SK DERMATOLOGY
COSMETIC & MEDICAL SKIN CARE

Please email completed forms to:
frontdesk@skdermatology.com
Or fax to:
(201) 503-0309

REGISTRATION FORM

LAST NAME____________________________FIRST NAME______________________M.I.______

STREET ADDRESS____APT#____________

CITY______________________________STATE____________ZIP CODE____________________

HOME PHONE_____________________________CELL PHONE____________________________

DATE OF BIRTH____________________________ EMAIL___________________________________

PHARMACY NAME/LOCATION________________________PHARM TEL#__________________

GENDER: MALE FEMALE PREFER NOT TO SPECIFY (circle one)

EMERGENCY CONTACT/NAME OF NEAREST RELATIVE YOU PERMIT THE DOCTOR TO CONTACT TO DISCUSS MEDICAL INFO SHOULD YOU NOT BE AVAILABLE:

NAME____________________________ TEL#____________________RELATION_____________

PRIMARY CARE PROVIDER____

ADDRESS OF PMD______________________________________TEL#______________________

HOW WERE YOU REFERRED TO OUR OFFICE?_______________________________________

INSURANCE INFORMATION: PLEASE PRESENT YOUR INS CARD TO THE RECEPTIONIST)

PRIMARY INSURANCE____

PRIMARY SUBSCRIBER NAME:______________________________DATE OF BIRTH:_________

RELATIONSHIP TO SUBSCRIBER: SELF______SPOUSE_______CHILD___________________

SECONDARY INSURANCE____

I authorize the 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 or insurance claim, I permit a copy of this authorization to be used in place of the original, and request of payment of insurance benefits either to myself or to the treating physician if assignment is accepted.

I am responsible for informing the office of changes in above information or insurance plans prior to seeing the physician.

A 24 hour cancellation notice for appointments is required, otherwise a fee of $25 for medical visits and $150 for cosmetic appointments will be applied to your balance.

Patient/guardian signature_____________________________________Date__________________

Sylvie Khorenian, MD
Elsa Ordoukhanian, MD
Terri Raymond, PA-C
O: 201-503-0302
F: 201-503-0309
frontdesk@skdermatology.com

Financial Policy

We are committed to providing you with the best possible care and are pleased to discuss professional fees with you at any time. Your clear understanding of our financial policy is important for our professional relationship.

GENERAL

There is no way we can possibly know or keep up to date with each insurance program's provisions. You must be aware and inform us of your insurance plan's requirements in advance of each and every appointment. Please be advised that if we have not been informed of your program's requirements and we provide a physician or laboratory service, you will be responsible for the fees. It is your responsibility to be aware of your deductibles, co-payments, co-insurances, and any changes in your policy.

PARTICIPATING HMO/PPO PLANS

By law we must collect your carrier designated co-pay at the time of your visit. We will submit claims to your insurance company. You are responsible for your annual deductible and co-insurance. We will require a copy of your insurance card and valid driver's or personal ID card upon check in.

MEDICARE

Effective 1/1/2021 our providers are **nonparticipating with Medicare.** This means they will charge the ALLOWABLE patient charges approved by Medicare for non-par providers. These are lower than our usual and customary fees. The patient will be responsible for payment of these charges at the time of their visit. Our office biller will submit the claim on your behalf and Medicare will reimburse 80% of the charges directly to the patient. If the patient also has secondary insurance, any remaining balances can be submitted by the patient to their secondary insurance.

SELF PAY PATIENTS

For patients with no insurance, the guarantor is responsible for the bill at the time of visit. Any diagnostic laboratory charges will be covered by your insurance as we will make every effort to utilize laboratories that accept most commercial insurances and Medicare.

COSMETIC SERVICES

Payment is due at the time of service. Some time consuming procedures may require a deposit in advance of the appointment to block the provider's time.

DIVORCED/SEPARATED PARENTS OF MINOR PATIENT

The parent who consents to the treatment of a minor is responsible for payment of service.

CANCELLATION POLICY

A **24 HOUR NOTICE** must be provided in the event you cannot keep an appointment, or a **cancellation fee** of **$25** for medical visits or **$150** for cosmetic visits will be applied to your account.

Payment may be in cash, check, or credit card. We accept **VISA, MASTERCARD AND AMERICAN EXPRESS.** Any patient balances are due immediately upon receipt of statement.

BENEFIT ASSIGNMENT: I hereby authorize the assignment of benefits (payments) directly to Dr. Sylvie Khorenian for all my insurance claims related to services received at SK Dermatology. I agree to pay any and all exceeding charges not covered by my insurance company. I understand co-pays, deductibles, and non covered services are due in full at the time of service.

Patient Name:______________________________DOB:____________________

Signature:________________________________Date:____________________

RECORD RELEASE: I authorize the release of any medical records necessary for the purposes of processing claims with my insurance company.

I have read and understand the above financial policy.

Signature of Patient/Responsible

Party:____________________________________Date:____________________

Sylvie Khorenian, MD Elsa Ordoukhanian, MD Terry Raymond, PA-C
630 E Palisade Ave, Englewood Cliffs, NJ 07632
O: (201) 503-0302 F: (201) 503-0309
frontdesk@skdermatology.com

HIPPA: Notice of Privacy Practices

Your Rights

The 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 a physician believes it is in your best interest to permit use and disclosure of your protected health information, this 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 your 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 of any changes. You then have the right to object or withdraw as provided within this notice.

Complaints

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

Our Commitment to Your Privacy

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 speak with our physicians.

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

Print Name: ______________________________ Signature: ______________________________ Date: ________________

CURRENT MEDICATIONS/SUPPLEMENTS

1.____

2.____

3.____

4.____

5.____

6.____

7.____

8.____

9.____

10.____

ALLERGIES____

____

____