Lenzy Dermatology
Yolanda M. Lenzy, MD
1176 Memorial Drive
Chicopee, MA 01020

_____New Patient Date: _____

_____Existing Patient Account #: _____

PATIENT INFORMATION *(This form should be completed by the parent or guardian of the minor patient.)*

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Name of the parent/guardian(s) the minor patient resides with: _____ **Relationship to patient:** _____

Birth Date: ___/___/___ **Sex: Male or Female** **Last 4 of SSN:** _____

Mailing Address: _____ **City/State/Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Employer: _____ **Referring Doctor:** _____

Primary Language: ☐ **English** ☐ **Other** (please specify) _____ ☐ **Declined to Provide**

Race: ☐ **White** ☐ **American Indian/Alaska Native** ☐ **Asian** ☐ **Black/African American** ☐ **Hispanic/Latino**
☐ **Native Hawaiian/Pacific Island** ☐ **Other** (please specify) _____ ☐ **Declined to Provide**

PLEASE INDICATE YOUR PREFERRED PHARMACY: Name: _____
Location: _____

EMERGENCY CONTACT INFORMATION: Name: _____
Phone: _____

RESPONSIBLE PARTY INFORMATION

Relationship to Patient: _____

This section should be completed with the person(s) information responsible for receiving statements and paying account balances.

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Birth Date: ___/___/___ **Sex: Male or Female** **Social Security Number:** _____

Mailing Address: _____ **City/State/Zip:** _____

Employer: _____ **Work Phone:** _____

INSURANCE AND MEDICAL RECORD AUTHORIZATION

I, the undersigned, hereby authorize Lenzy Dermatology to furnish information to my insurance carriers concerning my illness and treatment, and I hereby assign to the physician all payments for medical services rendered. I authorize the release of my medical records to the referring physician and to my insurance company should it be requested.

PHONE MESSAGE / CALL AUTHORIZATION

I, the undersigned, hereby authorize Lenzy Dermatology to **leave/send messages** by the following method(s) regarding my care or for appointment reminders:

Lenzy Dermatology's preferred method for our appointment reminder system is by **CALLS TO YOUR HOME OR CELL PHONE,** however, please select your preferred method of contact.

☐**Home Phone** ☐**Cell Phone** ☐**Text Message** ☐**Email:** _____ **(Email Address/Optional)**

PLEASE SEE REVERSE SIDE – SIGNATURE REQUIRED TWICE

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CONSENT FOR TREATMENT / INSURANCE RELEASE

I, the undersigned, hereby authorize Dr. Yolanda M. Lenzy, Ryan Mogadam, PA-C, to examine and treat me, including any biopsy or procedure(s), as deemed necessary to provide dermatologic care and aid in the diagnosis of my skin disorder. I understand that any procedure involves risks including, but not limited to, bleeding, infection and scarring. I am aware that scarring can result from any procedure and the type of severity of such scarring cannot always be predicted before the procedure.

I, the undersigned, hereby authorize Lenzy Dermatology to take photographs of me for my medical records and for educational purposes. I understand the photographs may include appropriate portions of the body to demonstrate procedures and that every effort will be made to protect my identity in those materials.

____I do ____I do not give authorization for photographs to be taken of me. ____*(Initials)*

I, the undersigned, authorize that the payment of insurance benefits be made on my behalf to Lenzy Dermatology for any services rendered to me. I further understand that prior to disbursing payment for services, my insurance company may require documentation from my medical records in order to process claims and approve payments.

I, the undersigned, understand that my insurance may not cover procedures and/or medications. I further understand that I am personally and fully responsible for any non-covered services, services deemed medically unnecessary, denied services, health insurance deductibles and co-insurance payments. I agree to assume full responsibility for the balance not covered.

We will not bill your insurance for services deemed medically unnecessary and payment is due at time of service.

I, the undersigned, understand that it is my responsibility to provide correct insurance information at the time of each visit. I further understand that I am personally and fully responsible for the full amount of any claims denied due to incorrect insurance information provided to Lenzy Dermatology.

I, the undersigned, understand I may be billed by an outside laboratory for work that is performed in this office either because my insurance company does not have a contracted lab or facility, or if services are not covered by my insurance company.

X _____ _____

Patient Signature ***(may be signed by parent/guardian of minor patient)*** **Date**

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Lenzy Dermatology has made available to you, a Notice of Privacy Practices. You have the right to request a copy of the Notice of Privacy Practices prior to signing this consent. A current copy of the Notice is posted in our office in a visible location at all times. The terms of the Notice may be revised or amended and you have the right to request a current copy of the Notice at any time.

The Notice provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a section explaining the patient's rights regarding your PHI. You have the right to request that we restrict or limit how PHI is used or disclosed for treatment, payment, or health care operations.

By signing this consent, you acknowledge that you have either received or waived your right to receive a current copy of the Notice. At any time, you have the right to revoke this consent by submitting your request in writing and signed by you, to Lenzy Dermatology.

In an effort to provide you with quality care, please provide the name(s) of all individuals you authorize Dr. Yolanda M. Lenzy, physician's assistant(s), and staff of Lenzy Dermatology to discuss or provide information in regards to your care (i.e. family, friends, etc.):

_____ _____ **Names of**

_____ _____ **Authorized Individuals**

X _____ _____

Patient Signature ***(may be signed by parent/guardian of minor patient)*** **Date**