ELYSE S. RAFAL, F.A.A.D.

Welcome to our practice. Thank you for placing your trust in us. We look forward to serving you with quality and compassionate care.

Patient Information

Today's Date: ______________________

First Name: ________________________M.I. ______________ Last Name: ______________________________

Address: ____

City: ____ State: ___________ Zip: ____________________

Social Security Number: _______________________________ Birth Date: ________________Age: _________

Gender: M F Marital Status: _____________________________

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native

☐ Native Hawaiian/Pacific Islander

☐ Other: ___________________________________

Preferred Language: ____

Emergency Contact & Phone: ____

Home Telephone: _______________________ Cell Phone: ____

Occupation: ____________________________ Work Telephone: _______________________________________

Preferred Phone (Circle One): Home Cell Work

Email Address: ____

Primary Physician: _______________________________________ Telephone: ___________________________

Address: ____

City: ____ State: _____________________ Zip: ________________

Pharmacy: ____ Telephone: ___________________________

Address: ____

City: ____ State: _____________________ Zip: ________________

How did you hear about us?

ELYSE. RAFAL, M.D. F.A.A.D.

Insurance Information

Name: ____ Primary Insurance: _________________________

Group Number: ___________________________ Primary Number: ___________________________

Start Date: _______________________________ End Date: ________________________________

Co-pay Amount: ___________________________ Do you need a referral? YES NO

Policyholder: ______________________________ Date of Birth: _____________________________

Address: _________________________________ Social Security Number: _____________________

Policyholder Employer: ______________________ Address and Phone #: _______________________

Secondary Insurance: ____

Group Number: ___________________________ Primary Number: ___________________________

Start Date: _______________________________ End Date: ________________________________

Co-pay Amount: ___________________________ Do you need a referral? YES NO

Policyholder: ______________________________ Date of Birth: _____________________________

Address: _________________________________ Social Security Number: _____________________

Policyholder Employer: ______________________ Address and Phone #: _______________________

2500 Route 347, Building 22A, Stony Brook, NY 11790
631-689-0300 Fax 631-689-1153

ELYSE S. RAFAL, F.A.A.D.

Claims Authorization **Name:** ____

I hereby authorize any physician, health care practitioner, hospital, or other medical or medically related facility, insurance company or consumer reporting agency to furnish any and all records, photographs, medical history, services rendered, or treatment given to me or any dependent for purposes of review, investigation, or evaluation of any claim submitted to insurer.

I also authorize insurer to disclose to a hospital or health care service plan, self-insurer, or any insurer medical information obtained if such disclosure is necessary to allow the processing of any claim.

If my coverage is under a group contract held by an employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with insurer including a reasonable time thereafter until its final consummation. This authorization shall be binding upon me, my dependents, and/or heirs, executors, and administrators.

Authorization to release:

Patient Information and Medical History forms. Furthermore, I hereby authorize Elyse S Rafal, M.D. to furnish the insured's insurance company all information which said insurance company may request concerning my present claim.

_______________________________ _______________________________ _______________________

Responsible Party's Signature Patient's Signature Date

Assignment:

I hereby assign to Elyse S. Rafal, M.D. all payment of authorized insurance benefits to which I am entitled for expense relative to the services performed from time to time but not to exceed my indebtedness to said doctor. It is understood that any money received from my insurance carrier over and above my indebtedness will be refunded to me when my account is paid in full. I understand I am financially responsible to Dr. Rafal for all professional fees for services rendered by her.

_______________________________ _______________________________ _______________________

Signature (Financially responsible party) Patient's Signature Date

2500 Route 347, Building 22A, Stony Brook, NY 11790
631-689-0300 Fax631-689-1153

ELYSE S. RAFAL, F.A.A.D.

Guarantee of Payment for Services

Name: ___________________________________

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, check, Visa, or MasterCard. We will be happy to assist in the processing of your insurance claim form. Any such request must be accompanied by a completed insurance form.

Returned checks and balances older than 30 days will be subject to finance charges of 1.5% per month and additional collection fees when indicated. Charges may also be made for broken appointments and appointments canceled without 24 hours advanced notice. All legal fees associated with a delinquent account are the responsibility of the patient, parent, or guardian.

You must realize, however, that:

1. Your insurance is a contract between you, your insurance company, and/or employer. We are not a party to that contract.

2. Not all services are a covered benefit of all contracts. Some insurance companies arbitrarily select certain services that they will not cover. Cosmetic procedures are usually not a covered expense.

3. If you are insured with a company that we currently participate with, please have your insurance ID card available for our information. Should this insurance company, for any reason, not reimburse us directly, or if we should not hear from this company in reference to a claim, you will be responsible for full payment.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. We do not routinely bill your insurance carrier unless we are a participating provider. You agree to be responsible for all professional services prior to or at the time services are rendered. All charges are your responsibility from the date the services are rendered.

We realize that temporary financial problems my affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I have read and understand all of the above information. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account. I will notify Dr.Rafal's office of any changes in my health insurance status.

____ ____________________________

Signature (Financially responsible party): Date

____ ____________________________

Patient Name (if different from above): Date

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ELYSE. RAFAL, M.D. F.A.A.D.

Acknowledgement of Receipt of Information

I was provided with the Disclosure of the Providers of Care in this organization, a copy of the Patient Bill of Rights and Responsibilities; information regarding the grievance process and information regarding the infection control processes of this organization.

Elyse S. Rafal, M.D., F.A.C.S. reserves the right to modify the above without notice.

Please check one of the boxes below:

I understand this information ☐ or I do not understand this information ☐

____

Name of Patient Signature of Patient Date

____

Signature of Patient Representative Relationship Date

____

Witness Date

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ELYSE. RAFAL, M.D. F.A.A.D.

Authorization for Examination

I, ____, represent to Elyse S. Rafal, M.D. and her staff that I am at least 18 (eighteen) years of age, or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by Dr. Rafal and such assistants or staff that may be assigned by her.

I understand that Dr. Rafal cannot bill my insurance carrier for cosmetic procedures, as they are non-covered medical expenses. However, if my procedure is determined to be non-cosmetic, I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payment of medical benefits directly to Dr. Rafal for services provided to me. A copy of this authorization shall be considered as valid as the original. In the event of litigation arising from treatment, I agree to submit the case to arbitration. I understand that photography is necessary part of the planning and evaluation of cosmetic procedures. I authorize the taking of photographs at the direction of Dr. Rafal and under such conditions as approved by her. These photographs are used solely for documentation purposes and will be kept confidential, unless a specific separate release is signed by me directing otherwise.

Patient Signature Patient Name Date

Patient Acknowledgment
Receipt of privacy Notice

I, ____ hereby affirm that I have received a copy of the *Notice of Privacy Practices* from ___________________, under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the *Notice*, and does not legally bind or obligate my in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

Patient Name: ____

____

Signature of Patient or Personal Representative

____

Name of Patient or Personal Representative

____

Date

____

Description of Personal Representative's Authority (if applicable)

▼▼▼ FOR OFFICE UES ONLY ▼▼▼

Received by:	
Date received:	Time received
Patient Declined ☐	
Staff Signature:	

ELYSE. RAFAL, M.D. F.A.A.D.

Patient Contact Questionnaire and HIPAA Acknowledgement

Patient Name: ____ Date: __________________

You may be contacted by this office to remind you of any appointments, healthcare treatment option or other health services that may be of interest to you. May we:

Contact you at home? YES NO Telephone # ______________________________

Leave voicemail? YES NO Telephone # ______________________________

Contact you at work? YES NO Telephone # ______________________________

Leave voicemail at work? YES NO Telephone # ______________________________

Contact you via cell phone? YES NO Telephone # ______________________________

Contact you via email? YES NO Email Address ____________________________

Can a message be left with our office name and what the call is in reference to? YES NO

Is there anyone we can leave a message with? YES NO

If yes, please list first and last name: ____

Would you like to authorize an individual as your personal representative? This person would have the authority to schedule, confirm, or change appointments only. YES NO

If yes, please list first and last name: ____

Elyse S. Rafal, M.D., F.A.A.D. has provided me with a copy of the privacy policy for this practice which describes my right as a patient under the HIPAA act. I have been provided the opportunity to read and understand my rights and ask questions regarding my rights and receive answers to my satisfaction.

Elyse S. Rafal, M.D., F.A.A.D. reserves the right to modify the privacy practices outlined in this notices.

Name of Patient Signature of Patient

Signature of Patient Representative Relationship of Patient Rep. to Patient

____ Witness

ELYSE. RAFAL, M.D. F.A.A.D.

WELCOME TO OUR PRACTICE. IT IS NECESSARY TO OBTAIN THE FOLLOWING INFORMOTION IN ORDER TO BEST SERVE YOU. THANK YOU.

Patient Name: ______________________________________ Male☐ Female☐
Last First

Social Security Number: ______________________ Date of Birth: ________________

Health Insurance: ____

Primary/Family Physician Name and Address | Referring Physician Name and Address

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

List all medication, (drugs) or over the counter products you take by mouth or use on your skin:

____

Are you allergic to any medication (drugs) Yes No Please specify below:

____

MEDICAL HISTORY: Please circle yes (Y) or No (N) for the following problems that you have now or have had in the past.

Y N Heart Disease
Y N Migraines
Y N High Blood Pressure
Y N Psychiatric Condition
Y N Skin Cancer
Y N Other Skin Disease
Y N Breathing Problems
Y N Tuberculosis
Y N Liver Disorder
Y N Stomach Intestinal Disorder
Y N Ear/Eye disorder
Y N Fainting Spells
Y N Joint Pain
Y N Prostate Disorder
Y N Thyroid Disease
Y N Diabetes
Y N Stroke
Y N Cancer
Y N Seizures
Y N Bleeding Disorder
Y N Blood Transfusion
Y N HIV/AIDS
Y N Allergies
Y N Other ________________

Have you ever had surgery? Yes No Type ______________________________

Have you or a close relative had skin cancer, melanoma or an atypical (funny looking or unusual) mole? YES ☐ NO ☐

WOMEN ONLY

Y N Presently Pregnant Y N Planning to become Pregnant Y N Breast Feeding

Y N Using Birth Control. If so, what kind

____

NEW PATIENT POLICY-PLEASE SIGN CHOICE 1 OR 2

1. COMPLETE EVALUATION, A FULL BODY SKIN EXAM (HEAD TO TOE).

____
Signature Date

2. AT THIS TIME I DO NOT DESIRE A FULL BODY SKIN EXAM

____
Signature Date