Dr. Gregory T. Lagos, FAOCD, FAAD
607 Chestnut Street
South Charleston, WV 25309
(304) 766-9136 Fax (304) 766-9139

New Patient Packet

Please complete these new patient papers and bring them with you to your scheduled appointment, along with your current ID, and Insurance cards, and a current list of your medications.

APPOINTMENT DATE: _____

APPOINTMENT TIME: _____

Please *arrive 20 minutes* prior to your scheduled appointment time.
Thank you.

Patient Name: _____ DOB: _____ Date: _____

Please list the phone number you prefer to be called with test results: _____

PATIENT HISTORY

Primary Care Physician: _____ Preferred Pharmacy: _____

Describe your skin problem: (Include onset, duration, history and therapies)

_____

Past Medical History

Do you now have, or have you ever been diagnosed with any of the following conditions: (Check if Yes)

□ Anxiety	□ Diabetes	□ Leukemia	□ Arthritis
□ End stage kidney disease	□ Lymphoma	□ Asthma	□ GERD/Acid reflux
□ Prostate cancer (males)	□ Atrial fibrillation	□ Hearing loss	□ Radiation treatment
□ Benign Prostate enlargement	□ Hepatitis B	□ Seizures	□ Bone Marrow Transplant
□ Hepatitis C	□ Stroke	□ Breast Cancer	□ High blood pressure
□ Colon Cancer	□ HIV/AIDS	□ COPD	□ High cholesterol
□ Coronary artery disease	□ Hyperthyroid (high)	□ Hypothyroid (low)	□ Lung Cancer
□ Depression	□ **None of these**		

Other medical problems not listed above**:** _____
_____

List any major surgeries:
_____

Skin Disease History: Have you ever had skin cancer? □ Yes □ No □ Not Sure
If yes, check what type(s): □ Basal Cell □ Squamous Cell □ Melanoma □ Not sure
Do you use sunscreen? □ Yes □ No
Have you ever used a tanning bed? □ Yes □ No
Do any of your blood relatives have melanoma? □ Yes □ No Relationship: _____

Medications:
Current medications: _____
_____
List any medication allergies:
_____

Social History: Do you drink alcohol? □ Yes □ No If yes, _____ drinks per day
Do you smoke? □ Yes □ Quit □ No If yes, _____ packs per day

ROS
Do you have problems with healing? □ Yes □ No or excessive scarring (keloid)? □ Yes □ No
Do you have any problems with your immune system? □ Yes □ No

Alerts
Have you ever had a bad reaction to local anesthesia? □ Yes □ No
Are you allergic to adhesive? □ Yes □ No
Are you allergic to topical antibiotic ointments? □ Yes □ No
Do you have an artificial heart valve? □ Yes □ No
Are you on blood thinners? □ Yes □ No
Do you have a defibrillator? □ Yes □ No
Do you have a pacemaker? □ Yes □No
Have you been told to take antibiotics prior to dental or surgical procedures? □ Yes □ No
Do you get a rapid heartbeat with epinephrine? □ Yes □ No
Are you pregnant or planning pregnancy? □ Yes □ No If pregnant, due date: _____

Do we have your permission to import your pharmacy records to help coordinate your care? □ Yes □ No

_____ _____ _____

Name Phone Relationship to patient

PATIENT INFORMATION

Patient Name_____
Address_____
City, State, Zip Code_____
Home Phone_____
Cell Phone_____
Work Phone_____
Employer_____
Birth Date_____
Social Security_____
Sex_____ Race_____ Age_____
Relationship to Insurance holder_____

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

Insurance_____

2nd Insurance_____

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_____

Our Practice Policy is to charge a $100.00 “No Show” Fee for missed appointments or appointments rescheduled with less than twenty-four hour notice. Additionally, a $200 Fee will apply for a “No Show” of a surgical procedure or a lesser than twenty-four hour notice to cancel or reschedule a surgical procedure.

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_____

ASSIGNMENT OF INSURANCE PAYMENTS

Patient: _____ Employer: _____

Claim Group: _____ SS#/ID#_____

I hereby assign to **The Center for Dermatology & Skin Care, Inc. and Dr. Gregory T. Lagos, FAOCD, FAAD,** (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 cogent 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)

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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 (i.e.: 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**

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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, FAOCD, FAAD, 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, FAOCD, FAAD, 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: _____