_____

PLEASE INDICATE WHICH NUMBERS WE CAN LEAVE CONFIDENTIAL HEALTH INFORMATION:

PRIMARY:_____ (HOME/CELL/WORK)

SECONDARY:_____ (HOME/CELL/WORK)

We have found that the majority of our patients request text message or email communication with our office to receive unencrypted email and text messages on secure services. Do we have permission to use:

Home Voicemail: Yes:_____ No:_____ (_____) _____-_____

Cell phone voice mail: Yes:_____ No:_____ (_____)_____ - _____

Unsecure Text: Yes:_____ No:_____ (_____)_____- _____

Unencrypted email: Yes: _____ No:_____ Email:_____

_____ _____
Signature of Patient or Legal Guardian Date

_____
Witness

Authorization for Release and Use of Photographs

PATIENT:_____ DOB:_____

Photographs (including digital images) will be taken for documentation purposes for treatment. These photographs will become a part of the EMR (electronic medical record) and will be handled in accordance with the Health Insurance Portability and Accounting Act of 1996 (HIPAA). In addition, the undersigned grants to the treating physician the on-going right to use photographs in the ways indicated below.

Your identity/personal information will never be disclosed. Please ***initial*** consent for each specific use:

Yes_____ No_____ For medical research, education, or science?

Yes_____ No_____ For use during in office patient consultations?

Yes_____ No_____ For Westwood Dermatology website?

Yes_____ No_____ For social media use by Westwood Dermatology social media account?

I am at least 18 years of age and am competent to contract in my own name. I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above consent form and fully understand its terms.

_____ _____

Signature of Patient (or Person Authorized) Date

_____ _____

Signature of Physician or Assistant Date

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OFFICE POLICY REGARDING PATIENT FINANCIAL RESPONSIBILITY

PROVIDING QUALITY MEDICAL CARE FOR OUR PATIENTS IS OUR PRIMARY CONCERN. THE FOLLOWING IS A SUMMARY OF OUR FINANCIAL POLICY. WE WOULD BE HAPPY TO PROVIDE FURTHER CLARIFICATION IF NECESSARY. WE ASK THAT YOU READ AND SIGN THE FOLLOWING TO ACKNOWLEDGE THAT YOU HAVE BEEN ADVISED OF YOUR FINANCIAL RESPONSIBILITY FOR MEDICAL SERVICES PROVIDED HERE.

- PRIOR TO SEEING A MEDICAL PROFESSIONAL AT THIS OFFICE I CAN REQUEST THAT A STAFF MEMBER DISCUSS THE LIKELY COSTS INVOLVED IN MY PROCEDURE(S) AND REVIEW MY FINANCIAL RESPONSIBILITY.

- THIS OFFICE PARTICIPATES WITH SOME INSURANCE PLANS. IT IS MY. RESPONSIBILITY TO PROVIDE THIS OFFICE WITH AN UP-TO-DATE INSURANCE CARD, AND TO NOTIFY THIS OFFICE OF ANY CHANGES TO MY INSURANCE PLAN.

- I UNDERSTAND THAT INSURANCE MAY NOT COVER ALL FEES. I AM RESPONSIBLE FOR UNDERSTANDING MY SPECIFIC INSURANCE PLAN AND FOR PAYMENT OF ALL CO-PAYS AND/OR DEDUCTIBLE CHARGES AT THE TIME OF SERVICE. (A BILLING FORM CAN BE SUPPLIED TO YOU FOR OUT OF NETWORK INSURANCE SUBMISSION IF REQUESTED.) **ANY RETURNED CHECKS WILL INCUR A $35.00 FEE THAT WILL BE ADDED TO THE BALANCE DUE.**

- I UNDERSTAND THAT SOME PROCEDURES PERFORMED AT WESTWOOD DERMATOLOGY GROUP ARE CONSIDERED COSMETIC AND WILL NOT BE COVERED BY INSURANCE. (YOU WILL BE NOTIFIED BEFORE ANY PROCEDURE IS PERFORMED IF THIS IS THE CASE.)

- ANY LABORATORY ANALYSIS THAT IS REQUIRED CAN BE SENT TO AN EXTERNAL LABORATORY OF MY CHOICE AND/OR AS REQUIRED BY MY INSURANCE.

- I UNDERSTAND THAT ANY REIMBURSEMENT SENT BY THE INSURANCE COMPANY DIRECTLY TO THE PATIENT/INSURED FOR SERVICES RENDERED BY OUR DOCTORS WILL BE REMITTED TO THIS OFFICE WITHIN 2 WEEKS OF RECEIPT OR EXTRA FEES WILL BE INCURRED.

- I UNDERSTAND THAT I HAVE FINANCIAL RESPONSIBILITY FOR PAYMENT OF MEDICAL SERVICES PROVIDED BY THIS OFFICE, AND HEREBY ASSUME AND GUARANTEE PAYMENT OF ALL EXPENSES INCURRED DURING MY OFFICE VISIT. SHOULD LEGAL ACTION BE REQUIRED TO SECURE PAYMENT OF THIS ACCOUNT, I AGREE TO PAY THE LEGAL EXPENSES INCURRED BY THIS OFFICE. **A 35% FEE WILL BE ADDED TO YOUR ACCOUNT SHOULD YOUR BALANCE BE FORWARDED TO A COLLECTIONS AGENCY.**

I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED ABOVE.

SIGNATURE OF RESPONSIBLE PARTY: _____
(MUST BE 18 YEARS OF AGE OR OLDER)
DATE: _____

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Treatment Consent

I UNDERSTAND THAT DERMATOLOGISTS OFTEN PERFORM BIOPSIES, LIQUID NITROGEN TREATMENTS OR MINOR SKIN SURGERIES. I UNDERSTAND THAT ANY TIME MY SKIN IS CUT (FOR A BIOPSY OR MINOR SKIN SURGERY) THERE IS A RISK OF A SCARRING, BLEEDING, INFECTION, ALLERGIC REACTIONS, SWELLING, RECURRENCE AND IF THE BIOPSY OR SURGERY NEAR THE EYES OR FOREHEAD, BRUISING AROUND MY EYES. I ALSO UNDERSTAND THAT ANY TIME LIQUID NITROGEN IS USED TO TREAT MY SKIN, A BLISTER MAY FORM AND THE TREATMENT MAY RESULT IN A LIGHTER OR DARKER DISCOLORATION OF THE AREA TREATED.

BY MY SIGNATURE BELOW, I HEREBY GIVE THE PHYSICIANS AT WESTWOOD DERMATOLOGY AUTHORIZATION TO TREAT MY SKIN WITH A BIOPSY, LIQUID NITROGEN OR MINOR SKIN SURGERY. OUR PHYSICIANS WILL ALWAYS DISCUSS THE PROCEDURE WITH YOU AND BE GIVEN CONSENT BY YOU BEFORE ANY PROCEDURE IS PERFORMED.

Patient Name: _____

Patient/Guardian Signature:_____ Date:_____

PATIENT INTAKE FORM

Please circle the following questions below so we can comply with the insurance guidelines set by the Federal Government, at our practice. Thank you.

1. **Medicare Patients:** Do you have any of the following chronic conditions? (please check off all that apply)
   __Heart failure ___Coronary Artery Disease (CAD)__Chronic Obstructive Pulmonary Disease__Diabetes

If you have any of these conditions, we encourage you to schedule routine visits with your PCP and/or the specialist who is monitoring/treating you.

2. Did you receive the flu vaccine this flu season? Yes or No
   If you have not received your vaccine, we encourage you to do so.

3. Have you ever received the pneumonia vaccine? Yes or No

4. Do you have a history of Melanoma? Yes or No

5. Is there any history of melanoma in your family? Yes or No

6. Do you smoke? Yes or No
   If yes, we encourage you to quit and we will provide you with information on the health benefits of quitting for you to review.

7. Number of alcoholic drinks you consume per day:
   - None
   - Less than 1 per day
   - 1-2 per day
   - 3 or more a day

8. Do you have a healthcare Proxy? Yes or No
   If yes, would you like to name your healthcare proxy:_____

9. Who is your primary care physician? _____

10. Height_____ Weight_____

11. **Urinary Incontinence (for female patients age 65 and older)-**Do you suffer from urinary incontinence:
    Yes or No

12. Have you had the TDAP/tetanus vaccine in the past 9 years? Yes or No

13. Have you had the shingles vaccine in the past 9 years? Yes or No

PATIENTS UNDER 18:

14. Have you received at least 2 HPV vaccinations (with at least 146 days between the two) OR 3 HPV vaccinations between your 9th and 13th birthdays? Yes or No
    If no, did you have an anaphylaxis reaction due to the HPV vaccine at any time on or before your 13th birthday? Yes or No

15. Did you have one dose of meningococcal vaccination or or between your 11th -13th birthdays? Yes or No
    If no, did you have an anaphylaxis reaction to the meningococcal vaccination on or before your 13th birthday?
    Yes or No

Name:_____**DOB**:_____