Patient Information			
First Name	Last Name		MI
Marital Status Single Married Divorced Widowed	SSN	Date of Birth	Gender M or F
Preferred Language	Ethnicity Hispanic Latino Non-Hispanic	Race American Indian, Black or African American, Native Hawaiian Other Pacific Islander, White, Other, Decline to Specify	

Emergency Contact			
First Name	Last Name		MI
Home Phone	Work Phone	Cell Phone	

Your Phone Number, E-mail, and Address (Circle Preferred Phone Number)			
Home Phone	Work Phone	Cell Phone	
Email (Enables your patient portal)	Street address		
City	State	Zip Code	

Primary Insurance and Responsible Party (Guarantor) Same as patient Y or N			
Insurance Co.	Policy #	Group #	
First Name	Last Name		MI
Date Of Birth	Gender M or F	SSN	

Secondary Insurance and Responsible Party (Guarantor) Same as patient Y or N			
Insurance Co.	Policy #	Group #	
First Name	Last Name		MI
Date Of Birth	Gender M or F	SSN	

Pharmacy		
	City	State

Primary Care Provider		
Full Name	City	State

Referring Provider		
Full Name	City	State

✗

Signature of Patient/Responsible Party Date

WINDSOR DERMATOLOGY
HEALTHY SKIN

HIPAA

Our office complies with the Health Insurance Portability & Accountability Act to ensure that all of our patients' information is kept properly confidential. Unless you notify us otherwise, we may use and disclose your medical records ONLY for the purposes of treatment (as regards coordination of your care with other providers and services), payment (as regards obtaining reimbursement for services, confirming coverage and billing your insurance company) and health care operations. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services. Unless otherwise notified by you, we may at times leave a message at your home phone answering machine, with a family member, or mail information to your home address regarding your medical information.

Please list any other parties who can have access to your health information (this includes step parents, grandparents, and any caretakers who can have access to this patient's records)

Name_____ Relationship _____

Name_____ Relationship _____

The undersigned acknowledges you have reviewed the posted currently effective notice of privacy practices for Windsor Dermatology, PC and The Psoriasis Treatment Center Of Central New Jersey. I understand that my personal information will only be used and/or disclosed as above, and that I have the right to request restrictions concerning the use of my personal information. A copy of this signed, dated document shall be as effective as the original. My signature will also serve as a PHI document release should I request treatment/medical records be sent to other attending doctors/facilities in the future.

You may refuse to sign this acknowledgement and authorization. In refusing, we may not be allowed to process your insurance claims.

Patient printed name	Patient signature	Date
Legal representative/parent name	Legal representative/parent signature	

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I authorize Windsor Dermatology, PC and The Psoriasis Treatment Center Of Central New Jersey to view my external prescription history via the Rx hub service of SureScripts. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. My signature certifies that I read and understood the scope of my consent and that I authorize the access.

Patient printed name	Patient signature	Date
Legal representative/parent name	Legal representative/parent signature	

WINDSOR DERMATOLOGY, PC

Jerry Bagel, MD, David S. Nieves, MD, Brian R. Keegan, MD, PhD, Matthew Halpern, MD, Wendy Myers, MD, Jessica Simon, MD,

WELCOME TO OUR OFFICE * THIS INFORMATION MAY SAVE YOU UNNECESSARY EXPENSE!

Please take some time to read our policy on medical insurance plans. Your signature below indicates your understanding and acceptance of our medical insurance policy. Please feel free to discuss any questions with our office staff.

- ***Primary*** insurance is coverage through **YOUR** employer or your spouse if you are not employed
- ***Secondary*** insurance is additional coverage through a **SPOUSE**
- ***Children*** with coverage through both parents will be considered to be primary under whichever parent's birthday falls first in the calendar year

If our office participates with either your primary or secondary insurance, we will submit the claim as appropriate and it is your responsibility at the time of service to provide our office with the following:

- All information that applies to the primary insured including date of birth and social security number
- The insurance claim submission address for both insurance companies
- The co-payment as required by your insurance company

***For plans requiring referrals you must have a valid referral*, which must be presented prior to service to qualify for your insurance benefit. If you do not have a valid referral as required by your insurance plan:**

- You may reschedule your appointment
- If you choose to be seen without a valid referral, you must understand that any charges incurred resulting from this visit will be your responsibility. *As per your contract with your insurance carrier, you have agreed to bring a referral coordinated by your Primary Care Physician to be treated by a Specialist.* We will submit to your insurance carrier and then bill you if necessary.

For plans requiring referrals for maximum or optimal benefits (POS or Point of Service Plans)

We do not require a referral for these plans, however, it is the responsibility of the insured to be aware of their insurance benefits.

- If you choose to be seen without a referral *you will be responsible for all deductibles or charges as per your contract with your insurance company.* We will submit charges with a referral when properly provided to us.
- We will submit to your insurance carrier and then bill you if necessary.

Following claim submission

- You will be billed for any deductibles or co-payments as determined by your insurance company.
- Payment is expected upon receipt of statement from our office.
- Occasionally, insurance companies will request information from you regarding medical claims. You must respond to these inquiries within 14 days, or you may be held responsible for the entire charge of the medical visit.

Medicaid Notice: The Physicians of Windsor Dermatology, PC do not participate with any Medicaid plans. This includes Medicaid plans offered by private insurance companies. If your primary or secondary insurance is a Medicaid plan and you accept services by a Windsor Dermatology, PC physician, you will be billed for services rendered. By signing, you understand that if you have a Medicaid plan you will be billed and responsible for any charges for services rendered.

Please note *cosmetic procedures are not covered by insurance plans and you will be responsible for these charges at the time of service. Your physician will notify you if a procedure is cosmetic and the cost of the procedure before service is rendered. If on the same date of service as a cosmetic procedure you also incur charges that will be accepted by your insurance company, these will be submitted to your insurance carrier on a completely separate basis.*

I am aware of, have read the above, and accept the insurance policy of this office as indicated by my signature below.

Signature of Patient/Responsible Party Date

SIGNATURE ON FILE

I authorize use of this form on all my insurance submissions, as well as the release of information to all my insurance companies allowing my physician to submit claims and receive payment for benefits covering services rendered for myself or dependents. I permit a copy of this authorization to be used in place of the original and understand that I am financially responsible for all charges as per my agreement with my insurance company and this office.

Name (Please Print) Date Signature

Windsor Dermatology Medical History Questionnaire

Name: _____ Date of birth: _____ Today's date:_____

HAVE YOU EVER HAD?

- ☐ Anxiety
- ☐ Arthritis (circle: osteo/rheumatoid/psoriatic)
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ BPH (benign prostatic hyperplasia)
- ☐ Breast cancer
- ☐ Colon cancer
- ☐ COPD / emphysema
- ☐ Coronary artery disease or heart attack
- ☐ Depression or bipolar
- ☐ Diabetes
- ☐ End stage renal or chronic kidney disease
- ☐ GERD / acid reflux / heartburn
- ☐ Hepatitis (what type? A / B / C)
- ☐ Hypertension / high blood pressure
- ☐ HIV/AIDS
- ☐ High cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung cancer
- ☐ Prostate cancer
- ☐ Seizures
- ☐ Stroke
- ☐ Anemia
- ☐ Congestive heart failure
- ☐ Multiple sclerosis
- ☐ Lupus
- ☐ Organ or bone marrow transplant
- ☐ Tuberculosis or (+) PPD skin test
- ☐ Surgery

  _____
  _____
  _____
- ☐ Any condition not listed above

  _____
  _____
  _____

HAVE YOU EVER HAD?

- ☐ Actinic keratoses
- ☐ Basal cell skin cancer
- ☐ Squamous cell skin cancer
- ☐ Melanoma
- ☐ Moles removed and found to be precancerous, dysplastic or unhealthy
- ☐ Eczema / atopic dermatitis
- ☐ Psoriasis
- ☐ Close relatives with melanoma (circle: father mother brother sister child)

SMOKING STATUS

- ☐ Never smoker
- ☐ Former smoker
- ☐ Current smoker – some days
- ☐ Current smoker – every day

IMMUNIZATIONS

- ☐ Current flu season vaccine received
- ☐ (Age 65+ only) Ever received pneumococcal vaccine (Prevnar, Pneumovax)

ALLERGIES

- ☐ Medications: _____
- ☐ Other: _____

CURRENT MEDICATIONS

Name	Dose/pill	# and type	#times/day
Example: ibuprofen	*200mg*	*2 tablets*	*3x/d*

PLEASE ANSWER ANY WHICH APPLY

- ☐ (women) Pregnant
- ☐ (women) Attempting pregnancy
- ☐ (women) Breastfeeding
- ☐ Joint replacement surgery
- ☐ Mechanical heart valve
- ☐ Mitral valve prolapse
- ☐ Defibrillator or pacemaker

NEW ACNE PATIENTS: CIRCLE ANY MEDICINES YOU HAVE TRIED ALREADY

Retin-A Differin Tazorac adapalene tretinoin Ziana Epiduo Benzaclin Duac Acanya clindamycin benzoyl peroxide Klaron sulfur washes Proactiv Aczone doxycycline Doryx Acticlate tetracycline minocycline Solodyn Accutane isotretinoin Claravis Absorica Zenatane

NEW PSORIASIS PATIENTS: CIRCLE ANY MEDICINES YOU HAVE TRIED ALREADY

Topical steroids: clobetasol Clobex Olux Taclonex betamethasone Ultravate halobetasol triamcinolone desonide
Other topical: Dovonex calcipotriene tar Tazorac Protopic Elidel
Phototherapy: UVB PUVA Laser
Oral therapies: methotrexate cyclosporine/Neoral Soriatane Otezla
Biologic Therapies: Enbrel Humira Stelara Cosentyx Taltz Amevive Raptiva

59 One Mile Road Ext, Suite G

East Windsor, NJ 08520

609-443-4500 - main

609-426-0530 - fax

www.WindsorDermatology.com

WINDSOR DERMATOLOGY
HEALTHY SKIN

JERRY BAGEL, M.D.

JUDIT O. STENN, M.D.

DAVID S. NIEVES, M.D.

MATTHEW HALPERN, M.D.
Fellow, American College of Mohs Surgery

BRIAN R. KEEGAN, M.D., PhD.

WENDY A. MYERS, M.D.

JESSICA SIMON, M.D.

Thank you for choosing Windsor Dermatology. To simplify and speed up your payment processes, we are happy to offer three additional choices along with our standard payment options:

*** Credit Card on File (CCOF)**

*** Online Bill Pay (available 24 hours a day)**

*** CareCredit**

You may now keep your credit card on file (CCOF) if you choose. Credit cards on file may be used to pay account balances after insurance has paid its portion. This makes it easier to pay deductibles and coinsurance whose amounts are not calculated by the insurer until days or weeks after the visit. Card numbers are stored securely throughout our HIPAA-compliant First Data credit card scanners or machines, administered by a financial institution. For your protection, only the last 4 digits of your card will appear in our system. You will be notified via email or phone message prior to any charge being placed on your credit card.

Online bill pay. Account balances can now be paid online via a secure link on our website. This feature is available 24 hours a day and it's speedy and convenient. Go to www.windsordermatology.com and click on "pay my bill".

CareCredit. CareCredit is a health and wellness credit card designed specifically for patients interested in financing out-of-pocket health care expenses. This offers you a resource to help pay for care immediately. You may use it for cosmetic procedures, deductibles, balances, or products. Balances may be paid monthly and may be interest-free for up to six months.

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PSORIASIS TREATMENT CENTER
OF CENTRAL NEW JERSEY

Credit Card on File Agreement

We have implemented a policy which enables you to maintain your credit card information securely on file with Windsor Dermatology, PC. In providing us with your credit card information, you are giving Windsor Dermatology, PC the option of having us charge your credit card on file for your co-pay(s), coinsurance and or any outstanding balance(s).

Co-pays: Co-pays are due at time of the office visit.

Balances: If your insurance provider has paid their portion of your bill and there is still a remaining balance owed, Windsor Dermatology, PC will mail one statement. If not paid within 30 days Windsor Dermatology, PC, will provide a courtesy phone message or e-mail prior to charging any balance owed by you to your credit card. A copy of the charge will be mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Services and Products: Self Pay services, Cosmetic fees, and Product fees are due at time of the office visit.

This card will only be authorized for the use of the credit card holder or any person(s) listed below by the credit card holder. **This agreement will expire on your credit card expiration date listed below.** You will be required to provide us with a new card. The card holder may also revoke this consent at any time in writing.

Visa ☐ **MasterCard** ☐ **Discover** ☐ **American Express** ☐

Credit Card Holder's Name: _____ DOB: ____ / ____ / _____
(*Please Print*)

Last Four Digits of Account Number: _____

Expiration Date: _____

Please fill out information below for any other person/s you authorize this credit card for:

Patient Full Name: _____ DOB: ____ / ____ / _____
(*Please Print*)

Patient Full Name: _____ DOB: ____ / ____ / _____

Patient Full Name: _____ DOB: ____ / ____ / _____

Authorized phone number for messages:_____

Authorized e-mail:_____

Credit Card Holder's Signature: _____ Date: _____