New York Dermatologic Surgery
Cosmetic and Laser Center

MONICA L. HALEM, M.D., F.A.A.D
988 FIFTH AVENUE
NEW YORK, NY 10075

TELEPHONE (212)-988-2400
FAX (212)-988-2446

LAST NAME: ___________________________ FIRST NAME: ___________________________ MIDDLE INITIAL: _______

STREET ADDRESS: ____ APT: ____________

CITY: ____ STATE: _______________ ZIP CODE: __________________

DATE OF BIRTH: ________/________/________ AGE: ________ SEX: MALE/FEMALE SSN# _______-______-_______

EMAIL: ____ OCCUPATION: ___________________________________

HOME NUMBER: (____)_________________ WORK: (____)_________________ CELL HOME: (____)________________

EMERGENCY CONTACT:____________________________________ PHONE NUMBER: (____)______________________

PHARMACY NAME: ____ PHONE NUMBER: (____)______________________

PRIMARY CARE PHYSICIAN: __________________________________ PHONE NUMBER: (____)______________________

REFERRING PHYSICIAN: ______________________________________ PHONE NUMBER: (____) ______________________

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: ____
NAME OF POLICY HOLDER: ____
MEMBER ID: ____

How did you hear about us?

Physician	Full name:
Insurance company	Name:
Magazine	
Radio/TV	
Internet	
The Physician/Practice website	
Seminar	Date/location:
A friend or family	Name:

Approval to contact you.	Best **phone number** to reach you:

We participate with Aetna, Cigna, Blue Cross and Blue Shield, Oxford, Empire and United Health Care; we do not participate with any other insurance plans. It is the patient's responsibility to obtain any referrals needed prior to appointment. If a needed referral is not provided for the day of service patient is the responsible party.

PATIENT SIGNATURE: ____ DATE: ________________________

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Please let us know the reason for your visit: ______________________________

ADDITIONAL SERVICES

At Dr. Halem's Dermatology and Dermatologic Surgery practice we offer variety of services including medical, cosmetic and laser. Please let us know what additional services you would like to learn about. Please check all that apply.

○ Skin care advice	○ Facial veins	○ Neck wrinkles
○ Skin care products	○ Facial redness	○ Liposuction
○ BOTOX® Cosmetic	○ Brown spots/age spots/freckle	○ Abdominal area
○ Juvederm Ultra	○ Drooping brow	○ Hips
○ Juvederm Ultra Plus	○ Drooping eyelids	○ Legs
○ Radiesse	○ Nose size or shape	○ Facial Contouring
○ Silicone	○ Facial fullness/drooping	○ Body Contouring
○ Restylane	○ Mole removal	○ Removal of Unwanted Hair
○ Facial fine lines/wrinkles	○ Scar revision	○ Length/Fullness of Eyelashes
○ Thin lips	○ Leg veins	○ Tattoo removal
○ Blotchy skin	○ Microdermabrasion	○ Ear Lobe Repair
○ Chemical peel	○ Facial Resurfacing	○ Acne Scar Treatment
○ Neck Tightening!	○ Skin Tightening	○ Upper & Lower Eyelid Surgery
○ Non Surgical Neck Lift	○ Non Surgical Face Lift	○ Facials

○ I'm not interested in any additional services provided at this time.

Please describe your skin care regiment:

AM: ______________________ PM: ______________________ Do you get Facials regularly? Yes No

______________________ ______________________
______________________ ______________________
______________________ ______________________

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Office Policy on Insurance, Payments and Credit Card Authorization

As a courtesy service to you, our office employs a billing service and participates with several insurance carriers. Please familiarize yourself with your insurance practices and policies.

1. If your insurance carrier requires you to pay a portion of your healthcare visits (i.e. co-payment, deductible, co- insurance), we are legally required to collect these and no exceptions will be made. You are required to pay your co-payment at the time of your visit.
2. If your insurance carrier requires you to have a referral to be seen in our office, you must provide a referral or you will not be seen.
3. If your insurance requires you to meet an annual deductible before your healthcare is covered, you will be billed for the services rendered if you have not met your deductible. In addition you will be responsible for any charges accrued that your insurance company does not cover.
4. You will be asked to leave a credit card number at the time of the check-in. This information will be held securely until your insurances have paid their portion and notified us of your share. At that time, any remaining balance owed by you will be charged to your credit card and a copy of the charge will be mailed to you.
5. Returned checks: I understand that there is a charge of $35.00 for all returned checks.
6. You are responsible for all cosmetic charges at the time of service.
7. There is a NO REFUND policy on all cosmetic procedures. _________ (Please Initial)
8. Please cancel appointment at least 24 hours in advance or they will be a charge of $50.00 for no show.
   ________ (Please Initial)

Please note that this will not compromise your ability to dispute a charge or your insurance company's determination of payment.
Unless otherwise specified, we will contact you via email regarding your balance. Please check here _ if you do not wish to be contacted via email and prefer correspondence via regular postal mail.

I_______________________________(print name) authorize Monica Halem, M.D. to charge outstanding balances to my credit card on file.

Card Type: VS__ MC___ AMEX___Exp Date: __/__ Security Code:________

Credit Card#: ____

IS THE CARD PROVIDED AN HRA OR FLEX SPENDING ACCOUNT? YES___ NO___

Select One:

___Credit card billing address is the **same** as current address.

___Credit card billing address is **different** from current address.
The correct address associated with the card provided is:

Street Address:___________________________________ Apt:____ City:____________________ State:___Zip:_____

I have read the above carefully and acknowledge these terms. I hereby assume all responsibility for any outstanding balances and (if selected) understand that these charges will be applied to the credit card I have provided.

Sign____ Date____________