MICHELE S. GREEN, M.D.

Name_____
Last **First** **Middle initial**

Address_____
Number **Street** **Apt#** **Town, State** **Zip**

Home_____ **Cell**_____ **Email**_____
Area Code Number **Area Code Number**

Please Circle: Preferred Contact Number Home Cell Work **Instagram**_____

Single Married Divorced Widowed **Male Female**

Birth Date_____ **Birth Place**_____

Age Last Birthday_____ **Social Security Number**_____

Have you ever been a patient in this office?_____ **Referred by:** _____
Physician, Real Self, Google, Internet, Other

Required Pharmacy Name_____**Required Pharmacy Number**_____

Required Pharmacy Address _____

Name & Telephone of Internist? _____

Medical Insurance Name_____**Insurance Address** _____

Primary Care Holder's Name _____ **Birth Date** _____

Insurance ID number_____ **Group number** _____

Occupation_____**Business Name**_____

Business Address_____
Number Street **City** **State** **Zip**
Business Phone_____
Area Code Number
Emergency Contact_____**Phone Number**_____
Name and Relationship **Area Code Number**

Emergency Contact Address_____
Number Street **City** **State Zip**

_____ _____
Patient's Signature **Date**

Please note Dr. Green is not contracted with any insurance company. Please contact your individual insurance carrier to confirm what your individual out-of-network benefits are. The initial consultation fee is $650.00 and can be applied towards any cosmetic treatment within 3 months. A 48-hour notice is required for cancellation otherwise the patient is responsible for a $650 cancellation fee for new patients and $200 for existing patients. Payment is due when services are rendered.

QUESTIONNAIRE

To help give you the best possible care, please carefully complete all questions on this form.

A. HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING:

1. Duodenal or peptic ulcer	**yes**	**no**
2. Other intestinal disease or colitis	**yes**	**no**
3. Liver disease or gall bladder disease	**yes**	**no**
4. Lung disease	**yes**	**no**
5. Heart disease	**yes**	**no**
6. High blood pressure	**yes**	**no**
7. Stroke	**yes**	**no**
8. Kidney disease	**yes**	**no**
9. Urinary or bladder problem or infection	**yes**	**no**
10. Venereal disease	**yes**	**no**
11. Blood disorder or lymph gland disorder	**yes**	**no**
12. Eye disease (glaucoma, cataract)	**yes**	**no**
13. Arthritis, joint problem, bone disease	**yes**	**no**
14. Thrombophlebitis	**yes**	**no**
15. Cancer	**yes**	**no**
16. Neurological disorder	**yes**	**no**
17. Frequent infections	**yes**	**no**
18. Emotional or psychiatric problem	**yes**	**no**

B. HAVE YOU OR ANY MEMBERS OF YOUR FAMILY (Specify Who) HAD:

1. Asthma	**yes**	**no**
2. Hay fever	**yes**	**no**
3. Eczema	**yes**	**no**
4. Hives	**yes**	**no**
5. Diabetes	**yes**	**no**
6. Psoriasis	**yes**	**no**
7. Skin cancer	**yes**	**no**
8. Glaucoma	**yes**	**no**
9. Other skin conditions (specify)	**yes**	**no**

C. HAVE YOU EVER HAD?

Difficulty with the healing of wounds		
2. Overgrown scars or keloids	**yes**	**no**
3. Allergy to local anesthetics	**yes**	**no**

D. HAVE YOU PREVIOUSLY HAD A SKIN PROBLEM OR BEEN UNDER THE CARE OF A DERMATOLOGIST? IF YES, DESCRIBE:

_____

E. HAVE YOU EVER HAD RADIATION? **yes no**

F. DO YOU TAKE ANY MEDICINES OR OVER-THE-COUNTER PREPARATIONS OR REMEDIES? **yes no**
PLEASE LIST_____

G. ARE YOU ALLERGIC TO ANY MEDICINES? **yes no**
IF YES, PLEASE LIST:_____

_____

H. PRIOR HOSPITALIZATIONS AND SURGERY (Please give dates):

_____

_____

I. FOR WOMEN ONLY

1. **Have you had vaginal yeast infections?** **yes no**
2. **Are you pregnant?** **yes no**
3. **Are you currently planning a pregnancy?** **yes no**

Please inform Dr. Green at any time if you do plan to or become pregnant during your treatment period.

At the time of your first visit to this office, it is necessary for your entire skin to be examined. This will enable Dr. Green to see not only the particular skin condition for which you are consulting us, but also other skin problems of which you may not be aware.

You will be provided with a proper gown for your examination.

If for any reason you do not wish to have such a general examination of your skin, please tell Dr. Green and she will make a note on your chart regarding your wishes.

DATE_____

SIGNATURE_____

MICHELE S. GREEN, M.D.

DERMATOLOGY AND
DERMATOLOGIC SURGERY

156 East 79th Street – Suite 1B
New York, N.Y. 10075

Tel: (212) 535-3088
Fax: (212) 535-0279

DATE: _____

DEAR PATIENT IN ORDER TO HELP YOU KEEP YOUR MEDICAL HISTORY UP TO DATE PLEASE LIST ALL PHYSICIANS YOU WOULD LIKE US TO SEND YOUR PATHOLOGY AND LAB REPORTS TO:

To: _____

Address: _____

Telephone: _____

To: _____

Address: _____

Telephone: _____

_____

Signature **Print**

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OFFICE POLICY

It is our office policy to have a 48-hour cancellation notice; otherwise, a missed appointment fee of $200.00 will apply for existing patients and $650 for new patients.

Missed appointments without notification will automatically be charged a missed appointment fee.

Payment is expected at the time of the visit. After 90 days all outstanding bills will automatically be forwarded for collection.

All bounced checks will incur a $20.00 fee.

All unpaid balances will accrue a finance charge of 3% per month and a $3.00 billing charge. I hereby authorize Dr. Michele S. Green, M.D., P.C. to charge to the below account, any outstanding balance. In the event that fees are not paid as delineated above, I agree to pay any and all collection and/or attorney's fees incurred.

Signature of Patient or Guardian_____

Method of Payment: MC_____ **VC**_____ **AMEX**_____

Credit Card Acct. #:_____ **Exp. Date:**_____

Driver's License #:_____ **State:**_____ **Exp. Date**_____

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Please note that Dr. Green is not contracted with any insurance company. Please contact your individual insurance carrier to confirm what your individual out-of-network benefits are. The initial medical or cosmetic consultation fee is $650.00. Following a medical consultation, you will be provided with a HICFA form that you can submit directly to your insurance company. For a medical consultation, your $650.00 consultation fee is not transferrable to any cosmetic or medical procedure. If your initial visit is cosmetic in nature, the initial consultation fee may be applied towards a cosmetic treatment within the first three months of your visit. The consultation fee is not, however, to be applied to any medical treatment or products available in the office. The follow-up fee for a cosmetic treatment is dependent on the procedure performed during the visit. The follow-up fee for a medical visit is $400.00. If you are on Accutane, the monthly office visit fee is $650.00. Any additional medical or cosmetic procedure performed will be an additional charge.

If you have decided to have a complete skin examination, we would like you to be aware that for each mole removal there is a fee of $400. The mole is then sent to the laboratory for examination and you will receive a separate invoice from the pathology lab that is independent of our office.

The following list is a list of the laboratories and the insurances which they contract with. Our office sends Dermatology (biopsy results) to the Ackerman Academy and Blood/Cultures to Quest and LabCorp. If your health insurance does not cover these laboratories, you may choose a different lab to send your specimens to. Please make Dr. Green or her assistant aware of your choice at the time of your visit.

Thank you very much for your assistance.

_____ _____

Patient's Signature Date

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I,_____, hereby consent to have my physician,
Michele Green, M.D., communicate with me or members of her staff, where appropriate or other physicians, nurse practitioners, and pharmacists via email regarding the following aspects of my medical care and treatment: test results, prescriptions, appointments, billing, etc. I understand there is a risk that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my physician and me or members of my physician's office staff or between my physician and other physicians, nurse practitioners, and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any email communication between my physician and me or members of her office staff or between my physician and other physicians, nurse practitioners, or pharmacists regarding my medical care and treatment may be made part of my medical record. I understand that in an urgent or emergent situation, I should call my provider or go to the Emergency Room and not rely on email.

Signature:_____ Date:_____

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LABORATORY INFORMED CONSENT

There is no charge at the office of Dr. Michele Green to draw your blood. LabCorp will send you a bill for any testing performed. The LabCorp fee will be dependent upon your insurance company and deductible.
We are happy to provide you with a lab requisition form at your request should you prefer to have your blood drawn at a lab of your choice.

Patient Signature: _____Date:_____

PRESCRIPTION INFORMED CONSENT

You can obtain prescription refills by contacting our office via telephone or email. Prescriptions are sent electronically to the pharmacy of your choice.

Maintenance medications, such as oral medications and topicals, can be renewed if you have had an office visit within the last 6 months. If you have not been seen in 6 months, you will need to schedule an appointment for an office visit to obtain a prescription refill. However, some patients may need labs or office visits more frequently. Please note that an office visit fee of $400 will apply, while patients on Accutane will incur a monthly office visit fee of $650 to process your medication and evaluate your progress.

We do not control the cost of medications. The price of medications is determined by your insurance company, your prescription benefit plan, and their agreement with the pharmacy you have chosen. If you are experiencing any issues with your prescription, such as cost, quantity, instructions, or coverage, please call our office during normal business hours. If you need assistance after hours, you can send us an email, and we will follow up with you and your pharmacy the following business day. We are closed on weekends, and any pharmacy issues will be addressed on Monday when the office reopens at 8:30 am.

Please be aware that antibiotics cannot be refilled, as an office visit is required every 3 months per NYS law.

Refills can only be authorized for medications prescribed by Dr. Green. We cannot refill medications prescribed by other physicians.

Patient Signature x_____Date:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Acknowledgement

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information ("PHI") about you. You have the right to review our Notice and ask questions about our privacy practices. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by calling (212) 535-3088. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you acknowledge that you have received our Notice of Privacy Practices.

_____

Name of Patient

_____

Signature of Patient

_____

Date

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Medical Photography Consent Form

PATIENT CONSENT

First Name Last Name DOB

I consent to medical images and/or videos to be made of me. I agree that duplicates may be made for the referring doctor.
By signing this form below I confirm that this consent form has been explained to me in terms which I understand.

I consent for these photographs and/or videos to be used in medical publications, including medical journals, textbooks, and online/offline electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs and/or videos will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

I agree that the images may be:	**YES**	**NO**
…placed in my medical record for future treatment	___	___
…electronically emailed to my treating health professional	___	___
…used by health professionals for education and training	___	___
…used in paper or electronic health publications	___	___
…used in commercial broadcast	___	___
…used in marketing materials	___	___
…used in internet or for marketing	___	___

By signing below, I confirm that I understand this consent form.

Signature of Patient **Date:**

Signature of Doctor/Health Professional/Staff (Witness) **Date**