THE CENTER FOR DERMATOLOGY & SKIN CARE, INC.
Gregory T. Lagos, DO, FAOCD, FAACS
Alexa Fruth, PA-C
Hailey Marcus. PA-C
607 Chestnut Street
South Charleston, WV 25309
(304) 766-9136 Phone
(304) 766-9139 Fax

ATTENTION

Please have ALL forms fully completed and

ready to present to the front desk

at the time of your appointment.

Failure to do so may result in long

wait time and/or rescheduling of your

Appointment.

Your appointment is scheduled for: _____

At:_____

Please bring ID and all up to date insurance cards

Also a list of current medications and allergies.

PATIENT INFORMATION

Patient Name_____
Address_____
City, State, Zip Code_____
Home Phone_____
Cell #_____
Work Phone_____
Employer_____
Birth Date_____
Social Security_____
Sex_____ Race_____ Age_____

Relationship to Insurance holder_____

Email Address: _____

Policy holder/guarantor _____
Address_____
City, State, Zip Code_____
Home Phone_____
Cell #_____
Work Phone_____
Employer_____
Birth Date_____
Social Security_____

Insurance_____

Pharmacy Name: _____

Family Doctor:_____

Address: _____

I give the physician or staff permission to speak with the following person(s) about my medical condition or any other information necessary for treatment or payment operations:

Name _____ Relationship to patient _____

_____ Phone # _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:
I hereby authorize release of any information required during the course of my examination and treatment to process this claim.

Signature_____Date_____

** MEDICARE PATIENTS ONLY **

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts the assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature_____Date_____

AUTHORIZATION TO USE AND DISCLOSE PHI FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I authorize the use and disclosure of my protected health information by Dr. Gregory Lagos, Alexa Fruth, PA-C, and The Center for Dermatology & Skin Care, Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care and to conduct health care operations of the Center for Dermatology & Skin Care, Inc.

My "protected health information" means health information including, as an example: health history, symptoms, examination and test results and records of treatment and payment for health services pertaining to me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and to present, past or future payment for the provision of healthcare and identifies me, or there is a reasonable basis to believe that the information may identify me.

I acknowledge that I have received a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures of my healthcare information relating to my diagnosis and treatment, obtaining payment for services and healthcare operations of The Center for Dermatology & Skin Care, Inc. I understand that I have the right to review the Notice prior to signing this authorization. I understand that The Center for Dermatology & Skin Care, Inc. has the right to change its *Notice of Privacy Practices* and that I may obtain a revised Notice if I so request.

I understand that I have the right to request restrictions on how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that neither Dr. Gregory Lagos, Alexa Fruth, PA-C, nor The Center for Dermatology & Skin Care, Inc. are required to agree to the restrictions requested.

I understand that I may revoke this authorization in writing at any time, except to the extent that The Center for Dermatology & Skin Care, Inc. has relied upon it.

Date: _____

Signature of Patient or Personal Representative:

_____

Date of Birth: _____

MEDICAL APPOINTMENT CANCELATION/NO SHOW POLICY

Thank you for trusting your medical care to The Center for Dermatology and Skin Care, Inc. When you schedule an appointment with The Center for Dermatology and Skin Care, Inc., we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment, please contact our office as soon as possible and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancelation/No Show Policy below:

- Effective June 1, 2024 any established/new patient who fails to show or cancels/reschedules an appointment and has not contacted our office within **at least 24 hours' notice** will be considered a "NO Show" and charged a **$100.00 Fee. If you were scheduled for a procedure the charge will be $200.00.**

- Any established patient who fails to show or cancels/reschedules an appointment without a 24 hour notice for a **second time in a 12 month period will be charged a $150.00 fee. Procedures a $250 fee.**

- If a **third** No Show or cancellation/reschedule without a 24 hour notice should occur, the patient will be charged and dismissed from this practice.

- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit.**

- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will **still remain** in effect. Also, as a courtesy, we give appointment cards before you leave our office.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our Office Manager who may be able to waive the No Show fee. You may contact our office 7 days a week at the number below. Should it be after regular business hours or weekends, you may leave a message with our Answering Service.

The Center for Dermatology and Skin Care, Inc. 304-766-9136

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Signature (Parent/Legal Guardian) Relationship to Patient

_____ _____

Printed Name Date

THE CENTER FOR DERMATOLOGY AND SKIN CARE, INC.

Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

PAYMENT IS DUE AT THE TIME OF SERVICES, (THIS INCLUDES COPAYS). WE ACCEPT CASH, CHECKS, AND VISA/MASTERCARD/DISCOVER/AMEX. WE OFFER EXTENDED PAYMENT PLANS.

Regarding Insurance:

ASSIGNMENT/PARTICIPATION-MANAGED CARE CONTRACTS:
We accept assignment of insurance benefits/managed care contracts with multiple insurance carriers. If you have any questions, our receptionist can assist you in determining if your insurance carrier is one The Center for Dermatology and Skin Care, Inc. is in contract with. **You are responsible for coinsurance, deductibles, and copayments which are due at the time of service.**

COPAYS: Credit will not be extended for any copayment.

ALL OTHER INSURANCE CARRIERS: Your insurance is a contract between you and your insurance company. The Center for Dermatology and Skin Care, Inc. is not a party to that contract. If your insurance company has not paid your account in full within 90 days, it becomes YOUR responsibility. Please be aware of some, and perhaps all, of the services rendered may be "non-covered" services and not considered reasonable and/or necessary under the Medicare Program and/or other medical insurances.

RETURN CHECK POLICY: If a check is returned to our office or our billing office, a MANDATORY $35 return check fee will be added to the balance due.

MINOR PATIENTS: The parent(s) or guardian(s) is responsible for full payment.
By signing below, I understand and agree to the terms I have read in the above Financial Policy.

MEDICAID: We **ARE NOT** Medicaid Providers and **CANNOT** bill Medicaid for services rendered. If you have Medicaid as a secondary insurance, you will be responsible for any charges incurred after your Primary Insurance pays their part (ie: deductibles, copays, etc).

COLLECTIONS POLICY: You agree, in order for us (or any other entity authorized by us) to service our account or collect any amounts that you owe us, you maybe contact by any information associated with your account. Please note that collection fees may be added to your overdue balances.

_____

Signature of Patient or Responsible Party **Date**

ASSIGNMENT OF INSURANCE PAYMENTS

Patient: _____

Employer: _____

Claim Group: _____

SS#/ID#: _____

I hereby assign to **The Center for Dermatology & Skin Care, Inc. and Gregory T. Lagos, DO,** (hereinafter the "health care provider) all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered by the Health Care Provider. This assignment shall not exceed my indebtedness to the Health Care Provider. I UNDERSTAND AND ACKNOWLEDGE THAT THIS DOCUMENT IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY INSURANCE POLICY.

I hereby authorize and direct _____ Insurance Company to pay by check payable and mailed to :

The Center for Dermatology & Skin Care, Inc.
607 Chestnut Street
South Charleston, WV 25309

If my current policy prohibits direct payment to a health care provider, I hereby authorize and direct my insurance company to make the check payable to me and mail it to **The Center for Dermatology & Skin Care, Inc.** at their address above.

I have agreed to pay the Health Care Provider, in a current manner, any balance of said professional service charges over and above any insurance payment so long as that balance does not exceed the allowable medical expense for services rendered as determined by my insurance company.

I also authorize the Health Care Provider to release any information pertinent to my case to any insurance company or adjuster deemed necessary in order to process any claim for reimbursement of charges incurred by me as a result of the professional services rendered by the Health Care Provider and I hereby release the Health Care Provider of any consequences or liability arising therefrom.

I authorize the Health Care Provider to initiate a complaint to the Insurance Commissioner on my behalf if the same shall become necessary for the processing and payment of my claim.

A photocopy of the Assignment shall be considered as effective and valid as the original.

Dated: _____, _____.

_____ _____

Signature of Policyholder Witness

_____

Signature of Claimant, if other than Policyholder

Dermatology Medical History

Patient: _____ **Today's Date:** ___/___/_____

DOB: _____ Male ☐ Female ☐

Are you **ALLERGIC to any medications?** ☐YES ☐NO If yes, please list below:

1. _____ Reaction: _____ 2. _____ Reaction: _____

List all **MEDICATIONS** you are currently taking (including prescriptions, over-the-counter meds, vitamins and herbals):

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

7. _____ 8. _____ 9. _____

Current Local Pharmacy _____ **Mail Order Pharmacy** _____

MEDICAL HISTORY:

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

	Yes	No		Yes	No
Anxiety	☐	☐	Hearing Loss	☐	☐
Arthritis	☐	☐	Artificial Heart Valve	☐	☐
Artificial Joint	☐	☐	Hepatitis	☐	☐
(if yes, which joint _____)					
Asthma	☐	☐	HSV (fever blister)	☐	☐
Atrial Fibrillation	☐	☐	High Blood Pressure	☐	☐
Blood Thinner	☐	☐	HIV/AIDS	☐	☐
Bone Marrow Transplant	☐	☐	High Cholesterol	☐	☐
Benign Prostatic Hypertrophy	☐	☐	Hyperthyroidism	☐	☐
Breast Cancer	☐	☐	Hypothyroidism	☐	☐
Colon Cancer	☐	☐	Leukemia	☐	☐
COPD	☐	☐	Lung Cancer	☐	☐
Coronary Artery Disease	☐	☐	Lymphoma	☐	☐
Depression	☐	☐	Prostate Cancer	☐	☐
Diabetes	☐	☐	Radiation Treatment	☐	☐
End Stage Renal Disease	☐	☐	Seizures	☐	☐
GERD	☐	☐	Stroke	☐	☐

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

(Women) Last Menstrual Period ___/___/_____

Are you pregnant? ☐YES ☐NO Due Date: ___/___/_____

Are you breastfeeding? ☐YES ☐NO

SKIN HISTORY:

Do you now, or have you ever had diseases or conditions of: (Please check YES or NO)

	Yes	No		Yes	No
Acne	☐	☐	Hay Fever/Allergies	☐	☐
Actinic Keratosis	☐	☐	Melanoma	☐	☐
Basal Cell Carcinoma	☐	☐	Poison Ivy	☐	☐
Blistering Sunburn	☐	☐	Precancerous Moles	☐	☐
Dry Skin	☐	☐	Psoriasis	☐	☐
Eczema	☐	☐	Squamous Carcinoma	☐	☐
Flaking or Itchy Scalp	☐	☐			

Other: _____

(Please complete back of this form)

Dermatology Medical History

Has anyone in your family had melanoma? ☐YES ☐NO If yes, who?_____
Do you have a family history of any skin cancer? ☐YES ☐NO If yes, what type?_____
Do you wear sunscreen? ☐YES ☐NO If yes, what SPF?_____
Do you tan in a tanning salon? ☐YES ☐NO
Do you have problems with healing? ☐YES ☐NO
Do you bleed easily? ☐YES ☐NO
Do you develop skin rashes in reaction to ☐Adhesives ☐Topical Antibiotic Ointment ☐Environment ☐Food _____
☐Latex ☐Other _____

SOCIAL HISTORY:

Tobacco Use -

Are you now or have you ever smoked? Never Smoker☐ Former Smoker☐ Current Smoker☐
If Current Smoker, how much _____

Do you drink alcohol? Yes☐ No☐ (if Yes, _____ drinks per day)
Do you use IV drugs? Yes☐ No☐ (if Yes, what? _____, How often?_____)

Have you received your pneumonia vaccine? Yes☐ No☐
Have you received your flu vaccination this year? Yes☐ No☐

ALERTS:

Do you have an allergy to Lidocaine? ☐YES ☐NO
Do you have an allergy to Epinephrine? ☐YES ☐NO
Do you have a history of MRSA infection? ☐YES ☐NO
Do you have a Pacemaker or Defibrillator? ☐YES ☐NO
Currently taking blood thinners or aspirin? ☐YES ☐NO
Need antibiotics prior to dental procedures? ☐YES ☐NO
Artificial Heart Valve? ☐YES ☐NO
Artificial Joint? ☐YES ☐NO
History of HIV/AIDS? ☐YES ☐NO
Hepatitis B or C? ☐YES ☐NO
Active TB? ☐YES ☐NO
Convulsions, Epilepsy, Seizures or Fainting? ☐YES ☐NO
Fever Blisters? ☐YES ☐NO
Keloids (raised scars)? ☐YES ☐NO

Would you be interested in discussing? ☐Botox ☐Fillers ☐Laser ☐Skin Care Regimens
☐Ultherapy ☐Other _____

_____ ___/___/_____
Signed by Patient or Guardian Date