THE DERMATOLOGY SPECIALISTS

Date:_____

Patient Registration

Patient Information (please complete using your name as listed on your insurance card)

First Name:_____Middle Initial:_____Last Name: _____
Address:_____Apt/Floor:_____City:_____State: __Zip Code: _____
Home Phone:_____Cell Phone:_____Work Phone: _____
Date of birth:_____Email:_____
Sex: M_____F_____Occupation:_____Employer: _____

Insurance Responsibility – Policy holder Information. If patient is policyholder, please disregard this section.

First Name:_____Middle Initial:_____Last Name: _____
Address:_____Apt/Floor:_____
City:_____State: _____Zip Code: _____
Home Phone:_____Cell Phone:_____Work Phone: _____
Email Address: _____
Date of Birth:_____Sex: M_____F_____
Occupation:_____Employer: _____

Preferred Pharmacy
Pharmacy Name:_____
Pharmacy Address:_____Pharmacy Phone # _____

Insurance Information
All Patients must provide a copy of their insurance card at the time of their visits.

Primary Insurance:_____Name of Insured:_____Relationship: _____
Insured's DOB:_____Policy/ID#_____Group # _____
Secondary Insurance:_____Name of Insured:_____Relationship: _____
Insured's DOB:_____Policy #_____Group # _____

Referring Physician Information
Referring Physician:_____Phone # _____
Primary Care:_____Phone # _____

HOW DID YOU HEAR OF OUR OFFICE? _____

AUTHORIZATION FOR MINOR TO BE SEEN WITHOUT GUARDIAN PRESENT: **I**_____**(name)** authorize my child _____**_ (minor name)** to be seen and receive treatment at Bobby Buka MD PC without my presence.

Emergency Contact Information
Name:_____Relationship:_____Phone: _____

I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare) for purpose of filing and payment of medical claims. I authorize payment of medical benefits of the provider.

Signature:_____ Date: _____

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Credit Card Authorization:

This information will be stored securely until the time when your insurances have paid their portion and notified us of any member responsibilities. At that time any remaining balance owed will be charged to the card on file. Please note that this will NOT compromise your ability to dispute charges or your insurance company's determination of payment. You may revoke this authorization at any time in writing. This authorization will remain in effect until cancelled.

I,_____(name) Authorize Bobby Buka MD PC to charge outstanding balances (max $500 per charge) to the following card:

Credit Card Information
Card Type: ☐ MasterCard ☐VISA ☐ Discover ☐ AMEX ☐Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

Signature:_____ Date: _____

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Physician-Patient Arbitration Agreement – The Dermatology Specialists

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by New York law, and not by a lawsuit or resort to court process except as New York law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to the treatment or service provided by the physician including spouse, or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. A neutral arbitrator shall be selected by the American Arbitration Association (AAA) within thirty days of a demand for a neutral arbitrator by either party. Commercial arbitration rules shall apply AND neutral arbitrator shall rule within 120 days of appointment. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the AAA has the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.
The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.
The parties agree that provisions of New York law applicable to health care providers shall apply to disputes within this arbitration agreement and only document discovery shall be permitted. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) pm the date of notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable New York statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the New York Code of Civil Procedure provisions relating to this arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered at any time for any condition.

Article 6: Retroactive Effect: Patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) effective as of the date of first medical services.

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive the copy of this arbitration agreement. NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE ONE OF THIS CONTRACT.

BY: The Dermatology Specialists

_____ _____

Patient's or Patient Representative's Signature Date

_____

Print Patient's Name

Patient Acknowledgment of The Dermatology Specialists Office Policies

To be completed by **ALL PATIENTS. If the patient is under the age of 18, this form is to be filled out by his/her PARENT or GUARDIAN. Please read each item below and initial the space provided.**

A. Insurance Information / Co-payments and Deductibles
Payment is required for all services at the time they are rendered. If this office accepts my insurance, I understand that I am still responsible for paying any co-payment and deductibles that my insurance does not cover**. I understand that regardless of insurance enrollment, I am ultimately responsible for all costs of dermatologic treatment rendered.** Checks returned for insufficient funds will be charged an additional $50 fee. Your signature below signifies your understanding and willingness to comply with this policy.

B. Referral Information
If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my Primary Care Provider and assure it is available to be presented at the time of my visit. I further understand it is my responsibility to keep track of the number of visits I have used on my referral and the expiration date of my referrals and obtain new ones as needed. I understand that any specialty treatments requiring pre-authorization are also ultimately the responsibility of the patient. **I understand that should I fail to present a valid referral, I may be responsible for any charges pursuant to specialist treatment.**

C. Insurance Cards
New patients or those patients who change insurance plans must provide a valid insurance card at the time of the visit. Should you be unable to produce this documentation, patients may pay in full at the time of service and submit the claim to your insurance carrier for reimbursement. **I understand that I am responsible for notifying the office of any changes to my insurance or contact information.**

D. Cancellation Policy
Should you be unable to keep your appointment, please contact our office. Failure to contact the office within 24 hours of your appointment will result in a $25.00 cancellation fee.

E. Statement of Financial Responsibilities
As a courtesy to our patients, our office will bill private insurance for office visits and surgical procedures. Cosmetic procedures are not covered by insurance and the cosmetic fee is the responsibility of the patient. Any surgery done for medically necessary reasons will be billed separately to your insurance. A statement will be sent our explaining the status of your account, and follow statements may reflect any remaining balance. Since the financial responsibility always resides with the patient, we want to keep you informed. For example: if your insurance has not paid within 30 days you may wish to call them directly to confirm payment within 60 days. After 60 days we may no longer pursue your insurance company, but you the patient, for the payment.

F. HIPAA Authorization
I request and authorize The Dermatology Specialists discuss my medical condition with, confirm my appointments with, and provide my results to this person:

Name of Individual (please print) _____ **Relationship to Patient** _____

This authorization has no expiration date. However, you have the right to revoke this authorization, at any time, by sending a letter to The Dermatology Specialists, 220 Front Street, New York, NY 10038. If you revoke this authorization, it will not be effective with respect to information that has already been shared. This authorization is purely voluntary—you cannot be required to sign it and your treatment and payment will not be affected if you do not give the authorization. Information provided under this authorization may be re-disclosed by the recipient, who is not subject to federal privacy standards.

G. HIPAA Acknowledgement
I acknowledge having received a copy of the practice's Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996.

By signing below, I, the patient or parent/guardian for those under the age of 18, indicate that I have read, understand, and accept this Patient Acknowledgment listed above and hereby comply with its nature.

_____ **Patient/Guardian Signature**

THE DERMATOLOGY SPECIALISTS

Employee/ Patient Health Screening

PLEASE READ EACH QUESTION CAREFULLY	PLEASE CIRCLE THE ANSWER THAT APPLIES TO YOU	
Have you experienced any of the following symptoms in the past 48 hours: • fever or chills • cough • shortness of breath or difficulty breathing • fatigue • muscle or body aches • headache • new loss of taste or smell • sore throat • congestion or runny nose • nausea or vomiting • diarrhea	**YES**	**NO**
Within the past 14 days, have you been in close physical contact (6 feet or closer for a cumulative total of 15 minutes) with: • Anyone who is known to have laboratory-confirmed COVID-19? OR • Anyone who has any symptoms consistent with COVID-19?	**YES**	**NO**
Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	**YES**	**NO**
Are you currently waiting on the results of a COVID-19 test?	**YES**	**NO**

NAME:_____ **DATE:** _____