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 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., 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., 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:_____

dermatology
MELISSA LAZARUS, MD, FAAD

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

PATIENT CONSENT FOR INFORMATION RELEASE

DATE:_____

PATIENT NAME:_____
First Middle Last

I, _____, give permission to Dr. Melissa Lazarus'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

dermatology
MELISSA LAZARUS, MD, FAAD

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

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

dermatology
MELISSA LAZARUS, MD, FAAD

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.

_____ _____
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:

1080 Kane Concourse Bay Harbor Islands, FL (305) 864-6200 phone : (305) 864 9906 fax

History and Intake Form

Past Medical History:

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other _____

Past Surgical History:

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None
Other _____

Skin Disease History:

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None
Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Any other family history: _____

Medications: (Please enter NAMES of all current medications)

_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____

Social History:

Sexual History:
- Not sexually active
- Sexually active with one partner
- Sexually active with more than one partner
- Same gender partner

Illicit Drug Use:
- Drug Use
- IV Drug Use

Alcohol Use:
- Alcohol: none
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

Safety:
- I feel safe at home.
- I do not feel safe at home.

Cigarette Smoking:
- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Pharmacy Name:
Pharmacy Number:
Pharmacy Zipcode:

Review of Symptoms: Are you currently experiencing any of the following?

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
Rash		
Immunosuppression		
Hay Fever		
Fever		
Unintentional weight change		
Thyroid problems (hyper or hypo)		
Sore throat		
Vision changes		
Abdominal pain		
Joint aches		
Muscles weakness		
Neck stiffness		
Seizures		
Headaches		
Cough		
Wheezing		
Anxiety		
Depression		

Alerts: Are you currently experiencing any of the following?

Alert	Yes	No
Allergy to adhesive		
Allergy to lidocaine		
Allergy to topical antibiotic ointments		
Artificial heart valves		
Artificial joints within 2 years		
Blood thinners		
Defibrillator		
MRSA		
Pacemaker		
Premedication prior to procedures		
Rapid heart beat with epinephrine		
Pregnancy or planning a pregnancy		
History of skin cancer		
Family history of skin cancer		
Diabetes		
Currently breastfeeding		
Demylinating disease		
History of lupus		

APPOINTMENT CANCELLATION/NO SHOW POLICY

Our goal is to provide quality medical care in a timely manner. In order to do so we have had to implement an Appointment Cancellation/No Show Policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

Please be courteous and call our offices if you are unable to attend an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary for you to cancel your scheduled appointment, please contact our offices no later than twenty four (24) hours in advance. Your early cancellation will give another person the possibility to have access to timely medical care.

Each time a patient misses an appointment without providing notification (no-shows), another patient is prevented from receiving care. A failure to be present at the time of your scheduled appointment will be recorded in the medical record, and an administrative fee of $25.00 for general appointments and $75.00 for surgical/cosmetic appointments will be accessed to the account. A letter will be generated and mailed to the address on file to alert the patient that they have failed to show up for an appointment. If an individual has three (3) no-shows within a one year period, they may be discharged from the practice.

While we understand that situations may arise preventing patients from arriving to their scheduled appointment on time, if a patient is more than fifteen (15) minutes late for their appointment without notifying the office, the appointment may be canceled.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have. We thank you in advance for your cooperation and understanding. By signing below you acknowledge that you have been presented with the above policy.

_____ _____

Patient Signature Date

_____

Printed Name

_____

Witness