PATIENT INFORMATION FORM

LAWRENCE J. FINKEL, M.D., P.C.

IN ORDER TO SERVE YOU, PLEASE COMPLETE THE FOLLOWING INFORMATION
ALL INFORMATION IS CONFIDENTIAL *(PLEASE PRINT)*

DATE_____

PATIENT'S FULL LEGAL NAME_____BIRTHDATE_____

ADDRESS_____
(STREET) (CITY) (STATE) (ZIP)

PRIMARY PHONE ( )_____SECONDARY PHONE ( )_____

PATIENT'S SOCIAL SECURITY #_____ PATIENT'S SEX: MALE_____FEMALE_____

EMPLOYER_____WORK PHONE ( )_____
(Parent's if patient is a minor)

WHOM MAY WE CONTACT IN AN EMERGENCY?_____PHONE ( )_____

PATIENT EMAIL:_____PRIMARY CARE PHYSICIAN:_____

PATIENT'S STATUS (CHECK ALL THAT APPLY)

☐ Single ☐ Married ☐ Widow ☐ Separated ☐ Divorced ☐ Student ☐ Employed

WHO MAY WE THANK FOR REFERRING YOU TO US

_____

PARENT/GUARDIAN NAME (if patient is a minor)

_____

WITH WHOM CAN WE DISCUSS YOUR MEDICAL INFORMATION *OTHER THAN PCP* (e.g. FAMILY MEMBERS)?

NAME_____RELATION_____PHONE_____

NAME_____RELATION_____PHONE_____

PREFERRED PHARMACY_____PHONE ( )_____

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INSURANCE INFORMATION
PLEASE ALLOW US TO PHOTOCOPY YOUR INSURANCE CARD(S)

PRIMARY INSURANCE

Name of Plan_____
Patient's relation to Insured: (circle) Self Spouse Child Other (specify)_____
Insured's Information *if different from Patient*:
Insured's Full Name_____ Birthdate_____Sex M F
Insured's Social Security Number_____Home #_____Work #_____
Address_____City_____State_____Zip_____

SECONDARY INSURANCE (if applicable)

Name of Plan_____
Patient's relation to Insured: (circle) Self Spouse Child Other (specify)_____
Insured's Information *if different from Patient*:
Insured's Full Name_____ Birthdate_____Sex M F
Insured's Social Security Number_____Home #_____Work #_____
Address_____City_____State_____Zip_____

*****PLEASE COMPLETE BACK OF THIS FORM*****

AUTHORIZATION FORM

Lawrence J. Finkel, M.D., P.C. will file with your insurance if **we** "*participate*" with your insurance plan**. Any co-payment, co-insurance, deductible, etc. are to be paid in full at the time of each visit before you are seen. We do not bill for co-payments**. If our office does not participate with your insurance, it will be your responsibility to file your insurance claims directly with your company. You will be responsible for full payment at the time of service. *Returned checks and balances older than 60 days will be subject to interest charges of one and one half percent per month (18% per year).* Returned checks are also subject to a $50.00 administrative fee. Any accounts turned over to our collection agency and/or attorney will be subject to a 25% charge to cover the collector's fees. We will be happy to discuss your proposed treatment and answer questions relating to your insurance.

1. I hereby authorize the release of any medical information and filing of insurance claims pertaining to services rendered to myself by Lawrence J. Finkel, M. D., P. C.

2. I authorize payment of medical benefits to Lawrence J. Finkel, M.D., P. C. and understand the above policies and agree to accept financial responsibility for services not covered by my insurance. I further agree to accept financial charges and/or collection fees assessed to my account for the untimely payment of overdue balances.

3. We require a 24 hour cancellation notice for all appointments. **There will be a $50.00 charge for appointments not cancelled 24 hours before the scheduled visit**. Our voice mail is available 24 hours a day, 7 days a week to take messages**. Remember, confirmation calls are a courtesy. Please do not rely on them to remember your appointment.**

4. *Any and all* pathology obtained will be sent to a laboratory; however, any additional costs or uncovered services from the pathologist and/or lab will be billed to you directly.

5. **IF your insurance requires you to have a written referral from your primary care physician, this is your responsibility to know this and obtain the appropriate referral for each visit.**

6. I understand that if, during the course of care, a health provider is directly exposed to my blood or body fluids in a manner which may transmit Hepatitis B or C or AIDS, for the protection and well-being of the health care provider, it is important that a test be made on my blood without charge to determine whether I am carrying the virus and that under Virginia Law (Section 32.1 – 36.1 et. seq.) I am deemed to have consented to said test(s) and to the release of the test results to the exposed health care provider. I also understand that health providers are deemed to consent to tests and the release of the results to me should I be similarly exposed.

Signed: _____ Date:_____
(Patient or Parent if Minor)

CONSENT TO TREAT A MINOR

I understand that I must attend the first visit with my child. In the event of my absence at subsequent visits, I hereby give my permission to Lawrence J. Finkel, M.D., P.C. to treat my minor child. I also understand this signed consent will be valid until the minor child is 18 years of age. I will be available by telephone should any questions arise.

_____ _____
Signature of Parent/Guardian Telephone Number

PATIENT'S MEDICARE AUTHORIZATION: (MEDICARE PATIENTS ONLY)

I request that payment of authorized Medicare benefits be made to me or on my behalf to Lawrence J. Finkel, M.D., P. C. I authorize any holder of medical information concerning me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 on the HCFA-1500 form or on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insured or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for their deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Signed_____Date:_____

LAWRENCE J. FINKEL, M.D., P.C.

PATIENT NAME_____DATE_____

REASON FOR VISIT_____

DURATION OF PROBLEM_____

ANY PRIOR TREATMENT OF PROBLEM_____

LIST MAJOR MEDICAL CONDITIONS YOU HAVE RECEIVED TREATMENT FOR_____

_____

LIST CURRENT MEDICATIONS_____

_____

DRUG ALLERGIES: **NONE KNOWN** ☐ **YES** ☐_____OCCUPATION_____

DO YOU DRINK ALCOHOL?: YES ☐ NO ☐ DO YOU SMOKE?: YES ☐ NO ☐

DO OTHER FAMILY MEMBERS HAVE THE SAME SKIN PROBLEM THAT YOU ARE HERE FOR?: YES ☐ NO ☐

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HAS ANYONE IN YOUR FAMILY EVER HAD: (CHECK ALL THAT APPLY)

Eczema ☐ Melanoma ☐ Asthma ☐ Allergies ☐ Psoriasis ☐ Other Skin Cancer ☐

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DO ANY OF THE FOLLOWING APPLY TO YOU: (CHECK ALL THAT APPLY)

Recent weight loss, weakness	☐	Stomach ulcers	☐
Fevers, chills, night sweats	☐	Vomiting or diarrhea	☐
Feel sick	☐	Liver disease	☐
HIV positive	☐	Painful urination	☐
AIDS	☐	Kidney disease	☐
Use illicit drugs	☐	Require renal dialysis	☐
Problems with your eyes	☐	Bladder or prostate problems	☐
Hearing difficulty	☐	Muscle weakness	☐
Mouth or throat sore	☐	Joint aches	☐
Breathing problems	☐	Artificial joints or implants	☐
Asthma	☐	Bone problems	☐
Hayfever	☐	Nerve problems	☐
Heart disease	☐	Psychiatric problems	☐
Do you have a pacemaker	☐	Skin cancer	☐
High blood pressure	☐	Melanoma	☐
Artificial heart valve	☐	Cancer	☐
Take aspirin/blood thinners	☐	Prior radiation or x-ray treatment	☐
Diabetes	☐	Anemia	☐
Thyroid disease	☐	Experience flushing	☐
Addison's disease	☐	Hepatitis	☐

Women Complete The Following

Irregular periods ☐ On birth control pills ☐ Pregnant now ☐ Nursing now ☐

LAWRENCE J. FINKEL, M.D., P.C.

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____
Printed Name – Patient or Representative

_____ ____/_____/_____
Signature Date

Relationship to Patient (if other than patient):_____

A copy of our Notice of Privacy Practices is available at our reception desk.

NEW PATIENTS ONLY!

This coupon entitles you to
15% off your first
scheduled treatment at
MedSpa 360.

(Must present coupon at first visit)
(Not to be combined with any other offer or promotion)

Complimentary consultations are available at MedSpa 360 for all cosmetic products and procedures. Call us to schedule at **540.347.SKIN (7546)**