DERMATOLOGY OF VIRGINIA - MEDICARE
DR. LIANA ABRAMOVA
PATIENT INFORMATION

☐ NEW PATIENT ☐ NAME CHANGE ☐ ADDRESS CHANGE ☐ INSURANCE CHANGE

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:

TODAY'S DATE ____/____/____

NAME: _____
LAST, FIRST, M.I.

DATE OF BIRTH: _____/_____/_____ AGE: _____ SEX: ☐ MALE ☐ FEMALE

MAILING ADDRESS _____
STREET CITY STATE ZIP

HOME PHONE: ( )_____ WORK PHONE: ( )_____

CELL PHONE: ( )_____ **E-MAIL**: _____

*BY PROVIDING YOUR EMAIL, YOU ALLOW US TO GIVE YOU ACCESS TO OUR PATIENT PORTAL AND SEND OUT EMAIL ANNOUNCEMENTS AND PROMOTIONS.

RACE: _____ LANGUAGE: _____ ETHNICITY: _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

NAME: _____
LAST, FIRST, M.I.

DATE OF BIRTH: _____/_____/_____

ADDRESS:_____
STREET, CITY, STATE, ZIP

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE : _____

INSURANCE COVERAGE - PRIMARY:

INSURANCE CO.NAME:_____

NAME OF POLICY HOLDER:(INSURED):_____

POLICY HOLDER (INSURED) DATE OF BIRTH: ____/____/____

POLICY#:_____GROUP#:_____

INSURANCE COVERAGE – SECONDARY (ONLY IF MEDICARE IS PRIMARY):

INSURANCE CO. NAME:_____

NAME OF POLICY HOLDER (INSURED):_____

POLICY HOLDER (INSURED) DATE OF BIRTH: ____/____/____

POLICY #:_____ GROUP NAME OR #:_____

REFERRED BY: _____

PRIMARY CARE PHYSICIAN _____ PHONE ( )_____

EMERGENCY CONTACT INFORMATION:

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?_____

PHONE (HOME)_____ (CELL) _____

RELATIONSHIP TO PATIENT: _____

PATIENT RESPONSIBILITY POLICY:

*I WILL PROVIDE A PHYSICAL COPY OF MY CARD AT EVERY VISIT. I UNDERSTAND FAXED COPIES ARE NOT ACCEPTED.

*I UNDERSTAND THAT THERE IS A $25 NO SHOW FEE WHEN I DO NOT SHOW FOR AN APPOINTMENT, OR CANCEL WITHOUT SUFFICIENT NOTICE. THERE IS A $50 FEE FOR MISSED SURGICAL AND COSMETIC APPOINTMENTS.

***HMO, PPO OR OTHER MANAGED CARE PATIENTS:** YOU WILL BE RESPONSIBLE FOR PAYING YOUR ANNUAL DEDUCTIBLE, COPAYMENT, AND CHARGES FOR ANY NON-COVERED, COSMETIC SERVICES AT THE TIME OF SERVICE.

***SELF PAY PATIENTS:** ALL BALANCES ARE DUE AT THE TIME OF SERVICE.

*THERE IS A $35 RETURNED CHECK FEE FOR ANY RETURNED CHECKS TO OUR OFFICE.

*THERE IS A $10 FEE TO, AT MY REQUEST, HAVE MY PROVIDER FILL OUT A FORM.

*IF MY INSURANCE REQUIRES A REFERRAL, I MUST HAVE IT IN HAND AT THE TIME OF SERVICE, AND NO FAXED COPIED ARE ACCEPTED.

*IT IS MY RESPONSIBILITY TO PROVIDE DERMATOLOGY OF VIRGINIA THE CORRECT AND UPDATED INSURANCE INFORMATION AT EACH AND EVERY VISIT.

*IF MY BILL IS NOT PAID IN FULL AFTER A SERIES OF COMMUNICATIONS FROM THE OFFICE, I UNDERSTAND THAT MY ACCOUNT CAN BE GIVEN TO AN OUTSIDE COLLECTIONS AGENCY, AND I WILL BE RESPONSIBLE FOR PAYING MY BALANCE AND ALL FEES INCURRED DURING THIS PROCESS.

PATIENT OR RESPONSIBLE PARTY SIGNATURE_____

DATE ____/____/____

HIPAA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations.

We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health
Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent signed by:

_____

Printed Name – Patient or Representative Signature

__/___/___
DATE

Relationship to Patient (if other than patient): _____

Use and Disclosure Authorization

I, _____, authorize Dermatology of Virginia, PC to use or disclose the following protected health information:

- Biopsy results, Blood test results, and any other Lab results
- Appointment information
- Billing information
- Visit Information

OR

- **ALL INFORMATION NEEDED**

This information may be disclosed to the following people:

-
-
-
-

This Authorization shall be in force and effective until

- No Expiration
- Date: _____

I understand as mentioned in Dermatology of Virginia, PC's Privacy Policy, that this authorization may be revoked at any time, in writing, by sending written notification to:

Dermatology of Virginia, PC
Dr. Liana Abramova
3930 Pender Drive Suite 210
Fairfax, Virginia, 22030

Office Financial Policy

Patient Name: _____ Date of Birth: ___/___/___

Dear Patient:

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

Medicare:

We are Medicare participating providers. We will bill Medicare and Secondary carriers. You will be responsible at the time of service for payment of:

a. The annual deductibles

b. Copayments

c. Charges for non-covered or cosmetic services*

* You will be asked to sign a Advanced Notice of Liability Form in the event that a service is provided which we know is not covered by Medicare.

If you have Medicare, as well as secondary coverage with a commercial plan that is not a secondary or is an insurance company with which we have no contract, we will file a claim to your secondary/supplemental carrier. You will be sent a bill and will be responsible for the balance your insurance deems as your responsibility.

Non-Medicare/Commercial Plans:

If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for all covered, medically necessary services rendered. You will be responsible at the time of service for payment of:

a. The annual deductibles

b. Copayments

c. Charges for non-covered or cosmetic services

We will file your primary insurance. For any remaining patient responsibility, payment is due 10 days after receipt of your statement.

In the event that you, as the patient, or we, as the physicians, are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

_____ ___/___/___

Patient signature **Date**

How did you learn about our practice?

□ From your Doctors. Please specify: _____

□ From your Family, Friends, Colleagues

□ From online websites or search engines (such as Google or Google ads, Bing, Yahoo...etc). Please specify: _____

□ From our website at www.skinva.com

□ From our letters, fliers, or advertisements

□ From ZocDoc (online appointment)

□ From previous experience with Dr. A.

□ From your insurance website

Thank you!

MEDICAL HISTORY FORM

PATIENT to please fill out:

NAME: _____ DATE: _____ BIRTHDATE:__/__/__

REFERRED BY:_____

LIST OF CURRENT DR. & SPECIALISTS _____

ALLERGIES: (DRUG, SEASONAL, AND FOOD ALLERGIES) _____

PHARMACY NAME/LOCATION: _____

MEDICAL HISTORY: (Check the following medical conditions that you currently have)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Bone Marrow Transplantation
- ☐ BPH (Benign Prostatic Hyperplasia)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Pulmonary Disease/COPD
- ☐ Coronary Artery Disease/Heart Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Reflux Disease)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension (High Blood Pressure)
- ☐ Hypercholesterolemia (High Cholesterol)
- ☐ HIV / AIDS
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pacemaker/☐Defibrillator
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke/TIA

☐ Other (Please List) _____

PAST SURGERIES:

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: (Mastectomy)
- ☐ Breast: Lumpectomy (Right/Left/Both)
- ☐ Breast: Breast Biopsy
- ☐ Colon (Colectomy) Colon Cancer Resection
- ☐ Colon (Colectomy) Diverticulitis
- ☐ Colon (Colectomy): IBS
- ☐ Colon Colostomy
- ☐ Gallbladder (Cholecysectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: PTCA
- ☐ Heart Mechanical Valve Replacement
- ☐ Heart: Bilogical Valve Replacement
- ☐ Heart: Transplant
- ☐ Joint Replacement Knee Date:____R or L
- ☐ Joint Replacement Hip Date:____R or L
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Nephrectomy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Liver: Liver Transplant
- ☐ Liver: Liver Shunt or Hepatectomy
- ☐ Ovaries: Endometriosis
- ☐ Ovaries: Ovarian Cyst
- ☐ Ovaries: Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate: Prostate Cancer
- ☐ Prostate: Prostate Biopsy
- ☐ Prostate: TURP
- ☐ Rectum: Rectal Resection APR
- ☐ Rectum: Rectal Resection
- ☐ Skin: Skin Biopsy
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Spleen: (Spenectomy)
- ☐ Testicles: (Orchidectomy)
- ☐ Uterus(Hysterectomy):Uterine Cancer
- ☐ Uterus(Hysterectomy):Cervical Cancer
- ☐Uterus(Hysterectomy):Fibroids

☐Other_____

SKIN DISEASE HISTORY: Have you had any of the following skin conditions:

- ☐ 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

☐ Other: _____

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

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FAMILY HISTORY:

Do you have a family history of Melanoma? Yes or No If yes, which relative?_____

Do you have a family history of:

☐Autoimmune Disorder ☐Carcinoma: Basal Cell ☐Carcinoma: Squamous cell

☐Diabetes ☐Eczema ☐Psoriasis ☐Hair Loss ☐Hay fever/Asthma ☐Other Cancer/Malignancy

(Please mark which relative & listed condition)

☐ Mother_____ ☐ Daughter_____ ☐ Nephew_____ ☐ Grandmother_____

☐ Father_____ ☐ Son_____ ☐ Niece_____ ☐ Grandson_____

☐ Sister_____ ☐ Uncle_____ ☐ Grandfather_____ ☐ Granddaughter_____

☐ Brother_____ ☐ Aunt_____ ☐ Other: _____

SOCIAL HISTORY:

Occupation: _____ **Place of Employment:**_____

If Retired: Previous Occupation:_____

Social History Details

☐ Currently Smokes ☐ Has smoked in the past ☐ Smokes Every Day ☐ Never Smoked ☐ Smokes few times per week

☐ Drug/Alcohol Use Type: _____ How Often?_____

Exercise:

☐ 1 time per day ☐ Few times per week ☐ Few times per month ☐ Never Exercise

REVIEW OF SYSTEMS:

Cardiovascular:

☐ Pacemaker ☐ Defibrillator ☐ Artificial joints w/in past two years

☐ Artificial Heart Valve ☐ Rapid heartbeat with epinephrine ☐ Chest Pain

Allergic / Immunologic:

☐ Premedication prior to procedures ☐ Allergy to adhesive ☐ Allergy to topical antibiotic ointments

☐ Allergy to lidocaine ☐ Immunosuppression

Endocrine: **Constitutional / Symptom:**

☐ Pregnant or planning a pregnancy ☐ Yeast infections w/antibiotics ☐ Fever or Chills ☐ Unintentional Weight Loss

Gastrointestinal: **Hematologic / Lymphatic:**

☐ GI Upset with Antibiotics ☐ Problems with bleeding

Integumentary/Skin:

☐ Problems with Healing ☐ Problems with scarring (hypertrophic or keloid)

☐ Changing Mole ☐ Rash

PATIENT to please fill out:

Please provide your complete list of Current Medications (including aspirin, herbals, vitamins – DOSAGE NECESSARY):

Medication	Dosage	Reason

At the direction of the Governor, Dermatology of Virginia is opening for some face to face elective procedures. Since state of Virginia continues to have an increase in Covid 19 cases, we will continue to screen some patients via teledermatology appointment first to minimize risk to our staff and to our patient.

As your healthcare professionals, we are committed to maintaining and improving your health while providing a safe environment. We understand that these are trying times and, with the American Academy of Dermatology and CDC guidelines, we have enhanced our strict protocols to provide for a safe treatment during your visit. On a daily basis, our staff will be screened for symptoms and signs for any illness. If a staff member exhibits any signs or symptoms, he/she will be sent home to commence the quarantine period and will not return until fully recovered.

Please note that all patients coming for appointments must wear a mask before entering our office.

All our staff will be wearing masks at all times.

Everyone will have temperature check prior to entering our office.

In order to maintain your safety we are asking a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

Do you have a fever within last 14 days?	Y or N
Do you have any cough or shortness of breath?	Y or N
Do you have any flu symptoms ?	Y or N
Within the last 14 days, have you traveled to any foreign country?	Y or N
Within the last 14 days have you traveled within the United States?	Y or N
Do you have diarrhea or loss of smell?	Y or N
Were your or anyone in your household diagnosed with Covid, if yes when?	Y or N

COVID-19 is an infectious virus that currently has no direct treatment and for which there is no current vaccine. While we have taken reasonable steps to limit the potential for transmission of COVID-19 in our office, you agree that you understand transmission of COVID-19 is still possible.

You understand our office offers a HIPAA compliant telemedicine option. However, your care and/or your preference requires an in-person visit with our staff and health care providers. Where required to provide you care, our staff and health care providers may be within 6 feet of you and may touch you and your personal objects. You understand that person-to-person contact may increase the chance of COVID-19 transmission. It may be necessary that you quarantine and/or take other steps in the event it is determined that you may have been exposed to COVID-19.