

MANHATTAN DERMATOLOGY, PLLC

www.dermatologistnewyork.org

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GEORGE KIHICZAK, MD

NAME _____ SSN # _____

ADDRESS _____ DOB _____

CITY _____ STATE _____ ZIP _____

HOME # _____ CELL # _____ WORK # _____

FAX # _____ PHARMACY # _____ EMAIL _____

PRIMARY CARE PHYSICIAN _____ PHONE # _____

GUARDIAN OR EMERGENCY CONTACT INFO _____

INSURANCE PLAN _____ ID # _____

LIST ALL ALLERGIES	LIST ALL MEDICATIONS, SUPPLEMENTS, VITAMINS
_____	_____
_____	_____
_____	_____

DESCRIBE TYPE, LOCATION, AND DURATION OF YOUR SKIN TROUBLE

CANCELLED/RESCHEDULED APPOINTMENT AND FINANCIAL POLICIES

If you must cancel or reschedule your appointment, we request that you do so at least ONE BUSINESS DAY prior to your appointment. If you miss an appointment without doing so, we reserve the right to refer you to another physician or charge a cancellation fee if the appointment was for a surgical or laser procedure.

For surgical procedures, you must cancel 24 HOURS prior to your appointment, or you will be charged a \$250 fee.

For Mohs Micrographic surgery appointments, you must cancel ONE WEEK prior to your appointment, or you will be charged a \$250 fee.

All copays are expected at the time of the visit.

It is your responsibility to understand your insurance plan's policies and to get referrals from your PCP if required by the patient's insurance plan. Even if we are in network with your insurance, deductibles or coinsurance may apply, which means you may be responsible for a portion of the charges.

This form and my signature affixed hereto may serve as a signature-on-file to be used to authorize disclosure of medical information necessary to process my insurance claim, including the diagnosis and records of any treatment or examination rendered to me, and to file all future insurance claims related to my care.

I also authorize my insurance company to pay directly to Dr. William T. Long, Dr. Wendy Long Mitchell, Dr. Shari Marchbein and/or Dr. George Kihiczak the amount due to me in pending claims for medical or surgical treatment or services rendered to me.

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices.

PATIENT'S OR RESPONSIBLE PARTY'S SIGNATURE _____ DATE _____