

LAKE NORMAN DERMATOLOGY, P.A.

20808 N. MAIN STREET, SUITE 103 CORNELIUS, NC 28031

TEL: 704-658-9730 FAX: 704-658-1457

WWW.LAKENORMANDERM.COM

Registration Form

DATE: _____

NAME: _____ D.O.B. _____
(last) (first) (middle)

S.S.N.(#): _____ AGE: _____ SEX: M F MARITAL STATUS: S M D W

HOME ADDRESS: _____ CITY: _____ ZIP CODE: _____

HOME #: _____ CELL #: _____ WORK #: _____

OCCUPATION/EMPLOYER NAME: _____

SPOUSE OR PARENT'S NAME: _____
(last) (first) (middle)

SPOUSE OR PARENT'S ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMERGENCY CONTACT NAME & PHONE NUMBER: _____

IF YOUR VISIT TODAY IS AT THE REQUEST OF ANOTHER PHYSICIAN PLEASE COMPLETE THIS SECTION.

Requesting Doctor: _____ Specialty: _____

(Note: Records are sent to referring physician unless specified otherwise by patient)

If you would like a summary of Dr. Sugarman's findings and treatment plan sent to other physicians, please write the names and addresses here: _____

INSURANCE INFORMATION

1. INSURANCE #1 (please give your insurance card to the receptionist for photocopying)

NAME OF INSURANCE COMPANY: _____

NAME AND RELATIONSHIP OF POLICY HOLDER TO PATIENT: _____

POLICY HOLDER'S DOB: _____ POLICY HOLDER'S SSN#: _____

2. INSURANCE #2 (please give your insurance card to the receptionist for photocopying)

NAME OF INSURANCE COMPANY: _____

NAME AND RELATIONSHIP OF POLICY HOLDER TO PATIENT: _____

POLICY HOLDER'S DOB: _____ POLICY HOLDER'S SSN#: _____

I authorize Dr. Joel Sugarman to release any and all medical records pertaining to me for any diagnosis and treatment received today or subsequently to my medical doctor(s) and my insurance company(s). I understand that I am responsible for payment of medical services provided and that my bill for medical services is due at completion of the appointment unless other arrangements have been made.

Signature: _____ Date: _____

Reviewed: _____

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Chief Complaint: Please list your skin problems or concerns (lesion, rash, acne, etc) with any specific information such as location, duration, symptoms, changes, or treatments.

Personal and Family Skin Cancer History:

- | | | | |
|---|-----|----|--------|
| 1. Have you ever had a skin cancer in the past? | YES | NO | Unsure |
| 2. Have any of your relatives ever had a skin cancer? | YES | NO | Unsure |
| 3. Have any of your relatives died of skin cancer? | YES | NO | Unsure |

Social History:

- | | | | |
|--|-----|----|-----------------|
| 1. Do you smoke tobacco? | YES | NO | Quit: _____ |
| 2. Do you drink alcohol? | YES | NO | _____ |
| 4. Have you ever used a tanning bed? | YES | NO | |
| 5. Have you ever purposely tanned by natural sunlight? | YES | NO | |
| 6. Have you ever had a blistering sunburn? | YES | NO | How many? _____ |

Review of Systems:

- | | | |
|--|------------|----------|
| 7. Do you take antibiotics at dentist or for surgeries ? | YES | NO |
| 8. Do you have any artificial joints ? | YES | NO |
| 9. Have you ever had a heart valve replacement? | YES | NO |
| 10. Do you feel that you have more moles than most people?
Have any of your moles recently changed? | YES
YES | NO
NO |
| 11. Have you ever received Radiation Therapy
(not x-rays) or been exposed to other radiation sources? | YES | NO |
| 12. Do you have diabetes or high blood sugar? | YES | NO |
| 13. Do you take any medications that impair (lower)
your immune system such as prednisone,
methotrexate, cyclosporine, Imuran or Chemotherapy? | YES | NO |
| 14. Have you ever had an organ transplantation? | YES | NO |
| 15. Are you HIV positive? | YES | NO |
| 16. Have you ever had hepatitis? | YES | NO |
| 17. Do you ever have chest pain or trouble breathing? | YES | NO |
| 18. Have you or family members ever had thyroid problems? | YES | NO |

Explanation of positive responses to questions 7-19: _____

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Reviewed: _____

MEDICATION LIST

(May make copy if have your med list)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

PREFERRED PHARMACIES

- _____
- _____
- _____
- _____

MEDICATION ALLERGIES

1. _____
2. _____
3. _____
4. _____

_____ **No Known Drug Allergies**

Reviewed: _____

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Consent for Use and Disclosure of Confidential and Protected Health Information

It is a prime directive of Lake Norman Dermatology, PA to protect patients' rights and confidential health information. Confidential information will not be left on home or work answering machines, voice mail, cell phones, or pagers. Information will not be left with persons other than the patient who answer calls made by our staff unless the answering person is a legal guardian or indicated on the following form. Moreover, we do not leave a message if the recorded voice mail greeting does not identify the owner by name or phone number.

I authorize Lake Norman Dermatology and/or their staff to leave medical information pertaining to my care by the following methods and I will assume responsibility to notify them whenever this information changes:

- | | | |
|---|------------------------------|-----------------------------|
| ➤ Home Telephone/Answering Machine | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ➤ Can we leave message regarding results? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ➤ Work Telephone/Voice Mail | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ➤ Cell Phone/Voice Mail | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ➤ Fax Medical Records for Referral | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ➤ Spouse: _____ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ➤ Parent: _____ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Please list any person(s) to whom you **DO NOT** want your private health information shared:

You acknowledge you have had an opportunity to review our Notice of Privacy Practices prior to signing this consent. We encourage you to review the Notice of Privacy Practices carefully, for it provides details on how we may disclose your protected health information. The Notice of Privacy Practices may change. A current copy may be requested during an appointment or by contacting the practice manager at (704) 658-9730.

You may request that we restrict how we use and disclose your private health information for the purposes mentioned above. If you would like to request a restriction, please do so in writing. However, we reserve the right to deny your request. If we grant your request, we are bound by the terms of the agreement.

You may also revoke this consent in writing; however, information on any treatment/service provided using this or prior consents may still be used or disclosed for purposes of treatment, payment, or health care operations. Refer to the Notice of Privacy Practices for further information.

By signing this form, I grant my consent to Lake Norman Dermatology to use and disclose my protected health information for the purposes of treatment, payment, and health care operations.

Signature of Patient or Surrogate Decision Maker

Date

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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 was signed by: _____
Printed Name – Patient or Representative

Signature Date

Relationship to Patient
(if other than patient): _____

Witness: _____
Printed Name – Practice Representative

Signature

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FINANCIAL POLICY

Lake Norman Dermatology believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy. Please take the time to read the following:

- 1. PAYMENT** is expected at the time of your visit. We accept cash, personal checks and Visa/ MasterCard. Payment will need to include any co-insurance or co-pay that you are responsible for. **If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, full payment is expected at the time of your visit.**
- 2. INSURANCE** We are participating providers with most insurance plans. We will file the necessary insurance claims on your behalf. Please remember that insurance is a contract between you the patient and your insurance company and ultimately you will be responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from your insurance, we will certainly refund any overpayment to you.

If our providers are not listed in your plan's network, you may be responsible for full or partial payment. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore our charges for your care are due at the time of service. Due to the many different insurance products, our staff cannot guarantee your eligibility and coverage.

- 3. REFERRALS:** You will be responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for lack of one.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

- 4. RETURNED CHECKS** will incur a **\$35.00** service charge. You will be required to bring cash or money order to cover the amount of the check plus the service charge.
- 5. ACCOUNTING PRINCIPLES** – Payment and credits are applied to the oldest charge first, except for insurance payments which are applied to the corresponding dates of service.

If you have any questions in regard to a billing statement, our accounts receivable staff will be available to assist you.

I have read and understand Lake Norman Dermatology's financial policy. I agree to be bound by its terms and I understand and agree such terms may be amended by the practice from time to time.

Signature of Patient (or Responsible Party, if minor patient)

Date

Please print the name of the Patient