



730 Weiland Rd
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www.greecedermatology.com

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WELCOME TO GDA

APPOINTMENT HOURS:

Monday	8:00am to 5:00pm	Thursday	8:00am to 5:00pm
Tuesday	7:30am to 3:30pm	Friday	8:00am to 11:30am
Wednesday	7:30am to 3:30pm		

INSURANCE: We are providers for all major insurances in the Rochester area including Aetna, Medicare, Blue Choice, MVP, BCBS and others. Please call your insurance company for any questions regarding your health insurance coverage.

Please bring your **insurance card and a photo ID** with you to your appointment.

CANCELLATIONS: If you are unable to keep your scheduled appointment, please call our office to notify us as soon as possible so that we may give that time to another patient.

PAYMENT: Cash, personal check or credit cards (Visa, Mastercard, Discover, American Express) are accepted as methods of payment. Payment for your visit is expected on the day of your appointment. There will be a \$10.00 additional fee if your copay is not received at the time of service. You are responsible for all cost of health services if your health insurance does not cover the office visit/procedures.

REGISTRATION FORM: Please complete the enclosed information sheet and medical history form and return in the self-addressed envelope prior to your appointment.

REFERRALS: Once you are an established patient, you must check to make sure that you have an authorization for your next appointment, if your insurance company requires one.

Please call our office should you have any questions or visit our website for further information and directions.

Thank you.

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Important notice

The atmosphere among employers and insurance companies has changed dramatically in recent years as the cost of health care continues to soar. In response to this problem, many employers have gone to what are called **high deductible plans** that require patients to pay a large amount of money out of pocket **before** any insurance coverage kicks in. Other plans may require a payment of a percentage, or copay for the services rendered.

The result of these events is that some of our returning patients are having to pay the entire bill or a percentage of their bill for services that were once completely covered. Depending on the procedures performed, these bills can be larger than anticipated. We are as disturbed as you are by this trend toward reducing the responsibilities of insurance.

We urge our patients to review their insurance policies and be aware of their coverage and associated financial responsibilities.

Thank you for your patience in this matter.



Appointment Date _____ Time _____ Dr. _____

Information should be updated yearly, or as needed

Patient Information

Legal Name _____ Date of Birth _____
MM - DD - YYYY

SEX: M / F Maiden name _____

Address _____
(Street) (City) (State) (Zip)

Primary Phone (____) _____ - _____ Work Phone (____) _____ - _____ ext. _____

Secondary Phone (____) _____ - _____ E-mail _____

Occupation _____ Employer _____

Primary Care Dr. _____ Address _____ Phone (____) _____ - _____

Emergency contact _____ Relationship _____ Phone (____) _____ - _____

Address _____
(Street) (City) (State) (Zip)

if a minor

Father's Name _____ Employer _____ Phone (____) _____ - _____

Address _____
(Street) (City) (State) (Zip)

Mother's Name _____ Employer _____ Phone (____) _____ - _____

Address _____
(Street) (City) (State) (Zip)

Insurance Information

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

SUBSCRIBER NAME _____ SUBSCRIBER NAME _____

SUBSCRIBER ID _____ SUBSCRIBER ID _____

My signature verifies that all information listed is true and to the best of my knowledge. I authorize insurance companies to pay provider directly. I understand that I am responsible for any and all charges not covered by insurance. It is understood and agreed that in the event any outstanding balance on my account becomes delinquent and has to be referred to a collection agency or address attorney for recovery, that I will be fully responsible for any and all collection fees and attorney fees.

Signature: Patient / Parent / Guardian / Power of attorney

Date

Patient History Form

Patient Name _____ Age _____ Primary Care Dr _____

Primary Phone # _____ Occupation _____ Pharmacy _____

Reason for Today's Visit? _____

What illnesses do you have (Ex: diabetes, heart disease, ulcers, etc)? _____

List any medications you are taking _____

Medication Allergies _____

Other Allergies (food, animals, mold, grass, etc) _____

What surgical procedures have you had? _____

Have you ever had problems with any of the following:	Yes		No		If yes, please explain:
Eyes					
Ears-Nose-Throat					
Dental					
Heart					
Lungs					
Digestive tract					
Arthritis					
Headaches/Seizures					
Depression/Anxiety					
Diabetes					
Thyroid disease					
High cholesterol					
Kidney Disease					
Liver Disease					
Skin					
Other					

Family History	YES
Melanoma	
Other Skin Cancer	
Eczema	
Lupus	
Psoriasis	
Other	

Social History	YES	NO
Alcohol		
Smoking		
Drugs		
Hobbies		

Women: Are you pregnant? YES NO

Planning to become pregnant? YES NO

Patient Signature _____ Date _____



*Sign and date this acknowledgement form *
*The FULL NOTICE OF PRIVACY PRACTICE is available upon request or online at www.greecedermatology.com *

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

SUMMARY

The confidentiality of your personal health information, commonly called your medical record, has always been a high priority for the nurses, doctors, staff and others involved in your healthcare at Greece Dermatological Associates. There are a number of reasons that we may need to use this information or release (disclose) it to others. This Notice of Privacy Practices is provided to Inform you of the way that we can use and release information from your medical record. THIS PAGE IS NOT THE FULL NOTICE OF PRIVACY PRACTICES, PLEASE READ THE ATTACHED DOCUMENT FOR ADDITIONAL INFORMATION. In addition to the longstanding commitment of Greece Dermatological Associates to protecting your information, there are certain obligations that we have under federal law. One of those obligations is to provide you with this Notice.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communication;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

I acknowledge that I have been provided Greece Dermatological Associate's Notice of Privacy Practices:

Patient or Representative Signature

Date

___ Patient refused to sign

If you would like to allow someone else to have access to your medical information, please list their names below:

I _____ (your name) hereby authorize _____
to receive information regarding my medical records.

I _____ (your name) hereby authorize _____
to receive information regarding my medical records.

I _____ (your name) hereby authorize _____
to receive information regarding my medical records.