

GREECE DERMATOLOGICAL ASSOCIATES, P.C.

MICHAEL B. BOBROW, M.D.
YANA V. IGNATOVICH, M.D.
SHAUNA L. COLE, MPAS, PA-C
MARIA A. DEROSA, MPAS, PA-C
CRYSTAL L. ENGLERT, MPAS, PA-C
STEPHANIE M. SAVAGE, FNP-C

120 ERIE CANAL DR. SUITE 200
ROCHESTER, NY 14626

585-719-9600
585-719-9872 (FAX)

WELCOME TO GDA

APPOINTMENT HOURS:

Monday 7:40AM TO 5:00PM
Tuesday 7:30AM TO 3:30PM
Wednesday 7:30AM TO 3:30PM

Thursday 7:40AM TO 5:00PM
Friday 8:00AM TO 1:00PM

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. You will not be seen without these.

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. Failure to notify us within 24 hours of your appointment may result in a **NO SHOW fee**. If you fail to show up to your new patient appointment, we will not be able to reschedule you.

PAYMENT: Cash, personal check or credit card (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 costs 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.

Greece Dermatological Associates
www.greecedermatology.com



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)

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

Home 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 _____

Cell 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		If yes, please explain:
	Yes	No	
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.