

**LAWRENCE J. FINKEL, M.D., P.C.**  
**360 CHURCH STREET**  
WARRENTON, VA 20186  
(540) 347-2020 PHONE (540) 341-7980 FAX  
[www.finkelderm.net](http://www.finkelderm.net)

Dear Patient:

Welcome to our Practice. We have you scheduled for your first appointment at our office on \_\_\_\_\_ at \_\_\_\_\_ a.m./p.m. Enclosed is information that we will need completed when you come for your appointment with either Dr. Finkel or our Physician's Assistant, Nichole Thomas. Bring these **completed** forms along with your **insurance card and any applicable co-payment or co-insurance. *IF your insurance requires a written referral, it is your responsibility to have the original, signed form from your Primary Care Physician BEFORE you are seen.*** If you are not sure whether or not you need a written referral, please contact your insurance company. **Should you not have your insurance card or referral at your appointment time, we will need to reschedule your visit. *In addition, if the patient is a minor, we do REQUIRE a parent to attend the first visit to obtain an accurate medical history.*** Your appointment time is reserved for you, and you must, therefore, notify us at least 24 hours in advance if you are not going to keep your appointment. We have a 24 hour-a-day answering service with which you can leave your message should the office be closed when you call. Your cooperation in arriving at our office on time will be greatly appreciated as it enables us to continue to run on schedule.

**Ample parking is available to our patients in the parking lot, on the street in front of the office and on the street in front of the Warrenton United Methodist Church.** If you have any questions, feel free to call our office. Thank you for your cooperation and we look forward to having you as a patient.

Dr. Finkel and Staff

**DIRECTIONS**

**FROM NORTHERN VIRGINIA:** TAKE 66 WEST TO EXIT 43A AT GAINESVILLE 29 SOUTH. PROCEED APPROXIMATELY 12 MILES TO BUSINESS 15/29 - WARRENTON EXIT. GO THROUGH 4 STOPLIGHTS--LOOK FOR PIZZA HUT ON LEFT--TAKE A LEFT ON CHURCH STREET. OFFICE LOCATED ON THE RIGHT AT THE CORNER OF CHURCH AND SULLIVAN STREETS.

**FROM FREDERICKSBURG AND I-95:** TAKE ROUTE 17 NORTH (EXIT 133B) AT FALMOUTH TOWARDS WARRENTON. GO APPROXIMATELY 30 MILES FROM FALMOUTH TO A RIGHT MERGE ON 29 NORTH TO WARRENTON. TAKE FIRST WARRENTON EXIT (LEFT AT STOPLIGHT) BUSINESS 15/29. GO THROUGH 6 STOPLIGHTS--LOOK FOR PIZZA HUT ON RIGHT--TAKE A RIGHT ON CHURCH STREET. OFFICE LOCATED ON THE RIGHT AT THE CORNER OF CHURCH AND SULLIVAN STREETS.

**FROM CULPEPER (RT. 229--RT. 211):** AT END OF ROUTE 211, TAKE LEFT AT LIGHT ONTO BUSINESS 15/29. ONCE ON BUSINESS 15/29, LOOK FOR PIZZA HUT ON THE RIGHT--TAKE A RIGHT ON CHURCH STREET. OFFICE LOCATED ON THE RIGHT AT THE CORNER OF CHURCH AND SULLIVAN STREETS.

**FROM CULPEPER (RT. 29):** TRAVEL 29 NORTH. TAKE 1ST WARRENTON EXIT (LEFT EXIT) BUSINESS 15/29. GO THROUGH 6 STOP LIGHTS. LOOK FOR PIZZA HUT ON THE RIGHT--TAKE A RIGHT ON CHURCH STREET. OFFICE LOCATED ON THE RIGHT AT THE CORNER OF CHURCH AND SULLIVAN STREETS.

**DIRECTIONS FROM MIDDLEBURG/WINCHESTER** - TAKE ROUTE 66 EAST TO ROUTE 17 SOUTH TOWARD WARRENTON. PROCEED APPROXIMATELY 10 MILES TO STOPLIGHT. TURN RIGHT ONTO BUSINESS 15/29. LOOK FOR PIZZA HUT ON THE LEFT--TAKE A LEFT ON CHURCH STREET. OFFICE IS LOCATED ON THE RIGHT AT THE CORNER OF CHURCH AND SULLIVAN STREETS.

**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 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'S STATUS (CHECK ALL THAT APPLY)**

Single  Married  Widow  Separated  Divorced  Student  Employed

WHOM 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. We do not bill for co-payments or co-insurances.** 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 \$25.00 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.
4. Any pathology obtained will be sent to a laboratory that your insurance participates with; however, any additional costs or uncovered services from the pathologist and/or lab may 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: \_\_\_\_\_  
(Patient or Parent if Minor)

Date: \_\_\_\_\_

### CONSENT TO TREAT A MINOR

In the event of my absence, I hereby give my permission to Lawrence J. Finkel, M.D. to treat my minor child. I 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: \_\_\_\_\_

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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

\*\*\*\*\*

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

**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.**