Mount Sinai St. Luke's
Mount Sinai Roosevelt

AMBULATORY PATIENT NOTIFICATION RECORD

I acknowledge that I have been given the following Notices as required by State and Federal regulations:

- New York State Patients' Bill of Rights
- Parent's Bill of Rights
- Mount Sinai St. Luke's and Mount Sinai Roosevelt Patient Information on Pain Management
- New York State Health Care Proxy
- Mount Sinai St. Luke's and Mount Sinai Roosevelt Summary of Policy on Advance Directives
- Mount Sinai Health System Notice of Privacy Practices

and I consent to share my health information for payment, treatment and hospital operations purposes.

_____ _____ _____
Patient/Parent/Personal Representative Signature | Date | Time

_____
Representative Relationship to Patient

Patient: ☐ Unable to sign Explain: _____
☐ Refuses to sign

_____ _____
Print Name | Title

_____ _____ _____
Employee Signature | Date | Time

ST. LUKE'S - ROOSEVELT HOSPITAL CENTER - 258A

NEW PATIENT REGISTRATION FORM

DATE	APPOINTMENT WITH	MR #

PATIENT INFORMATION

PATIENT'S LAST NAME/Apellido Del Paciente	FIRST NAME/Primer Nombre	DOB	AGE/Edad	SOCIAL SECURITY #

STREET ADDRESS/Direccion	APT. #	CITY/Ciudad	STATE	ZIP CODE	COUNTRY	SEX/Sexo (CIRCLE ONE)
						M F

HOME PHONE NO./Telephono	WORK PHONE NO.	MARITAL STATUS	SPOUSE'S NAME	SPOUSE'S WORK NO. EXT.
( )	( )	S M W D SP		( )

PATIENT EMPLOYER/Patron Del Paciente'	F/T STUDENT	ALLERGIES
	Y N	

EMPLOYER'S ADDRESS/Direccion Del Patron	CITY/Ciudad	STATE/Estado	ZIP CODE

EMERGENCY CONTACT PERSON/Contacto De Emergencia	RELATIONSHIP TO PATIENT	CONTACT'S HOME PHONE NO.	CONTACT'S WORK PHONE EXT.
		( )	( )

REFERRING MD NAME	ADDRESS	CITY	STATE	ZIP CODE	PHONE NO.
					( )

PRIMARY DOCTOR NAME	ADDRESS	CITY	STATE	ZIP CODE	PHONE NO.
					( )

GUARANTOR INFORMATION - Person responsible for payment, if other than self

GUARANTOR'S LAST NAME	FIRST NAME	RELATIONSHIP TO PATIENT	SOCIAL SECURITY #	DOB	HOME PHONE NO.
					( )

GUARANTOR'S ADDRESS	APT. #	CITY	STATE	ZIP CODE	COUNTRY	SEX/Sexo (CIRCLE ONE)
						M F

GUARANTOR'S EMPLOYER	ADDRESS	CITY	STATE	ZIP CODE	WORK PHONE NO.
					( )

INSURANCE INFORMATION

MEDICARE	EFF. DATE	MEDICAID #	EFF. DATE

PRIMARY INSURANCE COMPANY	EFF. DATE	POLICY #	GROUP #	CERTIFICATE #

ADDRESS	CITY	ZIP CODE	STATE	ZIP CODE	PHONE NO.
					( )

NAME OF INSURED	PATIENT RELATIONSHIP TO INSURED	SOCIAL SECURITY #	DOB	SEX/Sexo (CIRCLE ONE)
				M F

INSURED'S ADDRESS	APT. #	CITY	STATE	ZIP CODE	COUNTRY	HOME PHONE NO.
						( )

INSURED'S EMPLOYER	WORK PHONE NO.
	( )

SECONDARY INSURANCE COMPANY	EFF. DATE	POLICY #	GROUP #	CERTIFICATE #

ADDRESS	CITY	ZIP CODE	STATE	ZIP CODE	PHONE NO.
					( )

NAME OF INSURED	PATIENT RELATIONSHIP TO INSURED	SOCIAL SECURITY #	DOB	SEX/Sexo (CIRCLE ONE)
				M F

INSURED'S ADDRESS	APT. #	CITY	STATE	ZIP CODE	COUNTRY	HOME PHONE NO.
						( )

INSURED'S EMPLOYER	WORK PHONE NO.
	( )

AUTHORIZATION INFORMATION

ASSIGNMENT OF BENEFITS:

I hereby assign to _____ any insurance or other third-party benefits available for health care
NAME OF PRACTICE

services provided to me. I also understand that if benefits are assigned, or if by contractual arrangement, payment to the practice will be made by my insurance, that I am responsible for any co-payments and deductibles and that these amounts are due at the time services are rendered. I understand that the above practice has the right to refuse or accept assignment of such benefits (except when prohibited by contract). I also understand that in the event that services rendered are not covered under my "insurance", I will accept financial responsibility for all services provided to me. If benefits are not assigned to this practice, I agree to forward to the practice, all "insurance" payments that I receive for services rendered to me immediately upon receipt and/or to make payment, in full, for the services rendered to me (depending upon the agreement) at this time.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR RELEASE OF INFORMATION:

I authorize the release of any medical or other information as is necessary to process this claim based upon the "HIPAA Notice of Privacy Practices" information provided to me under separate cover. This information is on file as a permanent record and may be amended as is necessary.

Signature of Patient/Legal Guardian: _____ Date: _____

St. Luke's - Roosevelt Hospital Center
Department of Dermatology

If You Have Medicare or Any Other Insurance

Medicare and many other insurance companies now consider the removal of benign lesions to be cosmetic and not covered by their insurance policies. These lesions may include seborrheic keratoses, warts, nevi (moles), and sebaceous cysts. We physicians do not necessarily agree with this policy and suggest you discuss this with a representative of your insurance carrier. We will discuss the cost of "cosmetic" removal of these lesions with you. You will be responsible for the fees for these procedures at the time of service.

I agree that I have to pay for services provided to me by the Dermatology Associates of SLR, which are not covered by my insurance carrier. If I do not pay for the services, I understand that I will be responsible for all costs incurred by the practice in collecting such charges, including attorney fees, court costs, and/or collection expenses.

Patient Name: (Print): _____ Date: _____

Patient's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Required only if patient is a minor

Please note:

*Patients are responsible for obtaining referrals when needed.
*A separate referral will be needed if you are to have phototherapy treatments.
*A separate referral may be required for specific procedures or testing.
**Laboratory fees are a separate charge and you or your insurance will be billed by the appropriate lab.

Self Pay Patients

I agree that I have to pay for services provided to me by the Dermatology Associates of SLR. If I do not pay for services, I understand that I will also be responsible for all costs incurred by the practice in collecting such charges, including attorney fees, court costs, and/or collection expenses.

Patient Name: (Print): _____ Date: _____

Patient's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Required only if patient is a minor

**Laboratory fees are a separate charge and you will be billed by the appropriate lab.

Patient History / Intake Form SP / Historia del Paciente

Name/Nombre: _____ Date of Birth/Fecha de nacimiento: _____

Reason for today's visit / La razón principal de su visita hoy: _____

Do you have any allergies / Usted tiene alergias? _____

Current Medication(s) / Medicamento(s) que toma: _____

REFERRING PHYSICIAN/ NOMBRE DEL DOCTOR QUE LO REFIRIO: _____

Current or past problems with/Problemas del pasado o reciente con lo siguiente:

	Yes/Si	No	If yes, explain/Si su respuesta es Si, explique
Asthma/Asma			
Diabetes/Diabetis			
High Blood Pressure / Pression alta			
General Health/Salud en General			
Eyes/Ojos			
Ears/Nose/Throat/Mouth/ Oídos/Nariz/Garganta/Boca			
Heart/Corazón			
Lungs/Pulmones			
Stomach/Bowel/Estómago/intestino			
Kidneys/Riñones			
Arthritis/Muscles/Joints/ Artritis/Músculos/Collontura			
Skin/Piel			
Headache/Seizures/ Dolor de cabeza/Convulsiones			
Psychological Disorder/ Desorden Sicológico			
Thyroid/High Blood Pressure Tiroide/Presión Alta			
Blood/Bleeding Disorder Sangre/Desorden de sangre			
Allergic/Immunologic Alergico(a)/Immunológico			
Hepatitis/Hepatitis			

Females : Are you pregnant ? Yes/Si ____ No ____ Females : Planning to become pregnant ? Yes/Si ____ No ____
Mujer : Esta usted embarazada ? Mujer : Esta usted planificando un embarazo?

FAMILY HISTORY / PAST FAMILY & SOCIAL HISTORY / HISTORIA DE FAMILIA : (FAMILIA DEL PASADO & HISTORIA SOCIAL)

Mother/Mamá : Living/Viva/Deceased/Murió ____ Age/Edad :____ Father/Papá : Living/Vivo/Deceased/ Murió ____ Age/Edad :____

(√) Check following medical condition(S) that have occurred in your family/ Seleccione la condición médica que ha ocurrido en su familia:

DISEASE / ENFERMEDAD	MOTHER / MAMA	FATHER / PAPA	BLOOD RELATIVE/ FAMILIAR DE SANGRE
Allergies / Alergias			
Arthritis / Artritis			
Asthma / Asma			
Cancer / Cáncer			
Diabetes / Diabetis			
Eczema / Eczema(piel reseca)			
Hay Fever / Fiebre			
Heart Disease / Problemas del corazón			
High Blood Pressure / Pression alta			
Lung Disease / Pulmones			
Malignant Melanoma / Melanoma Maligno			
Psoriasis / Psoriasis (piel)			
Skin Cancer / Cáncer de la piel			
Tuverculosis / Tuberculosis			

SOCIAL HISTORY / HISTORIA SOCIAL

Do you live alone/Usted vive solo(a) : Yes/Si ____ No ____ Do you smoke/Usted fuma: Yes/Si ____ No ____ How frequent do you smoke /Cuan Frecuente fuma : ____

Do you drink alcohol/Usted bebe alcohol: Yes/Si ____ No ____ How frequent do you drink/Cuan Frecuente bebe : ____ Hobbies/Leisure Activities / Pasatiempo(s) : _____

Do you use recreational drugs/Usted usa droga recreacionales: Yes/Si ____ No ____ How frequent do you use/Cuan Frecuente las utiliza: ____ Occupation/Ocupación : _____

Reviewed: _____ Date : _____ Update : _____

(MD Signature)

Mount Sinai St. Luke's	Mount Sinai Roosevelt	Mount Sinai Beth Israel
☐ 1090 Amsterdam Avenue, Suite 11D New York, NY 10025 ☐ Clinic ☐ FPP	☐ 425 West 59th Street, Suite 5C, New York, NY 10019 ☐ Clinic ☐ FPP	☐ 10 Unions Sq East, Suite 3C, New York, NY 10003 ☐ Clinic ☐ FPP

Patient Name: _____

Date of Birth: _____

Telephone: _____

Email: _____

Pharmacy Name: _____

Pharmacy Tel: _____

Do you have a Primary Care Physician? _____ Yes _____ No

Name of Primary Care Physician: _____

Address: _____

_____

Telephone: _____

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Nombre del paciente: _____

Fecha de nacimiento: _____

Teléfono: _____

Corréo electrónico: _____

Farmacia: _____

Teléfono de Farmacia: _____

Usted tiene un médico de cuidado primario? _____ Si _____ No

Nombre del médico de cuidado primario: _____

Dirección del médico: _____

_____

Teléfono del médico: _____

Mount Sinai St. Luke's Mount Sinai Roosevelt

Practice: _____
Provider Name: _____

Patient Name: _____
Date of Birth: _____
Today's Date: _____

We are now required to ask you for the following information. One of the overarching goals of the whole effort to digitize medical records in this country is to be able to reduce health care disparities between different populations. Historically, health care has been shown to disadvantage certain populations based on race, ethnicity and language.

In order to carry out outcomes research and other observations of health data, being able to distinguish the experience of patients based on race, ethnicity and language is important. Thank you for your cooperation and please fill out the following:

(A) Preferred language

(B) Gender
__Female
__Male
__Transgender

(C) Race
-- American Indian or Alaska Native
-- Asian
-- Black or African American
-- Native Hawaiian or Other Pacific Islander
-- White

(D) Ethnicity
Hispanic or Latino
-- Not Hispanic or Latino

Mount Sinai St. Luke's Mount Sinai Roosevelt

Consultorio: _____
Nombre del proveedor: _____

Nombre del paciente: _____
Fecha de nacimiento: _____
Fecha: _____

Actualmente se nos pide que le preguntemos la siguiente información. Una de las metas primordiales de todo el proceso de digitalizar los registros médicos en este país es poder reducir las desigualdades en la atención médica que se da a distintas poblaciones. Históricamente, se ha mostrado que la atención médica desfavorece a ciertas poblaciones con base en la raza, el grupo étnico y el idioma.

Con el fin de investigar los resultados y otras observaciones de la información de salud, es importante poder distinguir la experiencia de los pacientes con base en la raza, el grupo étnico y el idioma. Gracias por su cooperación, responda a lo siguiente:

(A) Idioma en el que prefiere que le hablen

(B) Género
__Femenino
__Masculino
__Transgénero

(C) Raza
-- Nativo estadounidense o de Alaska
-- Asiático
-- Negro o afroestadounidense
-- Nativo de Hawái o de otra isla del Pacífico
-- Blanco

(D) Etnia
Hispano o latino
-- No hispano o latino

Mount Sinai Roosevelt Mount Sinai St. Luke's

AUTHORIZATIONS AND ASSIGNMENTS

1. FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT (All Patients) ☐ Yes ☐ No (Please initial) _____

In consideration of services, assignment of benefits and care rendered; I agree that I am responsible for any and all charges billed by Drs. _____ (the "Physicians") with respect to such services and care unless the contract between the Physicians and my insurance company provides otherwise. In the event that the requested services are not specifically authorized by my insurance company, I agree to pay for all services as agreed upon, unless otherwise provided by law.

I authorize payment of medical benefits to which I am entitled directly to the Physicians, to cover the cost of the care and treatment rendered to myself or my dependents in the office.

Upon receipt of a medical bill, I agree to immediately pay all amounts not covered by insurance. If any insurance I have rejects my claim or pays part of the claim, I shall be responsible for payment of any balance as determined by Mount Sinai immediately upon learning of such coverage, unless otherwise provided by law.

2. RELEASE OF INFORMATION ☐ Yes ☐ No (Please initial) _____

In the event my insurer denies payment to the Physicians for services rendered to me, I hereby give my consent to have an authorized representative of the Physician to contact my insurer and to provide to my insurer all information and documentation regarding the services rendered to me by the Physicians which may be required in order for my insurer to reevaluate its decision to deny payment for such services.

I authorize this practice, my treating physician, and their respective designees to use and disclose my health information for all necessary treatment, payment and health care operations purposes. I acknowledge that my health information may include information relating to mental illness and/or AIDS/ARC/HIV and that any such information may be disclosed (including examination and copying in either hard copy or digital format) to insurers, various credit agencies and guarantors solely if needed for payment of the professional charges (no clinical information will be disclosed to any credit agency).

3. MEDICARE-RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS (Medicare only - Part B providers)

☐ Yes ☐ No (Please initial) _____

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information (including information relating to mental illness and/or AIDS/ARC/HIV) needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable to physician (s) and/or the (s) or organizations providing the service (s)

4. INSURANCE NETWORK/PROVIDER NOTICE PURSUANT TO NYS "OUT-OF-NETWORK" LAW

I understand that the Physicians may be participating providers in certain health plan networks, and that a list of the plans that the Physicians participate in can be found on their website or can be provided to me upon request.

I understand that the Physicians may not participate in the same health plans and networks as the hospitals and facilities in the Mount Sinai Health System even though the Physicians may be employed by or affiliated with hospitals or facilities in the Mount Sinai Health System. I understand that I can determine the health plans participated in by physicians who are employed or contracted by Mount Sinai to provide hospital services by visiting http://www.mountsinai.org/patient-care/find-a-doctor ; I also understand that I can also determine the health plans accepted by hospitals and facilities in the Mount Sinai Health System by visiting the facility's web portal.

I understand that the Physicians charge for their services separately from the hospitals and facilities in the Mount Sinai Health System, and that any bills from hospitals or facilities in the Mount Sinai Health System for so-called "facilities" or "technical" fees will be sent separately from the Physicians bills for their "professional" services.

I understand that it is my responsibility to check with the "physician" arranging for my services regarding: (1) whether the services of any other physicians will be required for my care; and (2) whether the services of any other physicians (including but not limited to anesthesiologists, pathologists, and/or radiologists) may be reasonably anticipated to be provided in connection with my care. I further understand that I can check with the "physician" arranging for my services to obtain the contact information and/or health plan participation information for any physicians or facility whose services may be needed in connection with my care, and that I can also contact those physicians directly to obtain information regarding their health plan participation.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE ITEMS.

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATED

_____ _____

RELATIONSHIP TO PATIENT WITNESS TO SIGNATURE