RUSSAK DERMATOLOGY CLINIC

115 EAST 57TH STREET, SUITE 1220 NEW YORK, NY 10022
PHONE: (646) 873-7546 FAX: (646) 439-9070

PATIENT INFORMATION

Full Name: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Email: _____

Date of Birth (MM/DD/YYYY): _____ / _____ / _____ Social Security Number: _____ - _____ - _____

Primary Phone: _____ ☐ Cell ☐ Home ☐ Work

Secondary Phone: _____ ☐ Cell ☐ Home ☐ Work

How would you like to receive appointment reminders? ☐ Text ☐ Email ☐ None

DEMOGRAPHICS

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name of Employer or School: _____ Occupation: _____

Would you like to receive emails regarding our latest office promotions and services? ☐ Yes ☐ No

EMERGENCY CONTACT

Name: _____ Relation: _____

Phone Number (must be different from number listed above): _____

PRIMARY SUBSCRIBER ON INSURANCE

Full Name: _____

Relation: ☐ Spouse ☐ Child ☐ Parent ☐ Other Date of Birth: _____ / _____ / _____

REFERRAL INFORMATION

Referred by: ☐ Patient referral ☐ Charlotte's Book ☐ Previous patient ☐ Zoc Doc ☐ Yelp
☐ Google ☐ Facebook/Instagram ☐ NewBeauty Magazine ☐ Other

Name: _____ Phone: _____

PREFERRED PHARMACY

Name: _____ Phone number or cross streets: _____

Russak Dermatology recommends an in-network dermatological specialty pharmacy:* ***Apotheco.* *They offer free same-day delivery service to all boroughs. It is located at E 26th and 2nd Ave. Please note if you would like to opt for this pharmacy.*

RELEASE AND ASSIGNMENT

I hereby authorize Russak Dermatology physicians to release to your insurance company or representative any necessary information including the diagnosis and the records of any treatment or examination that may be necessary for either medical care or in processing application for financial benefit. **I understand I am responsible for any balance not covered by insurance.**

Print name: _____ Today's date: _____

Signature: _____

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CONSENT FOR COMMUNICATION VIA EMAIL/TEXT MESSAGE

(Provider-Patient)

I, _____, hereby consent to have my physician at Russak Dermatology Clinic communicate with me or members of their staff, where appropriate or other physicians, nurse practitioners and pharmacists via email/text regarding the following aspects of my medical care and treatment: [test results, prescriptions, appointments, billing, etc.]. I understand that e-mail/text is not a confidential method of communication. I further understand that there is a risk that e-mail/text communications between my physician and myself 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 understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail/text. I understand that for sensitive medical information, email/text should be concise. If there is a problem that is complex or sensitive to discuss via email/text, I should schedule an office visit.

I consent to communication via: ☐ Email ☐ Text message ☐ Both ☐ I do not consent

Patient Acknowledgement and Agreement: I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email and text messaging as a form of communication between RDC staff and myself, and consent to the conditions and instructions outlined.

Patient first and last name: _____

Today's date: _____

Patient signature: _____

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Aesthetic Cancellation Policy

Please note our aesthetic treatment cancellation policy. We require 48-hours notice of any cancellations or re-scheduling requests. Failure to do so will result in a $150 cancellation fee. We understand emergencies arise. In the event you need to re-schedule less than 48-hours, you may transfer fee towards re-scheduling your treatment. If you must cancel or do not show day of, the cancellation fee is non-refundable. If scheduled treatment was a part of a series, a session will be deducted from package.

Please arrive 5-10 minutes before your scheduled treatment time. Regretfully, untimely arrivals may be subject to shortened treatment time, in order to remain on schedule for subsequent guests. If an untimely arrival results in having to reschedule treatment, a $150 cancellation fee will be charged and can be applied towards rescheduled treatment.

Patients will receive courtesy appointment reminders 72-hours prior to appointment via consented form of communication (ex: email, text, phone).

Patient Acknowledgement and Agreement: I acknowledge that I have read and fully understand this consent form.

Patient first and last name: _____

Today's date: _____

Patient signature: _____

JULIE E. RUSSAK, M.D., FAAD

BOARD CERTIFIED DERMATOLOGIST

115 EAST 57TH STREET, SUITE 1220 NEW YORK, NY 10022

PHONE: (646) 873-7546 FAX: (646) 439-0070

EMAIL: INFO@RUSSAKDERMATOLOGY.COM

Dear Patient:

Thank you for letting Julie E. Russak, M.D., FAAD participate in your care. We are committed to providing you with the best possible care and service. I would like to take this opportunity to review your health plan benefits as provided to us by your insurance company.

Your Insurer shares the cost of healthcare with you by defining your financial responsibility in your benefit plan. The type of cost sharing includes:

- **Copays**: a fixed dollar amount that is required to be paid *at the time of each office visit.*
- **Deductible**: the amount you have to pay out-of-pocket each year for health related expenses before your insurance policy begins to pay 100%. Medicare and many insurance companies have an annual deductible for both in-network as well as out-of-network coverage.
- **Co-insurance**: the portion of the balance of covered medical expenses, which you must pay after payment of the deductible. For example: Medicare Part B requires patients to pay a co-insurance of 20% of the allowed charges. Medicare pays the remaining 80%.
- **Referrals**: if your insurance requires a referral, that is **your** responsibility to obtain it from your PCP, otherwise treatment may be delayed or coverage denied by your insurance company. If you do not know whether or not your plan requires a referral for you to be seen by a specialist, please let the front office know so we can verify that information on your behalf.

We are legally required to process claims in accordance with the terms in your policy. We are not allowed to ignore our contractual obligations with your insurance carrier.

Since you are ultimately responsible for payment of the medical services provided to you, it is our policy to obtain your credit card number and authorization to process a claim should your health plan not honor the claim we submit for services provided to you.

In providing your credit card information below, you authorize payment by credit card for service in absence of coverage by your insurance plan (including, but not limited to: copays, deductibles, co-insurance, and/or uncovered services).

Your understanding of your health care benefits is important to our professional relationship. Please ask if you have questions about our fees, financial policy, or your financial responsibility based on your insurance plan.

Name on credit card: _____

Credit card type: Visa / MC / Amex Credit card number: _____

Expiration date (MM/YYYY): _____ CID: _____

Print name: _____ Signature:_____

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PATIENT HISTORY

NAME: _____ **DATE:** _____

1. Please indicate your key skin concerns and list corresponding body area.

- ❑ Acne scarring
- ❑ Acne/breakouts
- ❑ Abnormal scarring
- ❑ Blotchiness/redness
- ❑ Dryness
- ❑ Eczema
- ❑ Fine lines/wrinkles
- ❑ Hair loss
- ❑ Laxity/loss of volume
- ❑ Moles/abnormal skin growth
- ❑ Pigmentation
- ❑ Rash
- ❑ Rough, uneven texture
- ❑ Psoriasis
- ❑ Skin cancer
- ❑ Spider veins/vascular abnormality
- ❑ Unwanted hair
- ❑ Underarm sweating
- ❑ Other (please specify) _____

2. Please list previous medical treatments done to address your skin concern(s).

FOR OFFICE USE ONLY

3. Fitzpatrick Type

4. Skin condition

❑ Dry ❑ Normal ❑ Combination ❑ Oily

PATIENT HISTORY

RUSSAK DERMATOLOGY CLINIC

NAME: _____ **DATE:** _____

1. Please indicate your key skin concerns or areas that you would like to improve.

FACE

- ❑ Fine lines and wrinkles
- ❑ Submental fullness "double chin"
- ❑ Laxity/loss of firmness
- ❑ Loss of volume
- ❑ Hair loss
- ❑ Uneven skin tone
- ❑ Blotchiness/redness
- ❑ Spider veins/vascular abnormality
- ❑ Pigmentation
- ❑ Rough, uneven texture
- ❑ Dryness
- ❑ Large pores
- ❑ Acne/breakouts
- ❑ Acne scarring
- ❑ Abnormal scarring
- ❑ Unwanted hair
- ❑ Other (please specify) _____

EYES

- ❑ Fine lines and wrinkles
- ❑ Dark circles/uneven pigmentation
- ❑ Puffiness
- ❑ Under eye bags
- ❑ Drooping eyelids
- ❑ Loss of volume
- ❑ Laxity
- ❑ Thinning/crepey skin
- ❑ Sparse eyelashes
- ❑ Other (please specify) _____

LIPS

- ❑ Fine lines and wrinkles
- ❑ Loss of volume
- ❑ Thinning/crepey skin
- ❑ Other (please specify) _____

BODY (please specify exact area)

- ❑ Unwanted fat/contouring
- ❑ Cellulite
- ❑ Abnormal scarring/stretchmarks
- ❑ Thinning/crepey skin
- ❑ Loss of laxity/firmness/volume
- ❑ Rough uneven texture
- ❑ Underarm sweating
- ❑ Unwanted hair
- ❑ Other (please specify)

2. Please indicate which aesthetic treatments you have done in the past. Be sure to include **date of the last treatment** and your **level of satisfaction with results**.

- ❑ Microdermabrasion
- ❑ Chemical peels *(list what type)*
- ❑ Botox
- ❑ Fillers
- ❑ Photorejuvenating Laser *(list what type)*
- ❑ Skin Tightening Laser *(list what type)*
- ❑ IPL
- ❑ Laser hair removal
- ❑ Cosmetic surgery

3. Please list your full AM & PM skincare regimen.

4. Please check all of which you would like to learn more about.

- ❑ **Comprehensive Wellness Analysis** – Pinpoints nutrient deficiencies, cortisol levels and food sensitivities that can cause chronic inflammation and accelerated glycation. Results are used to build custom treatment plans addressing overall wellbeing and beauty from the inside out.
  - ❑ Request Patient Testimonials
- ❑ **View our Before & After Galleries** – Including injectables, body contouring, laser resurfacing, cellulite reduction & hair restoration.
- ❑ **Request a detailed AM/PM skincare regimen** with one of our Clinical Aestheticians.
- ❑ **Tour our state-of-the art clinical spa, Russak+ Aesthetic Center**.