Disclosure Information

To Our Patients:

Welcome to the practice, which is owned by Diane C. Madfes.

Your Surgeon/Physician: We would like you to know that Dr. Diane C. Madfes is board certified by the American Board of Dermatology and is licensed in the State of New York, Connecticut and Florida. She has been in practice since 1996 and attended Brandeis University and Albert Einstein School of Medicine. She completed her internship in internal medicine at Yale University and her dermatology residency at Albert Einstein School of Medicine. You may request her C.V. which we keep on file. Her training is extensive in the field of dermatology surgery.

Your Surgeon/Physician: We would like you to know that Dr. Esther L. Williams is board certified by the American Board Of Dermatology and is licensed in the State of New York. She has been in practice since 2014 and attended Columbia University and Albert Einstein School of Medicine. She completed her internship in internal medicine at Staten Island University Hospital and her dermatology residency at Downstate Medical Center. You may request her C.V. which we keep on file. Her training is extensive in the field of dermatology surgery and skin cancer.

Should you choose to have surgery at this Organization, Dr. Diane C. Madfes or Dr. Esther L. Williams will be performing your surgery.

The Team: Our team is made up of competent individuals that will assist in providing safe patient care. All our medical assistants are all certified and play an important role in your care.

Should you have a problem: Please be advised that if you have a grievance or concern the following mechanism exists: Ask for the grievance form from the receptionist. Or you may call the accrediting organization that oversees our compliance with standards of care: The Joint Commission on Accreditation of Healthcare Organizations at (800) 994-6610 or emailing complaint@jointcommission.org.

Make a suggestion: If you have a suggestion, please place this in writing and hand it to the receptionist or mail it to the office.

Play a part in your care: We encourage all patients to be actively involved in their care, so please speak up and ask questions to anyone in this organization.

Additionally, please be advised that this organization does not recognize DO NOT RESUSCITATE orders or Living Wills. If you have any questions, please see the receptionist.

Infection Control: We provide various in-services to our staff regarding Infection Prevention and Control issues on an annual basis. We also monitor our organization for numbers of infections. This practice educates staff upon hire and annually thereafter in hand hygiene and we follow the CDC guidelines for hand hygiene. We encourage staff to stay home when they are sick. We provide tissues and garbage cans throughout the facility and encourage everyone to cover their mouth when coughing and sneezing and then wash their hands.

Should you have a procedure or surgery in this organization, we want you to know that we value patient safety. Therefore you may hear us performing certain tasks or asking certain questions that may surprise you. Even though we may know you, we will ask you identifying information such as your date of birth or your address besides asking you to tell us your name. We take a pause or a "time out" before we actually start your procedure to assure once again that we have everything that we need and the entire team is in agreement. Only the physician performing your procedure will mark your surgical site. This organization adheres to strict infection control measures before during and after your procedure including but not limited to: procedural technique, the environment of care, care of equipment and instruments, and education of all staff in the most up to date infection control measures.

JOINT COMMISSION ONLY: If anyone has concerns about patient care and safety in the organization, that the organization has not addressed, you are encouraged to contact the organization's management. If you feel the concerns were not resolved through the organization, you are encouraged to contact the Joint Commission by calling 800-994-6610 or emailing complaint@jointcommission.org.

Signature: ____

Date: ____

Patient Consent Form: Use and Disclosure of
Health Information Protected under HIPAA

Pursuant to the information contained in the Notice of Privacy Practices, I give permission for the use and disclosure of Protected Health Information (PHI) in order to carry out Treatment, Payment, and Healthcare Operations (TPO).

I am aware that I have the right to review the Notice of Privacy Practices prior to signing this consent. Should the Notice of Privacy Practices be revised, I am aware that I may obtain a copy of the revised form by contacting the Medical Director of this facility.

I give my consent for this organization to contact me by calling my home or other designated location in order to leave a message (mechanically or with another person) or to speak to me directly regarding any matter which will help with the conduct of Treatment, Payment, and Healthcare Operations.

Further, I give my consent for the use of mail or e-mail to designated locations, including my home, to assist the organization in carrying out the described activities of Treatment, Payment, and Healthcare Operations.

I hereby consent to the use and disclosure of my PHI for the purpose of Treatment, Payment, and Healthcare Operations (TPO). This consent is good until revoked in writing, except to the extent those disclosures have been made in reliance upon my prior consent.

Services are provided without regard to sex, race, color, religion, national origin, or disability.

Patient Name:_____________________________________ Date: __________________

Patient Signature_________________________________

If applicable, Legal Guardian Name and Signature: ____

-DIANE C. MADFES, M.D., P.C
1 East 69th Street
New York, NY 10021

THIS PATIENT INFORMATION FORM IS PART OF YOUR MEDICAL RECORD AND MUST BE COMPLETED IN ITS ENTIRETY

PATIENT INFORMATION FORM

DATE_____/_____/_____ SS#______-______-______ DATE OF BIRTH_____/_____/____ AGE_____ SEX: M F

PATIENT____ ____ MARITAL STATUS: S M D W
(Last) (First) (Middle)

HOME ADDRESS: ____ APT # ______

____
(City) (State) (Zip Code)

HOME PHONE: (_______) ________-_________ CELL PHONE: (_______) ________-_________

WORK PHONE: (_______) ________-_________ OCCUPATION: ________________________

EMPLOYER NAME: ____

WORK ADDRESS: ____

REFERRED BY: ____

PRIMARY CARE PHYSICIAN: ___________________________ PHONE NUMBER: (______) ________-________

ADDRESS: ____

EMERGENCY CONTACT: _____________________________ RELATIONSHIP: _______________________

PHONE NUMBER: (_______) ________-__________

IF MINOR – FINANCIAL INFORMATION

PERSON RESPONSIBLE FOR PAYMENT: ____
(Last) (First) (Middle)

RELATIONSHIP TO PATIENT____

SS#_______-_______-_______ BIRTHDATE_____/_____/_____

HOME ADDRESS: ____
(City) (State) (Zip Code)

HOME PHONE: (_______) _________-__________ WORK PHONE: (_______) __________-_________

EMPLOYER NAME____

WORK ADDRESS____
(City) (State) (Zip Code)

CONSENT FOR PHOTOGRAPHING:

I HEREBY GIVE MY PERMISSION TO MY PHYSICIAN OR ANY ASSISTANT THAT SHE MAY DESIGNATE TO TAKE PHOTOGRAPHS FOR DIAGNOSTIC PURPOSES AND TO ENHACE THE MEDICAL RECORD. I AGREE THAT THESE PHOTOGRAPHS WILL REMAIN IN HER PROPERTY AND SHE MAY USE THEM FOR MEDICAL, SCIENTIFIC OR OTHER PRESENTATIONS AND PUBLICATIONS.

PATIENT NAME (PRINT) ____

SIGNATURE_________________________________ DATE_______________________________

MEDICAL HISTORY: (CHECK ALL THAT APPLY)

YES	NO	
____	____	DUODENAL OR PEPTIC ULCER
____	____	OTHER INTESTINAL DISEASE OR COLITIS
____	____	LIVER OR GALLBLADDER DISEASE
____	____	HEART DISEASE (RHEUMATIC FEVER, PACEMAKER, OTHER)
____	____	HIGH BLOOD PRESSURE
____	____	STROKE
____	____	KIDNEY DISEASE
____	____	URINARY OR BLADDER PROBLEM OR INFECTION
____	____	HEPATITIS A, B, OR C
____	____	HERPES SIMPLEX
____	____	VENEREAL DISEASE
____	____	BLOOD OR LYMPH GLAND DISORDER
____	____	EYE DISEASE (GLAUCOMA, CATARACT, OTHER)
____	____	THROMBOPHLEBITIS
____	____	CANCER
____	____	FREQUENT INFECTIONS (SKIN OR OTHER)
____	____	NEUROLOGICAL DISORDER
____	____	EMOTIONAL OR PSYCHIATRIC PROBLEM
____	____	EXCESSIVE BLEEDING WHEN CUT
____	____	DIFFICULTY WITH THE HEALING OF WOUNDS
____	____	OVERGROWN SCARS OR KELOIDS
____	____	ALLERGY TO LOCAL ANESTHETICS
____	____	HAVE YOU HAD VAGINAL YEAST INFECTIONS?
____	____	ARE YOU PREGNANT?
____	____	ARE YOU CURRENTLY PLANNING A PREGNANCY?

PLEASE INFORM THE DOCTOR AT ANY TIME IF YOU PLAN TO OR BECOME PREGNANT DURING YOUR TREATMENT PERIOD.

HAVE YOU OR ANY MEMBERS OF YOUR FAMILY (SPECIFY WHO) HAD:

YES	NO		
____	____	ASTHMA	
____	____	HAYFEVER	
____	____	ECZEMA	
____	____	HIVES	
____	____	DIABETES	
____	____	PSORIASIS	
____	____	SKIN CANCER	WHO? ______________________________
____	____	GLAUCOMA	
____	____	OTHER SKIN CONDITIONS (SPECIFY)	

SOCIAL HISTORY:

DO YOU DRINK ALCOHOL? YES NO IF YES, __________ DRINKS PER DAY

DO YOU USE RECREATIONAL DRUGS? YES NO IF YES, WHAT? _______________
HOW MUCH? _______________

DO YOU SMOKE? YES NO IFYES, HOW MUCH? _______________

ANY CONDITIONS NOT LISTED ABOVE:

____

____

HAVE YOU EVER HAD:

YES NO

____ ____ **HAVE YOU PREVIOUSLY HAD A SKIN PROBLEM OR BEEN UNDER THE CARE OF A DERMATOLOGIST? IF YES, PLEASE DESCRIBE:**

____

____ ____ **DO YOU TAKE ANY MEDICINES, DRUGS, OVER-THE-COUNTER PREPARATIONS, VITAMINS OR HERBAL REMEDIES? IF YES, PLEASE LIST:**

____

____

____ ____ **ARE YOU ALLERGIC TO ANY MEDICINES, DRUGS, LATEX, OVER-THE-COUNTER PREPARATIONS OR HERBAL REMEDIES? IF YES, PLEASE LIST**

____

____

PRIOR HOSPITALIZATIONS AND SURGERY (PLEASE GIVE APROXIMATE DATES)

____

____

THE DERMATOLOGICAL EXAMINATION WHICH YOU ARE ABOUT TO RECEIVE IS NOT A COMPLETE PHYSICAL EXAMINATION. IT IS SUGGESTED THAT YOU HAVE A COMPLETE PHYSICAL EXAMINATION PERIODICALLY BY YOUR FAMILY PHYSICIAN OR INTERNIST.

I certify that I have read and filled out the patient registration and medical history form fully and correctly to the best of my knowledge, and that the information that I have supplied is complete and correct. I understand that withholding medical information could lead to complications or problems that may have been prevented if that information were known prior to my care and treatment. I acknowledge that I read information regarding the provider of care in this organization, DNR (Do No Resuscitate), Patient's Bill of Rights and Responsibilities, HIPAA regulations, and information regarding the grievance process.

SIGNATURE: ______________________ **DATE:** __________

PLEASE ADD ANY ADDITIONAL INFORMATION WHICH YOU FEEL MAY ASSIST THE DOCTOR IN YOUR CARE:

____

____

1 East 69th Street
New York, NY 10021

PATIENT INFORMATION FORM

THE PRACTICE FINANCIAL POLICY WILL BE GIVEN TO PATIENTS AT THE TIME OF REGISTRATION
ALL PATIENTS MUST SIGN THIS FORM.

OUR PRACTICE FINANCIAL POLICY

Dr. Diane Madfes and her staff are dedicated to providing you with the best possible care and service. To assist you, we have the following financial policies. If you have any questions, please feel free to discuss them with our staff.

PAYMENT IS EXPECTED AT THE TIME OF TREATMENT.
WE WILL PROVIDE YOU WITH A FORM TO PRESENT TO YOUR INSURANCE CARRIER (IF APPLICABLE).
WE ACCEPT CASH, PERSONAL CHECKS, AND CREDIT CARDS
(AMERICAN EXPRESS, MASTERCARD, AND VISA)

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

PATHOLOGY AND LABORATORY FEES

Pathology and laboratory fees are separate from our fees and will be billed directly to you.
You will receive a separate bill from the lab company.

I have read, understand, and agree to the financial policies of this office. I am fully responsible for all professional fees and services rendered.

Signature:

____

Parent/Guardian
(if minor)

____

Today's Date: ___________

Your Name____

Date_____________________

INITIAL LEARNING ASSESSMENT

During your visit with our organization you will be presented with information that may be new to you. To aid in providing the best care possible please answer the following questions. Then return this form to the front desk. Thank you.

How do you like to learn new things? Please check all that apply

	Reading		Brochures
	Discussion		Hands On/Demonstration

Factors that can affect learning:	**Yes**	**No**	**Comments**
Do you speak English in your home?			If no what language do you speak? Name of interpreter:
Can you read English?			
Can you write English?			
Do you hear well?			If no, do you utilize a hearing device? Yes No
Do you see well?			If no, do you utilize glasses or contacts? Yes No
Do you have any cultural or religious practice/beliefs that may affect your care or treatment?			If Yes, explain

Other comments

____

____

____

TURN PAGE OVER

DIANE C. MADFES, M.D. P.C.

UNIVERSAL MEDICATION FORM

Date form started:

Name:	**Address:**
Phone Number:	**Allergies:**
Birth Date:	

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: 1) Prescription and over-the-counter medications (examples: aspirin, antacids); herbals (examples: ginseng, gingko); and vitamins. Include medications taken as needed (example: nitroglycerin). Please also include if you received any injections recently, i.e. steroids. **2)** CROSS OFF any medications you no longer taken. **3)** Keep this card in chart at all times. Show this card to every doctor visit on every visit, every visit to an emergency room and on admission to any hospital. **4)** NEVER take drugs prescribed for someone else.

OFFICE USE ONLY

DATE PRESCRIBED	**NAME OF MEDICATION / DOSE**	**DIRECTIONS: (How many times a day do you take this and when.)**	**Medication held due to procedure**		**DATE STOPPED**	Notes: Reason for taking / **Doctor Name**	**Name of Medication in Office**	**Contra-indicated ?**	
			Yes	No				Yes	No
			Yes	No				Yes	No
			Yes	No				Yes	No
			Yes	No				Yes	No
			Yes	No				Yes	No
			Yes	No				Yes	No
			Yes	No				Yes	No
			Yes	No				Yes	No
			Yes	No				Yes	No
			Yes	No				Yes	No
			Yes	No				Yes	No
			Yes	No				Yes	No
			Yes	No				Yes	No

Patient Signature if applicable______________________________ Date______________

Responsible Adult Signature______________________________ Date______________

Signature of representative of organization accepting the patient______________________________ Date______________

MADFES AESTHETIC MEDICAL CENTER

ONE EAST SIXTY- NINTH STREET
NEW YORK, NEW YORK 10021

PHONE (212) 249-8118
FAX (212) 249-8884

CONSENT TO TREAT A MINOR

By signing below, I ___________________________________ parent/guardian of

_____________________________________, give permission to Dr. Diane Madfes and

Dr. Esther Williams to treat my child today and in the future.

This consent will be kept in my child's medical record.

Print Name:____

Parent/guardian Signature:____

Date:____