dermatology
MELISSA LAZARUS, MD, FAAD

1080 KANE CONCOURSE · BAY HARBOR ISLANDS · FLORIDA 33154
PHONE 305 864 6200 WEB WWW.LAZARUSMD.COM

PLEASE FILL OUT BOTH PAGES OF THIS FORM COMPLETELY

Name_____ Today's Date_____/_____/_____
First Middle Last

Local Address_____
Street Apt# City State Zip

Summer Address_____
Street Apt# City State Zip

Home Phone Number: ( )_____ Cell Phone Number: ( )_____

Other Phone Number: ( )_____ E-mail address _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered Primary Physician:_____

Age: _____ Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female Social Security Number:_____

Employer:_____ Business Phone Number: ( )_____

Emergency Contact: _____ Emergency Contact Phone: ( )_____

Insured Name: _____ Insured Date of Birth: _____/_____/_____

Party Responsible for Payment: _____ Address _____

Primary Insurance:_____ Policy Number:_____

Do you have a secondary carrier ☐ yes ☐ no Name of Company:_____

Policy Number:_____ Group Number:_____

GUARANTOR AGREEMENT:
By signing this form as Patient/Guardian/Agent/or Guarantor, spouse or agent of the aforementioned parties, I hereby agree that any and all charges that arise within the treatment, past or future treatment if related to the incident or condition giving rise to this admission or service, not covered by any insurance, program, sponsorship, or other third party coverage I may have are due and payable by me at the time of discharge or discontinuation of treatment. I hereby acknowledge that Melissa Lazarus, M.D., P.A.; Melissa Lazarus, M.D.; Loretta Ciraldo, M.D. has agreed to bill my insurance or other third party carrier and has agreed to do so as a courtesy and Melissa Lazarus, M.D., P.A.; Melissa Lazarus, M.D.; Loretta Ciraldo, M.D. has the right to demand payment in full from me at any time prior to full payment from any insurance carrier or third party unless it is contractually stated that I will not be billed. I hereby acknowledge that I have been told, prior to receiving treatment that I will be billed by Melissa Lazarus, M.D., P.A.; Melissa Lazarus, M.D.; Loretta Ciraldo, M.D.
I further agree that if I am more than thirty (30) days late in the payment of any bill connected with this treatment and past treatment, a finance charge of 1.5% per month will accrue on the unpaid balance; and if delinquent account is referred to **a collection agency and/or attorney, I agree to pay the attorney's fees, court costs, and collection agency fees associated with the collection process.** I understand that any lab charges (including pathology services performed by my physician or another physician) are separate from the charges of my medical care. I understand that I am personally and fully responsible for any non-covered services, denied services, health insurance deductibles and co-insurance payments.
Note: If your secondary is an automatic crossover, Medicare will send the claim automatically to them. If not, you are responsible for your deductible and 20% co-pay at the time service is rendered. You will need to send your Medicare explanation of benefits to your secondary carrier. If your secondary is a crossover but fails to pay in a timely fashion, you are ultimately responsible for the 20% co-pay that Medicare does not pay.

MISSED APPOINTMENTS:
In order to provide the best possible service and availability to all our patients, it is our policy to charge our office visit fee ($85.00) for any appointment not cancelled at least 24 hours prior. Please call us as early as possible if you know you will need to reschedule your appointment.

CONSULT FEES:
There will be a charge payable at the time of service for any cosmetic consultation or service performed. The charge is payable at time of service. In the instance the bill is unpaid, there is a service and collection fee, as well as legal fees.
I have read and understand the financial policy stated above and authorize the release of any information necessary to process my claims. As a member of a managed care group, I assume all responsibility for any services rendered that are not a part of my referral, whether or not covered or paid by my insurance, and I will pay for those services at the time that they are rendered.

SIGNATURE_____ DATE:_____

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Medical History

Whom may we thank for referring you to our practice?_____

List all medications which you currently take:_____

List all allergies to medications:_____

List all other known allergies:_____

List all surgeries within the past 5 years:_____

Female patients only: Are you currently pregnant or trying to become pregnant? ☐ Yes ☐ No ; If Yes, due date_____

Are you currently nursing? ☐ Yes ☐ No

Do you use sunscreen: ☐ Daily ☐ Only when outside ☐ Occasionally ☐ Never

Check all medical conditions which you have or may have had:

☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma (of skin) ☐ Melanoma (Depth_____) ☐ Other Skin Cancer

☐ Blistering Sunburns ☐ Tanning Bed Use

☐ Cancer (non-skin) Type:_____ Date:_____ Treatment:_____

☐ Bleeding Tendency	☐ Hay Fever	☐ Eczema
☐ Diabetes	☐ Hepatitis (type:_____)	☐ Psoriasis
☐ HIV	☐ Convulsions	☐ Lupus
☐ Heart Attack	☐ Cataracts	☐ Asthma
☐ Hypertension	☐ Glaucoma	☐ Stomach or Duodenal Ulcers
☐ Thyroid	☐ Pacemaker/Defibrillator	

Family History of Skin Cancer ☐ No ☐ Yes If yes, type: ☐ Basal Cell ☐ Squamous Cell ☐ Melanoma ☐ Unknown

Do you have a heart murmur, or an artificial heart valve, joint, or other prosthesis that requires you to take antibiotics prior to dental procedures? ☐ No ☐ Yes If yes, what antibiotic do you usually take? _____

Are you allergic to Band-aids, tape or adhesive? ☐ No ☐ Yes

Are you allergic to latex? ☐ No ☐ Yes PLEASE LET OUR STAFF KNOW IF YOU ARE ALLERGIC TO LATEX.

Do you smoke? ☐ No ☐ Yes ☐ Formerly (Quit) Do you drink alcohol ? ☐ No ☐ Yes If yes, how much_____

Do you use illegal drugs? ☐ No ☐ Yes

Please list any other information we need to know about you or your health:_____

We offer a full range of cosmetic procedures. Please indicate if you are interested in learning more about:

☐ Botox ☐ Fillers (Restylane/Perlane/Juvederm) ☐ Sculptra ☐ Fraxel ☐ Intense Pulse Light (IPL) Treatment

☐ Laser Hair Reduction ☐ Treatment of Veins ☐ Chemical Peels ☐ Custom Skincare regimen ☐ Medical-Grade Facials

I hereby acknowledge that I have read this form and I understand its contents and agree with all of the provisions contained herein.

Signature: Date:

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PATIENT CONSENT FOR INFORMATION RELEASE

DATE:_____

PATIENT NAME:_____
First Middle Last

I, _____, give permission to Dr. Melissa Lazarus and Dr.
First Middle Last

Loretta Ciraldo's office to give my personal medical information to _____
First Last

and only him/her. This consent authorizes this office to allow _____ to
First Last

receive all medical information regarding my health.

_____

Signature of Patient/Guardian Date

_____

Witness Signature Date

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Dear Patient,

Please **initial each item below** where there is a blank line that you have read and understand our office policy regarding the payment of amounts that are the responsibility of the patient:

_____ For patients with no insurance coverage, payment is due at the time of service. We accept cash, checks, and major credit cards. Returned checks are subject to a $50 fee.

_____ We will bill your insurance carrier for all covered services if you are covered by a plan that we contract with as participating providers. You are required to pay for all co-payments at the time of your visit.

_____ For patients who have insurance coverage with a plan in which we are not participating providers, you are required to play 50% of the balance at the time of service and we will bill your insurance showing your payment. The insurance will then let us and you now if there is a remaining balance, for which at that time you will be billed. Payment must be made to our office by you accordingly.

_____ For amounts due after insurance has processed the claim (such as un-met deductibles or non-covered services), we will send you three consecutive statements at 30-day intervals.

_____ You have 30 days after the third statement is sent to pay in full the balance indicated on the statement. If payment is not received, your account will be submitted to a national collection agency and/or credit bureau and/or attorney for further action. You will be responsible for all attorney's fees, court costs, and collection agency fees associated with the collection process. No additional contact will be made by our office.

It is the responsibility of the patient to notify our office if there is any change in your mailing address or contact information.

Signature of Patient/Guardian Date

Staff Witness

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have reviewed/received a copy of Dr. Melissa
Patient Name

Lazarus's Notice of Privacy Practices.

HIPAA

_____ _____
Signature of Patient/Guardian Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement. But was unable to do so as documented below:

Date:	Initials:	Reason: