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 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, Wendy Myers, MD,
Jessica Simon, MD, Matthew Halpern, MD,
Alexa Hetzel, M.S., PA-C, Brianna Butler, M.S., PA-C

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

WINDSOR
DERMATOLOGY

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)

Credit Card Number: _____

Expiration Date: _____ **CCV:** _____

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: _____

COSMETIC FINANCIAL POLICY

Thank you for choosing Windsor Dermatology as your cosmetic dermatology specialists. Please review our policy carefully before scheduling your upcoming treatment in order to avoid any misunderstanding and/or confusion.

SERVICES THAT REQUIRE A NON-REFUNDABLE DEPOSIT:

- **Cosmetic Consultations:** A $75 deposit required at check in.
- **CoolSculpting**: A $300 deposit per session is due at scheduling.
- **Lasers (IPL, PDL, CO2 resurfacing):** A $50 deposit is due at scheduling.
- **PICO-Tattoo Removal:** A $50 deposit is due at scheduling.
- **Injectables and laser hair removal**: A $50 deposit is due at scheduling for appointments 30 minutes or longer.
- **PRP:** A $50 deposit is due at scheduling.
- **Hydrafacial:** A $50 deposit is due at scheduling.

PAYMENT OPTIONS

All balances are due at the time of service. We accept cash, personal check, and major credit cards. We also offer CareCredit, a convenient financing option for health care expenses. Please ask our reception staff how to apply.

CANCELLATION POLICY

We understand sometimes situations arise which would require you to postpone your appointment. Cancellation provided with short notice prevents our staff from making time available for other patients waiting to be seen. We ask that as soon as you become aware of the need to cancel/postpone your appointment, you notify our office at once.

- If you cancel 7 or more days before the appointment, the deposit will be applied to the new date
- If you cancel less than 7 calendar days before the appointment, the deposit will be forfeit

For cases in which the full cost of the procedure was paid in advance (i.e. to secure a prepayment discount), then the amount paid in excess of the deposit will be refunded based on the calendar days advance notice provided:

- 7 or more calendar days notice: 100% refund of the excess
- 5-6 calendar days notice: 75% refund of the excess
- 3-4 calendar days notice: 50% refund of the excess
- 2 calendar days notice: 25% refund of the excess
- 0-1 calendar days notice: no refund

For any appointment cancelled by Windsor Dermatology, all funds paid will be refunded.
I have read the above and have a full understanding of my financial responsibility.

Patient Signature	Print name	Date