Jeffrey Rapaport, M.D., P.A., F.A.A.D.
Dermatology, Cosmetic and Laser Surgery

Jeffrey Rapaport M.D.,P.A.,F.A.A.D.
Diplomate, American Board of Dermatology
Clinical Instructor. Mount Sinai School of Medicine

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Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID- 19

The novel coronavirus, COVID-I9, has been declared a worldwide pandemic by the World Health Organization. COVID-I9 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the Congregation of groups of people.

Jeffrey Rapaport M.D., P.A. has put in place preventative measures to reduce the spread of COVID-I9; however, the Practice cannot guarantee that you will not become infected with COVID-19 or that you are not already an asymptomatic carrier of COVID-19. Further, receiving services at the Practice could increase your risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-I9 and voluntarily assume the risk that I may be exposed to or infected by COVID-I9 by receiving services at the Practice and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-I9 at the Practice may result from the actions, omissions, or negligence of myself and others, including, but not limited to, Practice owners and employees.

In consideration for being permitted to receive services at the Practice, I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I may experience or incur in connection with receiving services at the Practice. On my behalf, and on behalf of my heirs, executors, administrators, personal representatives, and assigns, I hereby release, covenant not to sue, discharge, and hold harmless the Practice, its employees, agents, and representatives, of and from any claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of the Practice, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after receiving services at the Practice.

______________________________ ______________________
Signature of Patient/Parent/Guardian Date Date:
Print Name

____
Print Name

JEFFREY RAPAPORT, M.D., P.A.

PATIENT CONSENT FOR USE AND DISCLOSURE AS WELL AS RECEIPT OF NOTICE OF PRIVACY PRACTICES.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your Protected Health Information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices that follows this summary):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and ensure all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

By signing this form I acknowledge receiving Jeffrey Rapaport M.D.,P.A.'s privacy practices and consent to its use.

______________________________ Signature of Patient or legal Guardian

______________________________ Print Name of Patient

______________________________ Print Name of legal Guardian

______________________________ Date

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Thank you for choosing our office for your Dermatology needs

Please **read and acknowledge** the following office policies:

- **Insurance Coverage-**It is the patients' responsibility to determine if our office in in-network with your insurance plan. If you are un sure if we are a participating provider with your insurance, please call the customer service number located on your card, **prior to being seen** to ensure you do not receive a bill for your visit.

- **Lab Work-** It is your responsibility to inform us if we have to use a particular **LAB.**

- **Referrals**- **Referrals are the PATIENT Responsibility.** We are considered a **SPECIALIST** by your insurance company. If you insurance plan require a referral for treatment by a specialist it is **YOUR RESPONSIBILITY** to provide a referral **at the time of your visit** if you do not provide the proper referral (on the proper form) **you will be responsible to pay fir the office visit at the time of service.**

  Upon check-out, please verify that your referral will be active for your next visit.
  If you do not provide a referral and it is determined later that on is required **you will Receive a bill.**

- **Co-pays**- Co-pays are due prior to each office visit, even if you are being treated for a recurring issue.

  The only time your copay will not be collected:
  - When you are following up from a surgery with Dr. Matthew B. Quan within 90 of your original surgery date.
  - MOHS Surgery/Excision of a skin cancer
    If you treatment is deemed cosmetic, in which case you will pay completely out of pocket at the time of service.

- **Medication Prior Authorizations**- Prior authorizations for prescriptions are **NOT DONE** in this office. If your insurance company requires a prior authorization, we will prescribe a generic or alternate medication upon notification from your pharmacy that is cover under your insurance plan, or we will recommend an over the-counter alternative if one is available. We will try our best to handle this a timely manner.

- **Appointments**- We do our best to run on schedule or as close to schedule as possible, we ask that you show the same courtesy in return. We provide a 15 minute grace period in regard to your scheduled appointment, **any patient who exceed the grace period may be told to reschedule.** If you need to cancel an appointment, please provide at least 24 hours' notice as a courtesy to our practitioners and staff.

Do you have any cultural, language, visual or auditory factors affecting your care? **YES / NO**
Do you have an advance directive or living will? **YES / NO**

Thanks you for your cooperation in regard to our office policies.

_________________________ Name

_________________________ Date

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Primary Care Physician:

Name: ______________________________

Address: ______________________________

____

____

Phone: ______________________________

Fax: ______________________________

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Carrie Mallen, PA-C, MS
Lisa A. Desiato, PA-C
Corinne A. Carmona, F.N.P, A.P.N-C

Federal Law does not allow us to share information about your medical services (including treatment, payment, insurance details, appointment scheduling, etc.) without your written approval. Please provide us with the names and phone numbers of anyone with whom we are at liberty to share your information. Please include your spouse, family members, emergency contact, attorney if applicable), or other authorized representatives.

Patient Name:________________________

Patient/Guarantor Signature: __________________________
Date: ____________________

Name: ____________________________
Relationship: _______________________
Phone: ____________________________

Name: ____________________________
Relationship: _______________________
Phone: ____________________________

Name: ____________________________
Relationship: _______________________
Phone: ____________________________

I authorize you to communicate with me or above person, via encrypted Email or encrypted text. __________________

JEFFREY RAPAPORT MD PA

New Patient Information Form

Please fill in the following information as completely as possible

Patient information: Relation to Guarantor: Self: ______ Spouse: ______ Child: ______ Other: ______

Last Name ______________________________ First Name ____ MI ______ Pat Acct# __________

Maiden Name ______________________________ Social Security # ______________________________

Address ______________________________ City ____________________ State __________ Zip Code ________________

Phone Number ________________________ Cell phone # ____________________________ Email ______________________________

Date of Birth ______/_______/________ Age _______ Marital Status ______________________________ Sex ____________

Employer, including address ______________________________ Work phone # (_____) ________________________ Ext ________

Emergency Contact ______________________________ Relation ________________ Phone ____________________

Race ________________________ Ethnicity ______________________________ Language ______________________

Student: Yes________ No ________ Full Time ________ Part-time ________ Name of School ______________________

Guarantor responsible party information

Name ______________________________ Last Name ______________________________

Address ____

Zip ____________ City ______________________________ State __________ Email ______________________

Telephone (_______) ________________________ Marital Status ______________________________

Social Security # ______________________________ Employer ______________________________

Date Of Birth ________/________/________ Telephone (________) ________________________ Ext ________________

Race ________________ Ethnicity __________________ Language ________________ Decline to Answer ________

Insured (Policyholder) information—Primary Carrier—Please present your insurance card to the front counter

Insurance Co Name & Phone ______________________________ Policy # ______________________

Address 1 ______________________________ Group # ______________________

Address 2/City St Zip ____

Patient relation to insured: Self ________ Spouse ________ Child ________ Other ________

Policy Holder Name/Address 1 ____

Address 2/City St Zip ____

Telephone (________) ________________________ Date of Birth ________/________/________ Sex ________

Insured (Policyholder) information—Secondary Carrier— Please present your insurance card to the front counter

Insurance Co Name & Phone ______________________________ Policy # ______________________

Address 1 ______________________________ Group # ______________________

Address 2/City St Zip ____

Patient relation to insured: Self ________ Spouse ________ Child ________ Other ________

Policy Holder Name/Address 1 ____

Address 2/City St Zip ____

Telephone (________) ________________________ Date of Birth ________/________/________ Sex ________

I authorize the release of all medical records to the referring physicians and to my insurance company. I further authorize payments to be made directly to JEFFREY RAPAPORT M.D., P.A. I understand payment is due at the time of service.

Signature of Responsible Party ____ Date ____________________

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Name: ______________________________ **Date:** ____________

Reason for visit: ______________________ **Account # :** ____________

History and Intake Form

Past Medical History: (please circle all that apply)

	Self- Family Hx		Self- Family Hx		Self- Family Hx
Anxiety	___ ___	Coronary Artery Disease	___ ___	Hypothyroidism	___ ___
Arthritis	___ ___	Depression	___ ___	Hyperthyroidism	___ ___
Artificial joints	___ ___	Diabetes	___ ___	Leukemia	___ ___
Asthma	___ ___	End Stage Renal Disease	___ ___	Lung Cancer	___ ___
BPH	___ ___	GERD	___ ___	Lymphoma	___ ___
Bone Marrow	___ ___	Hearing Loss	___ ___	Pacemaker	___ ___
Transplantation	___ ___	Hepatitis	___ ___	Prostate Cancer	___ ___
Breast Cancer	___ ___	Hypertension	___ ___	Radiation Treatment	___ ___
Colon Cancer	___ ___	HIV/AIDS	___ ___	Seizures	___ ___
COPD	___ ___	Hypercholesterolemia	___ ___	Stroke	___ ___
OTHER ____________		Valve Replacement	___ ___	None	

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Other ________________________________

Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None

Skin Disease History: (please circle all that apply)

Acne	Eczema	Psoriasis
Actinic Keratoses	Flaking or Itchy Scalp	Squamous Cell Skin Cancer
Asthma	Hay Fever/Allergies	None
Basal Cell Skin Cancer	Melanoma	
Blistering Sunburns	Poison Ivy	
Dry Skin	Precancerous Moles	

Other ____

Do you wear Sunscreen? Yes No
If yes, what SPF? ________
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? ______________________________

Medications: (Please enter all current medications)

____
____
____

Allergies: (Please enter all allergies)

____
____
____

Social History: (Please circle all that apply)

Currently Smokes - daily	Has never smoked
Currently Smokes - not daily	Drug Use
Has smoked in the past	None

Other____