

Khan Dermatology and Cosmetic Surgery

Misbah Khan, MD FAAD FACMS
345 East 37th Street, Suite # 309
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*Fellow American Academy of Dermatology
Graduate American College of Mohs Surgery
Fellow American Society of Dermatologic Surgery
Fellow American Society of Laser Medicine and Surgery
Assistant Clinical Professor Dermatology Weill Cornell Medical College*

Patient Registration Form

Patient Name _____

Date of Birth _____

Address: _____

Social Security # _____

Gender _____ Minor _____

Home Phone (____) _____ Cell _____

Work (____) _____ Ext _____

Best time and Place to reach you

Email _____

Employer _____

Occupation _____

Primary Care Physician (Name and Address)

Who referred you to us? _____

May we thank them? _____

Marital Status: Married _____ Widowed _____ Single _____ Divorced _____

In case of emergency, Contact:

Name & Relationship to patient: _____

Home phone: _____ Cell: _____

Billing Information:

Who is responsible for this account? _____

DOB: _____

Relationship to the Patient: _____

Social Security # _____

Insurance Assignment and Release

My visits to M Khan Dermatology and Cosmetic Surgery will not go through my medical insurance carrier due to the fact that: (check all that applies)

1. I do not have medical insurance coverage, so I accept responsibility to pay consult fee and all pertinent charges in full (Consult fee is applicable to all new patients)
2. I am visiting this office strictly for cosmetic reasons, not medical, so I accept responsibility to pay in full.
3. My treating physician, Dr Khan, does not accept medical insurance, so I accept responsibility to pay in full

Name and Signature of the patient, beneficiary, guardian or representative

Date

PATIENT MEDICAL HISTORY

ALL QUESTIONS MUST BE ANSWERED. IF A QUESTION DOES NOT APPLY TO YOU, WRITE "NONE"
OR "N/A" FOR NOT APPLICABLE

Patient Name: _____

DOB: _____

Dermatologic History

1. Reason for visit: _____

2. How long this has been going on?

3. What areas are being affected?

4. How has this been treated so far?

5. Other Skin conditions

6. Topical (Skin) Medications prescriptions and over the counter

Detailed Medical History

Please answer all questions. If answered "YES" please provide the list of medications you are using or have used to treat that particular Medical condition.

Medical Conditions	Yes	No
Anemia		
Arthritis		
Artificial joints/ joint disorder		
Asthma or other related lung problems		
Cancer		
Cardiac Pacemaker		
Cold sores, fever blisters		
Depression or other related disorders		
Diabetes		
Eye disorders / Glaucoma		
Hay fever / Allergies		
Heart Disease / murmur		
Hepatitis		
High blood pressure		
History of skin Cancer / previous Mohs surgeries		
HIV infection / AIDS		
Keloids / Red Scars		
Kidney / Bladder problem		
Mitral Valve Prolapse or other related heart conditions		
Neurological Disorders		
Radiation Therapy		
Recent weight loss or weight gain		
Rheumatic Fever		
Seizures		
Stomach / Bowel Problems		
Stroke		
Thyroid Disease		
Ultraviolet Light Therapy		

Do you take any medications on a regular basis? If yes, please provide a detailed list below:

Family history of skin cancer / skin diseases if any

Please list any surgeries you have had in the past

Do you need antibiotics before any surgical procedures? If yes, please provide the names

List any other medical conditions for which you are currently being treated

Are you allergic to any medications, related substances, foods, shellfish etc. Please list all

Do you have any history of prolonged bleeding during surgeries or blood clots

Women ONLY: Are you.....

Pregnant or think maybe? _____

Nursing? _____

Taking oral contraceptives? _____

Taking hormone replacements? _____

Patient Name

Misbah Khan, MD FAAD FACMS
Physician Name

Patient Signatures

Physician Signature

Date

Date

Signature of the Guardian if under 18 yrs of age

COSMETIC PROCEDURE QUESTIONNAIRE

Patient Name: _____

Aesthetic issues and areas of concern/interest that you would like to talk to Dr Khan about:

1. Liposuction Revision/Defects
2. Knee Contouring
3. Mini-SIF® (Minimally-invasive Stromal fat Injection and Fractional laser resurfacing)
4. Neck liposuction and neck lift
5. Lip Augmentation
6. Lip lift Surgery
7. Ear Lobe repair
8. Eyelid surgery
9. Fat grafting
10. Fraxel and or Fractional CO2 laser treatments
11. Forehead rejuvenation (frown lines etc)
12. lines around the mouth and nose
13. tired looking skin/ skin sagging
14. Paradoxical Adipose Hyperplasia (PAH) surgery (CoolSculpting Defect correction)
15. SmartLipo Defect correction
16. Brazilian Butt Lift (BBL) Revision
17. Liposuction/ Body Sculpting
18. large pores, clogged pores
19. Brown and or Red spots
20. Sun damage
21. Scar Revision (acne, traumatic, surgical etc,)
22. Leg Veins
23. Rosacea, facial redness
24. excessive sweating (underarms, palms etc)
25. Hair loss with PRP and Amniotic Tissue matrix/stem cells
26. Cellulite
27. Tattoo Surgery
28. Lower facelift (to sharpen jawline)

What cosmetic procedures you have had in the past? Please list all

Were you satisfied with the results? If not please explain why

CONSENT TO PHOTOGRAPH

1. I consent to be photographed during the course of my treatment with M Khan Dermatology and Cosmetic Surgery. I understand the purpose of such photographs is to track the progress of my treatment(s). I understand that my photographs are part of my medical records and are therefore a property of M Khan Dermatology and Cosmetic Surgery. Unidentifiable photos might be used for marketing and other promotional purposes by M Khan Dermatology and Cosmetic Surgery.

Patient Name, Signature and Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO:

Below please list the name (s) relationship of any person other than yourself that you authorize M Khan Dermatology and Cosmetic Surgery to release your medical information to.

1. I authorize the following third parties (i.e., spouse, parent, partner etc) to view or receive verbal information regarding my record (s):

Print Name and Relationship

Patient Name and Signature

2. I do NOT authorize the release of my medical information to any third parties.

Patient Name and Signature

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

I hereby give my consent for M Khan Dermatology and Cosmetic Surgery. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO) (M Khan Dermatology and Cosmetic Surgery, Notice of Privacy Practices provides a more complete description of such uses and disclosures).

I have the right to review the Notice of Privacy Practices prior to signing this consent, M Khan Dermatology and Cosmetic Surgery reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to M Khan Dermatology and Cosmetic Surgery main address 345 East 37th street Suite #309, New York, NY 10016.

With this consent, M Khan Dermatology and Cosmetic Surgery may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. With this consent, M Khan Dermatology and Cosmetic Surgery may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements and material related to my clinical care as long as it is marked Personal and Confidential.

With this consent, M Khan Dermatology and Cosmetic Surgery may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements and material pertaining to my clinical care. I have the right to request that M Khan Dermatology and Cosmetic Surgery restrict how it uses or discloses my PHI to carry out my TPO. M Khan Dermatology and Cosmetic Surgery is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to M Khan Dermatology and Cosmetic Surgery use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, M Khan Dermatology and Cosmetic Surgery may decline to provide treatment to me.

Patient name, Signature and Date

Print Name and Signature of Legal Guardian or Parent

Date

Khan Dermatology and Cosmetic Surgery

ACKNOWLEDGEMENT OF INSURANCE PLAN NON-PARTICIPATION

Patient Name and Date

I am fully aware that Misbah Khan, M.D. is non-participating with any/all medical insurance carriers. I acknowledge and agree that I am fully responsible for any/all costs incurred for my treatment in this office, whether that treatment is of a medical or cosmetic nature. I understand that I am responsible to pay the full cost that M Khan Dermatology and Cosmetic Surgery has determined to be appropriate for the treatment I receive.

I also understand that I am personally responsible for insurance submission of claims should I choose to attempt to obtain reimbursement from my health insurance carrier.

Patient Signature and Date

Khan Dermatology and Cosmetic Surgery

NO SHOW / CANCELTION POLICY FOR CONSULTATION (MEDICAL AS WELL AS COSMETIC) VISIT

If it is necessary for you to cancel your scheduled appointment we ask that you call by 10am one (1) business day in advance. Appointments are in high demand, and your early cancellation will give another patient the opportunity to access timely care.

NO SHOW / CANCELTION POLICY FOR COSMETIC OR MEDICAL (SURGICAL) PROCEDURES

Cosmetic or Medical procedures are subject to at least a 2-week cancellation notice. If you are unable to keep your appointment due to medical reasons we require you submit a letter from your primary care doctor's office. Although Facility fee or Operating room fees are non-refundable (see below), additional charges can be credited back to the patient upon receiving the letter.

How to Cancel Your Appointment

To cancel a scheduled appointment, please call
Office – 917-853-DERM (3376) or EMAIL us at info@mkhandermatology.com

If you do not reach a receptionist, please leave a detailed message with our answering service.

Late Cancellations for Consultation

Late cancellations i.e., less than a 24 hour (one business day) notice for a Medical/Cosmetic consultation visit; OR less than 2 week notice for a medical/cosmetic (surgical) procedure, will be considered a “no show”.

No Show Policy

A “no-show” is someone who misses an appointment without canceling it by 10am one (1) working day in advance.

No-Show/Late Cancellation Fees

Any Medical appointment that is a “No Show” is subject to \$350/visit

Any Cosmetic procedure appointment that is a “No Show” will result in a fee of \$350.00

Any Cosmetic Surgical Appointment for which an Operating Room had to be reserved for will result in a charge consisting of Facility Procedure Room Fee or Operating Room fees (non-refundable) + 50% of the total of the cost of the procedure as determined by Dr Khan (can be refunded in case of an emergency cancellation/no show).

If you are unable to keep your scheduled appointment, we want to remind you of the importance of follow up treatments as indicated by your physician.

We reserve the right not to refill prescriptions or see the patient until any cancellation/no-show fees are paid in full. Please note that if you are running late for your scheduled appointment, you should call to alert the office. While we will do our best to accommodate late patients, we may have to reschedule your appointment based on availability.

This agreement is entered on: (Date) _____

Patient Name and Signature and Date

Print Name of Legal Guardian or parent if a minor, signature and Date