**FARAH DERMATOLOGY AND COSMETICS, LLC**
*General Dermatology - Dermatologic Surgery - Dermatopathology - Laser & Cosmetics*

1000 E. Genesee Street, Suite 601
Syracuse, NY 13210-1853
Telephone (315) 422-8331 - Fax (315) 422-3129

**Fuad S. Farah, M.D.**
Emeritus Professor of Medicine
Upstate Medical University

**Ramsay S. Farah, M.D.**
Chief Section of Dermatology
Associate Professor of Medicine
Associate Professor of Pathology
Upstate Medical University

**Joyce B. Farah, M.D.**
Assistant Professor of Medicine
Fellowship Trained in PDT
Upstate Medical University

## Office Visit and Insurance Policy

Patient Name: _____ Date of Birth:_____

Thank you for your visit to our office today. We are happy to serve you. You will be seen by one of our two Dermatologists today. Whether you are a long-time patient, or a new patient, we would like to take this opportunity to outline our longstanding office policy so that your initial visit is clear and runs smoothly. Once you have read these points, your signature below will be much appreciated.

1. Please note that your visit today may include medically necessary biopsy or removal of the skin tissue and that this will result in an additional charge beyond the initial/return office visit fee that will be explained to you on the consent sheet that you sign prior to the biopsy.
2. Please note that in addition to the visit, **all specimens whether benign or not**, are set to the pathology laboratory for diagnosis. The pathology lab handles the insurance coverage for these tests independent of our office. Therefore, any questions that you may have about coverage for the pathology processing and reading by the Dermatopathologist must be directed to the laboratory. **For this reason, we may need your insurance card for the laboratory.**
3. Our Dermatologists may also additionally require diagnostic testing, such ordering a blood work panel or hormone testing. Fee for any of these services are handled by laboratories outside of our practice and any questions about those charges much be directed to the diagnostic laboratory. **Again, for this reason, we will need your insurance card so that the laboratory can bill your insurance**.
4. As stated by our telephone receptionist, we would like to kindly remind you that the Farah doctors do not participate with any insurance plan and are out-of-network with all insurance companies at all four office locations (Syracuse, Fulton, Watertown and Camillus). Therefore, the expenses for today's visit and any further visits are your responsibility and the doctors' charges paid in full at the end of each visit are non-refundable.
5. We will provide you with detailed receipt that you can submit to your insurance company. Depending on your plan, you may get reimbursed from your insurance company, but we make no guarantees.
6. Many of our patients report that insurances do cover most, if not all, of the fees for their office visit. However, certain insurance plans will not reimburse any money if the patient requests and seeks services from a physician who is NOT part of the network. Therefore, we do encourage you speak with your health insurance company about reimbursement prior to your visit.

**By signing below I understand all of the above and agree to receive services from the physician today**

_____ _____

**Patient/Guardian Signature** **Date**

Fulton: 120 Cayuga St
Suite A
Fulton, NY 13069
www.farahdermatology.com

Camillus: 5700 W. Genesee St
Suite 201 North
Camillus, NY 13031

Watertown: 19316 U.S Route 11
Suite A
Watertown, NY 13601
www.aad.org

# FARAH DERMATOLOGY AND COSMETICS NEW PATIENT FORM

FUAD S. FARAH, MD, EMERITUS PROFESSOR - RAMSAY S. FARAH MD. FAAD - JOYCE B. FARAH MD. FAAD

1000 E. Genesee St. Ste 601 SYRACUSE, NY 13210 – 120 Cayuga St. Suite A FULTON, NY 13069

5700 W. Genesee St. Ste 201 N CAMILLUS, NY 13031 – 19316 U.S. Route 11 Suite A WATERTOWN, NY 13601

**Please be sure to fill out all information clearly and carefully to the best of your ability. All categories marker with an (*) ARE REQUIRED. Please be aware that payment is required at the time of service. Please call our main office (315)-422-8331 for any questions about payment or any other issues. We look forward to seeing you.**

***Full Name:**_____ ***Date of Birth:**__/__/__ ***Date:**_____

***Street Address:**_____ ***City:**_____ ***State:**_____ ***Zip:**_____

***Home Phone:**_____ ***Cell Phone:**_____ **Email:**_____

**Social Security #:**_____ - _____ - _____ ***Health Care Proxy Full Name:**_____

**Patient Occupation:**_____ **Marital Status:**_____ **Number of Children:**_____

***Emergency Contact:**_____ ***Relationship to Patient:**_____ ***Phone:**_____

***Name of Primary Care Doctor:**_____ **Phone:**_____

***Name of Referring Doctor (If Referred):**_____ **Phone:**_____

***For Patients Under the Age of 18 (Please Fill out #1):**

1. **Parent/Guardian Name:**_____ **Address/Phone:**_____

***CURRENT MEDICATIONS:**

_____

_____

_____

***DRUG/NON-DRUG ALLERGIES:***

_____

_____

_____

***Recent Hospital Admissions Within the Last Year:**

| Year | Reason, Illness or Operation | Year | Reason, Illness or Operation |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

***Medical History Check All that Apply:**

| | | | | | |
|---|---|---|---|---|---|
| | Glaucoma | | Colitis | | Eczema |
| | Cataracts | | Cancer | | Psoriasis |
| | Asthma | | Arthritis | | Rash |
| | Hay Fever | | Tuberculosis | | Abnormal Moles |
| | Valve Replacements | | Depression | | Hives |
| | Artificial Joints | | Anxiety | | Frequent Sun Exposure |
| | Jaundice | | Bipolar Disorder | | Hair Loss |
| | History Cardiac Disease | | History of Tanning Bed use | | None Of The Above |

***Questions (1+2) Below for Women Ages 16-50 ONLY (Circle One):**

| 1. Are You Currently Pregnant or Planning Pregnancy? | 2. Are Your Menstrual Periods Regular? | 3. What Are Your Methods of Birth Control? |
|---|---|---|
| Yes or No | Yes or No | _____ |

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## Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third party-payers
- Conduct normal healthcare operations such as quality assessment and physician certifications

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is uses or disclosed to catty out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Patient Guardian: _____

Signature: _____

Date: _____

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**Office Use Only**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below.

| Date: | Intitals: | Reason: |
|---|---|---|
| | | |

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# Release of Medical Records

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

I authorize **Ramsay S. Farah M.D and Joyce B. Farah M.D** to release any and all of my medical records, including but not limited to:

- Records of office visits and treatments rendered, clinical laboratory reports, diagnostic test results, x-ray reports, videotapes and photographs.

Such records may be released to my attorney, another physician, or any other health care professional for the purpose of discussing my condition, consulting on my case, or reviewing my medical records.

These records may also be released to any governmental agencies, insurance companies for the purpose of pursuing payment, insurance reimbursement, submitting claims for services rendered or to be rendered to me, or preforming quality assurance reviews as required by law.

**Patient/Guardian Name**:_____ **Date Of Birth**:_____

_____
**Patient Signature**

AUTHORTY TO REVOKE PERMISSION TO RELEASE RECORDS MUST BE OBTAINED IN WRITING FROM THE PATIENT

THIS DOCUMENT IS PART OF PATIENT'S MEDICAL RECORDS

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## Release of Information:

By signing below, you are allowing Dr. Farah's office to leave messages on your answering machine/voicemail when confirming your appointment and asking you to please call the office regarding medical information.

Also,

List below the names and telephone numbers of any persons we are allowed to disclose your medical information to. This includes laboratory and pathology results as well as general discussion about your care and/or medications.
Thank you.

| Name: | Relationship to Patient | Telephone number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Patient/Gaurdian Name:_____ Date of Birth: _____

Patient/Guardian Signature: _____ Date: _____

Farah Dermatology and Cosmetics LLC

HealtheConnections

New York State Department of Health

**Authorization for Access to Patient Information Through a Health Information Exchange Organization**

| Patient Name | Date of Birth |
|---|---|
| Other Names Used (e.g., Maiden Name): | |

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow **Farah Dermatology and Cosmetics LLC** to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealtheConnections website at http://healtheconnections.org/ .

My information may be accessed in the event of an emergency, unless I complete this form and check box #3, which states that I deny consent *even* in a medical emergency.

**The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.**

**My Consent Choice**. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for **Farah Dermatology and Cosmetics LLC** to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for **Farah Dermatology and Cosmetics LLC** to access my electronic health information through HealtheConnections.

☐ **3. I DENY CONSENT** for **Farah Dermatology and Cosmetics LLC** to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency.*

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

| Signature of Patient or Patient's Legal Representative | Date |
|---|---|
| Print Name of Legal Representative (if applicable) | Relationship of Legal Representative to Patient (if applicable) |

**Details about the information accessed through** HealtheConnections **and the consent process:**

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization and/or Health Plan listed may access ALL of your electronic health information available through HealtheConnections. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from HealtheConnections. You can obtain an updated list at any time by checking HealtheConnections website at http://healtheconnections.org/ or by calling 315.671.2241 x5.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through HealtheConnections for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization at: **315-422-4553**; or visit HealtheConnections website at http://healtheconnections.org/; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as HealtheConnections ceases operation. If HealtheConnections merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through HealtheConnections while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form.