SYLVIE D. KHORENIAN, M.D., P.C.
Cosmetic and Medical Dermatology

630 East Palisade Avenue
Englewood Cliffs, NJ 07632
Tel: (201) 503-0302
Fax: (201) 503-0309
E-Mail: Derma630@aol.com

REGISTRATION FORM

LAST FIRST MI

Name________________________ ________________________ _______
Street____ Apt #________
City______________________________ State______________ Zip Code___________
Home Phone________________________ Occupation_____________________________
Cell Phone__________________________ Employer______________________________
Pharmacy Phone____________________ Business Phone_________________________
Date of Birth________________________ Social Security #________________________
Email Address____
Female☐ Male ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐

Name and phone number of the nearest relative with whom the doctor may discuss any medical information in the event you are unavailable_____________________________

How were you referred to our office? ____

Primary Physician _______________________ Phone Number_____________________

PRIMARY INSURANCE ____
Policy Number__________________________ Group Number____________________
SECONDARY INSURANCE ____
Policy Number__________________________ Group Number____________________

I authorize any holder of medical or other information about me to release to the Social Security Administration or Health Care Financing Administrations or its intermediaries or carriers, or to the billing agent of this physician, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request of payment of medical insurance benefits either to myself or to the treating physician if assignment is accepted.
The patient is responsible for informing the office of changes in information or insurance plans prior to seeing the physician.

Effective July 2012, a 24hr cancellation notice for appointments is required; otherwise, a fee of $25 for Medical Office Visits or $150 for Cosmetic Procedures will be applied to your balance.

We require a credit card to be on file for any co-pay, deductible, co-insurance, or non-covered service payments. Charges or refunds to your credit card will ONLY be made once your insurer has provided us with your EOB (explanation of benefits).

Type of Credit Card: Visa_____ Amex____ Mastercard ___
Name on Card: __________________________________
Credit Card Number: _____________________________
Exp Date: _________________ Security Code__________

Patient/Cardholder Signature: ___________________________ Date_____________

SYLVIE D. KHORENIAN, M.D., P.C.
Cosmetic and Medical Dermatology
630 East Palisade Avenue
Englewood Cliffs, NJ 07632
Tel: (201) 503-0302
Fax: (201) 503-0309
E-Mail: Derma630@aol.com

HIPPA

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes: information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend you protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You may have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2013.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please as to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that your have received this Notice of our Privacy Practices.

Print Name: ____

Signature: ____

Date: _____________________

SYLVIE D. KHORENIAN, M.D., P.C.
Cosmetic and Medical Dermatology

630 East Palisade Avenue
Englewood Cliffs, NJ 07632
Tel: (201) 503-0302
Fax: (201) 503-0309
E-Mail: Derma630@aol.com

Dear Patient,

Due to the HIPPA laws, which protect your medical information from being disclosed to a third party without your permission, including members of your family, we would need your written consent in order to do so. Please give us the name(s) of persons with whom the doctor may disclose medical information when you are unreachable.

I authorize Dr. Khorenian to discuss my medical condition and/or treatment with any of the following family members or significant others.

Name/Relation	Telephone Number
______________________________	__________________________
______________________________	__________________________
______________________________	__________________________
______________________________	__________________________

IDENTITY THEFT PROTECTION

Due to New Federal Regulations regarding identity theft you will be asked to show your driver's license or any other government issued photo identification and a current insurance card at the time of your visit.

Patient Name: ____

Signature:____

Date: ____

SYLVIE D. KHORENIAN, M.D., P.C.
Cosmetic and Medical Dermatology

630 East Palisade Avenue
Englewood Cliffs, NJ 07632
Tel: (201) 503-0302
Fax: (201) 503-0309
E-Mail: Derma630@aol.com

FINANCIAL POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions regarding our fees and policies.

There is no way we can possibly know, or keep up to date with each program's provisions. It is your responsibility to know and advise us of your plan's requirements in advance, each and every time we provide service. Please be advised that if we have not been informed of your program's requirements and if we provide a physician or laboratory service, you will be responsible for the fees.

We will do our best to comply with your company's requirements. Patients must inform us of changes in information or insurance plans prior to seeing the physician.

Participating Plans: By law we must collect your carrier designated co-pay at the time of your visit. We will submit claims. You are responsible for your annual deductible and co-insurance.

Medicare: We will submit claims to Medicare. The patient will be responsible for the deductible and the co-insurance, which can be billed to a secondary insurance if you have one. Medical Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Dr. Khorenian for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and it's agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

Laboratory Services: Patients must inform the nurse prior to a diagnostic procedure, which laboratory is participating with your insurance.

Divorced/Separated parents of minor patients: The parent who consents to the treatment of a minor is responsible for payment of service.

Payment may be in cash, check, or credit card. We accept VISA, MASTERCARD, and AMERICAN EXPRESS.

Appointments: A 24 HOUR NOTICE must be provided in the event you cannot keep and appointment or a charge will be administered to your account.

Thank you for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient's Name: ___________________________________ DOB: __________________

Signature: _______________________________________ Date: __________________