

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)

CELL 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 () _____

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: _____
(Patient or Parent if Minor)

Date: _____

CONSENT TO TREAT A MINOR

I understand that a PARENT must attend the first visit with their 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

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

Eczema Melanoma Asthma Allergies Psoriasis Other Skin Cancer

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

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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)**

CONSENT TO RECEIVE ELECTRONIC COMMUNICATIONS

We know you are busy. Let us help by sending automated reminders for paying your balance online for our office. **Beginning July 1, 2024**, we will be able to send emails and/or text messages to our patients to let you know what your balance is and how to pay it electronically. This is a great tool to utilize to save you time.

Please indicate if you would like to receive emails or text messages below. Copays are still to be paid at the time of your office visit.

You can withdraw your consent to receive electronic communications at any time by calling our office. Please note that you are responsible for providing our office with **your cell phone number and/or email address.**

Printed name

Signature

Date

Parent/Guardian

_____ Email Address
_____ Cell phone number
<input type="radio"/> Yes, I would like to receive electronic communications.
<input type="radio"/> No, please do not send me electronic communications.

LAWRENCE J. FINKEL, M.D., P.C.
MEDSPA 360
360 CHURCH STREET
WARRENTON, VA 20186
540-347-2020 www.finkelderm.com