FDL Dermatology, P.L.L.C.

Courtney Herbert, M.D.
1715 North George Mason Drive, Suite 406
Arlington, VA 22205
(703) 310-7400 / (703) 574-3184 (fax)

WE LOOK FORWARD TO HAVING YOU AS OUR PATIENT

Please be prepared to give the receptionist your photo I.D. and current insurance card(s)

PATIENT INFORMATION (PLEASE PRINT) ACCOUNT

LAST NAME (Legal)	FIRST NAME (Legal)	MIDDLE INITIAL

STREET ADDRESS:	CITY	STATE:	ZIP:

HOME PHONE	WORK PHONE	CELL NUMBER	PATIENT'S DOB (REQUIRED)

sex M F	SS#:	EMPLOYMENT STATUS: (CIRCLE ONE) student working retired disabled

MARTIAL STATUS (CIRCLE ONE) single married divorced widowed	NAME OF PRIMARY CARE PHYSICIAN:

Were you referred by a physician? _____ Yes _____ No	NAME OF REFERRING PHYSICIAN:

PERSON RESPONSIBLE FOR PAYMENT

LAST NAME (Legal)	FIRST NAME (Legal)	MIDDLE INITIAL

RELATIONSHIP TO PATIENT (Please circle one)

SELF SPOUSE FATHER MOTHER OTHER_____

PRIMARY INSURANCE -- Please enter name exactly as shown on insurance card

INSURANCE COMPANY NAME:	CIRCLE IF KNOWN: HMO PPO INDEMNITY HSA FSA INDIVIDUAL

POLICYHOLDER'S NAME (as shown on card) (REQUIRED)	POLICY HOLDER'S DATE OF BIRTH: (REQUIRED)

POLICY HOLDER'S SS#	RELATIONSHIP TO PATIENT (Please circle one) SELF SPOUSE FATHER MOTHER OTHER_____

SECONDARY INSURANCE -- Please enter name exactly as shown on insurance card

INSURANCE COMPANY NAME:	CIRCLE IF KNOWN: HMO PPO INDEMNITY HSA FSA INDIVIDUAL

POLICYHOLDER'S NAME (as shown on card) (REQUIRED)	POLICY HOLDER'S DATE OF BIRTH: (REQUIRED)

POLICY HOLDER'S SS#	RELATIONSHIP TO PATIENT (Please circle one) SELF SPOUSE FATHER MOTHER OTHER_____

TERTIARY INSURANCE -- Please complete back side

TERTIARY INSURANCE -- Please enter name exactly as shown on insurance card

INSURANCE COMPANY NAME:	CIRCLE IF KNOWN: HMO PPO INDEMNITY HSA FSA INDIVIDUAL
POLICYHOLDER'S NAME (as shown on card) (REQUIRED)	POLICY HOLDER'S DATE OF BIRTH: (REQUIRED)
POLICY HOLDER'S SS#	RELATIONSHIP TO PATIENT (Please circle one) SELF SPOUSE FATHER MOTHER OTHER_____

A. DEEMED CONSENT FOR DESIGNATED BLOOD BORNE PATHOGENS & CONSENT FOR MEDICAL CARE: I understand that Virginia law requires health care providers to notify me that hepatitis B and C or HIV (AIDS) Virus testing on sample of my blood may be done if a health care worker is exposed to my blood or body fluids. I understand that this following notice is to advise me that this is in effect at this facility:
As health care providers under the Virginia Acts of Assembly Section 32.1--45.1, whenever any health care worker associated with or working for FDL Dermatology, P.L.L.C. is directly exposed to body fluids of a patient in a manner which , according to the guidelines of the Center for Disease Control, may transmit human immunodeficiency virus or hepatitis B or C, FDL Dermatology, P.L.L.C. will proceed to test the patient through his or her physician and the health care worker(s) who was/were exposed. When a person is tested, FDL Dermatology, P.L.L.C. automatically tests for hepatitis B and C for the safety of all concerned. I voluntarily consent to medical care at FDL Dermatology, P.L.L.C., which may include examination, tests, photographs and treatment by doctors and staff. No promises have been made to me as to the results of this treatment or examination.

B. FEES & PAYMENTS: As a courtesy to its patients, FDL Dermatology, P.L.L.C. is pleased to assist in the submission of medical claims to insurance companies for payment. I understand that it is my responsibility to confirm that the physician I see at FDL Dermatology, P.L.L.C. is a participating provider under my policy. Further, I understand that my insurance company may not cover 100% of my bills for service provided, and that I will be responsible for the payment of any remaining balance due.
I understand that it is my responsibility to provide FDL Dermatology, P.L.L.C. with appropriate and current insurance information -- and to notify FDL Dermatology, P.L.L.C. immediately upon any changes in my insurance coverage -- to ensure efficient claims billing and payment. In the event that I fail to provide all the necessary and current insurance information, I understand that my insurance company(ies) may deny payment of claims relating in services rendered to me, and I understand that I may be fully responsible for my entire account balance. If I am covered by an insurance company that requires a referral from my primary care physician or carrier, it is my responsibility to obtain that referral authorization prior to my visit and furthermore understand, if a required referral is not obtains, I am responsible for the charges.
I understand that I will be responsible for paying co--payments, deductable, and any fees relating to services rendered that are not fully (or at all) covered by my insurance company(ies). Finally, I understand that my co--payments are to be made at the time the service are rendered.

C. INFORMATION RELEASE: I authorize FDL Dermatology, P.L.L.C. and Courtney Herbert, M.D. to release to my Insurance Carrier any information needed to determine benefits payable to the related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to FDL Dermatology, P.L.L.C. and Courtney Herbert, M.D.

D. PAYMENT AUTHORIZATION: I authorize insurance payment, if any, directly to FDL Dermatology, P.L.L.C. and Courtney Herbert, M.D. I realize I am responsible for non--covered services.

E. Medicaid: I understand FDL Dermatology, P.L.L.C. and Courtney Herbert, M.D. does not participate with Medicaid and I will be billed directly for charges incurred.

F. Patient Discharge/Collection Fees: In the event of failure to pay for medical services rendered, I understand that I may be discharged from the services of FDL Dermatology, P.L.L.C. until such time as my account is paid. Additionally, I understand that I may be referred to a collection agency for non--payment of fees due for services rendered by FDL Dermatology, P.L.L.C. I understand that I will be responsible for a 30% collection fee, all agency and attorney fees and costs associated with the collection process (such as court costs), and that these fees and costs will be added to my account balance. I understand that I will be responsible for paying the entire amount of my balance due in addition to the collection agency fee. Further I understand that my PHI will necessarily be revealed in these efforts to collect payment of monies owed.

G. Returned Check Fee: I understand that in the event that my check is returned for insufficient funds, I agree to provide cash, money order or certified check for the full amount of the payment owed, in addition to a $30.00 returned check charge.

H. Missed Appointment Fee: I understand that I will be assessed a $50.00 fee if I miss an office visit and a $100.00 fee if I miss a surgical or cosmetic procedure without having provided a 24--hour advance notice of cancellation.

I. Transfer of Records: I understand that I will be charged a fee to transfer my records to another physician:$15.00--$25.00 for charts fifteen (15), pages or less in length, and $50.00 for charts exceeding fifteen (15) pages in length. This payment is due in full prior to the copying and forwarding of records.

J. Refill Policy: I understand that is FDL Dermatology, P.L.L.C. policy and practice to give patients enough medication to sustain them until their next visit; that follow up visit is required for prescriptions that are over one year old; and that depending on the situation, the patient may be given a one--time refill to carry them over until their next follow--up visit.

As the responsible party, I understand and agree to the policies of FDL Dermatology, P.L.L.C. and Courtney Herbert, M.D. as stated in sections a, b, c, d, e, f, g, h, I, and j.

I understand that I am financially responsible for all services rendered.

Signature (Parent/Guardian, if patient is a minor) X _____
Date _____

OFFICE USE ONLY Data Reviewed by: _____ Verified by: _____

FDL Dermatology, P.L.L.C.
Medical History
Courtney Herbert, M.D., M.P.H.

1715 North George Mason Drive, Suite 406
Arlington, VA 22205
(703) 310-7400 / (703) 574-3184 (fax)

Patient's Name: _____ Date: ____/____/_____

Reason for today's visit: _____

Are you allergic to any medications? **YES** **NO** If "yes", list below and explain reason

Have you ever had dental anesthesia (Novocaine)? **YES** **NO** Any adverse reactions? **YES** **NO**

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

Do you have now, or have you ever had any of the following: (Please circle all that apply)

Skin:
- Melanoma
- Squamous Cell Carcinoma
- Basal Cell Carcinoma
- Merkel Cell Carcinoma
- Dysplastic/Atypical Mole
- Keloid Scar
- Psoriasis
- Dermatitis Herpetiformis
- Lupus
- Vitiligo
- Other:_____

Cardiovascular:
- High Blood Pressure
- Heart Attack
- Heart Murmur or Irregular Heartbeat
- Blood Clots
- High Cholesterol
- Anemia

Other Systemic:
- Asthma
- Emphysema
- Chronic Obstructive Pulmonary Disease
- Migraines
- Amputation
- Dialysis
- Nausea, Vomiting, Diarrhea when taking antibiotics
- Yeast infection when taking antibiotics
- Arthritis
- Convulsions, Epilepsy, or Seizures
- Cancer: _____
- Diabetes: Type_____
- Thyroid: _____
- Kidney: _____
- Gastrointestinal: _____

List any other diseases or conditions:

List surgical procedures you have had in the last 12 months:

Do you have a family history of the following
(if yes circle and state who):

Melanoma
Basal Cell Carcinoma
Squamous Cell Carcinoma
Merkel Cell Carcinoma

Social History:

Do you drink alcohol: **YES** **NO** If yes, _____ drinks per day
Do you use IV drugs: **YES** **NO** If yes, what? _____ How often? _____
Do you smoke: **YES** **NO** If yes, how much? _____
Are you a former smoker: **YES** **NO**
Have you had or have you been exposed to HIV: **YES** **NO**
Have you been exposed to Hepatitis B or C: **YES** **NO**
(Women) Are you pregnant: **YES** **NO** If yes, due date: ____/____/____
Are you breastfeeding: **YES** **NO**
What is your occupation: _____ Hobbies: _____

How did you hear about our office?

SIGNATURE _____ DATE _____

FDL Dermatology

Client Name (Please print legibly):_____

Email:_____

Cell Phone Number:_____

Areas of interest (please check all that apply)

- o Botox
- o Skin Care Advice
- o Laser Treatment
- o Age Spots
- o Chemical Peels
- o Undereye Circles
- o Juvederm or Dermal Fillers
- o Sunscreen Advice
- o Microdermabrasion
- o Underarm Sweating
- o Acne