LAKE NORMAN DERMATOLOGY, P.A.

PLEASE COMPLETE THE ENTIRE FORM AND RETURN WITH YOUR CURRENT INSURANCE CARD & PHOTO ID

Last Name: _____ First Name: _____ M. Initial: ____

Address: _____ Home #:_____

City _____ State _____ Zip _____ Work #:_____

Birth date: _____ Age: _____ Sex: M ❑ F❑ Cell #: _____

Race: African American ❑ Asian ❑ Caucasian ❑ Hispanic ❑ Other ❑ Martial Status: S M D W

Employer: _____ SS#:_____

Occupation: _____ email address: _____

Employer Address: _____ City _____ State_____Zip_____

Primary Insurance Company: _____ Copay amount: _____

Policy holder's name: _____ Relationship: _____

Policy holder's SS #: _____ Policy holder's DOB: _____

Secondary Insurance: _____ (if applicable)

Policy holder's name: _____ Relationship: _____

Policy holder's SS #: _____ Policy holder's DOB: _____

Relative/contact that <u>does NOT live with you</u>: _____ Ph: _____

Address: _____ Relationship: _____

If applicable:
Physician who sent you to our office: _____ Specialty: _____

Records are sent to the referring physician. If you would like a summary of your visit sent to other physicians, please list their names and addresses here: _____

_____

_____

I AUTHORIZE: use of this form for all my insurance transmissions.
release of any relevant information to my insurance company.
my physician's office to act as my agent in assisting me obtain payment from my insurance company.
that I am aware that I am responsible for all charges regardless of insurance coverage.
payment of the medical benefits for services rendered to be sent directly to my physician.

I voluntarily consent to healthcare treatment from Lake Norman Dermatology. No guarantees have been made to me regarding the result of treatments by my caregivers.

I permit a copy of this authorization to be used in place of the original.

I understand that I am responsible to knowing my insurance coverage and for obtaining any referrals that may be needed.

I fully understand that I am responsible for any charges not covered by my insurance company, and that payment arrangements can be made with the billing department. If payments are not made, these balances may be transferred to a collection agency or attorney, and are subject to additional fees.

Patient's Signature: _____ **Date**: _____

History & Intake Form Name:_____ Date: _____

Cell Phone #:_____ Home Phone #:_____ Primary Care Physician: _____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibulation
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Coronary Heart Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation treatment
Seizures
Stroke
NONE
Other_____
_____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Breast : Breast Biopsy
Lumpectomy (R, L, Both Breasts)
Mastectomy (R, L, Both Breasts)
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: Inflammatory Bowel Disease
Colon Removed
Gallbladder Removed
Heart: Mechanical Valve Replacement
Heart: Coronary Artery Bypass Surgery
Heart Transplant
Heart Stent
Joint Replacement : Hip (R, L, Both)
Joint Replacement : Knee (R, L, Both)
Kidney : Kidney Biopsy
Kidney : Kidney Stone Removal
Kidney Removed
Liver surgery
Ovaries Removed: Endometriosis
Ovaries Removed: Ovarian Cancer
Ovaries Removed: Ovarian Cyst
Pancreas Removed
Prostate Biopsy
Prostate Removed
Rectal Surgery
Spleen Removed
Testicles Removed
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Hysterectomy: Cervical Cancer
NONE
Other _____
_____

Skin Disease History: (please circle all that apply):

Melanoma
Squamous Cell Carcinoma
Basal Cell Carcinoma
Actinic Keratoses
Atypical Moles
Acne
Asthma
Blistering Sunburns
Dry Skin
Eczema
Excessive Sweating
Flaking or Itchy Scalp
Hay Fever/Allergies
Psoriasis
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 **blood** relative? _____

Medications: (please list all current medications):

Name of Rx	Strength & Form (ex. 10 mg tablet)	How many times per day?

PLEASE CONTINUE INTAKE ON BACK

Drug Allergies: (please list all known drug allergies AND reaction)

_____ _____
_____ _____
_____ _____

Social History: (please circle all that apply)

Cigarette Smoking:
Currently smokes
Former smoker
Has smoked in the past
Never smoker

Alcohol use:
NONE
less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

(Women) How many times in the past year have you had 4 or more drinks in a day? _____
(Men) How many times in the past year have you had 5 or more drinks in a day? _____
(If over 65) How many times in the past year have you had 4 or more drinks in a day? _____

Have you had a flu shot this flu season? Y / N When? _____

Have you received the shingles vaccine? Y / N

If over 65, have you received the pneumonia vaccine? Y / N

Please list any family health history in first degree relatives only (non-skin related): _____

_____

Pharmacy Information: Preferred Pharmacy:_____

Phone #: _____ City or Zip Code: _____

Review of Systems: Are you currently experiencing any of the following? (Please circle yes or no)

chest pain	Y / N
cough or shortness of breath	Y / N
gastrointenstinal issues including diarrhea or bloody stool	Y / N
headaches or seizures	Y / N
immunosupression	Y / N
autoimmune arthritis (i.e. rheumatoid) or other autoimmune disorder (lupus)	Y / N
fever or chills	Y / N
rash	Y / N
thyroid problems	Y / N
sore throat	Y / N
visual changes	Y / N
joint aches	Y / N
depression	Y / N

Alerts: (please circle yes or no for the following)

artificial heart valve	Y / N
allergy to lidocaine	Y / N
rapid heart beat with epinephrine	Y / N
defibrillator or pacemaker	Y / N
problems with bleeding or clotting including blood thinners	Y / N
pregnant or planning a pregnancy	Y / N
premedication prior to procedures	Y / N
recent travel outside of the country	Y / N

LAKE NORMAN DERMATOLOGY, P.A.

20808 Main Street, Cornelius, NC 28031

Phone: 704-658-9730 **Fax: 704-658-1457**

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this Notice please contact the Privacy Officer.

Valerie Plaska - HIPAAOfficer@lakenormanderm.com

Effective Date: October 1, 2005 **Revised: July 20, 2015**

We are committed to protect the privacy of your personal health information (PHI)

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:
- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: www.lakenormanderm.com

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or lab) who, at the request of your physician, becomes involved in your care.

We may also share your PHI with people that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for, such as:
- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that they will pay for your the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations. Examples:
- Training students, other health care providers, or ancillary staff to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:
- If required by law: In compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: For the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: To a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: To a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.
- Medical research: To researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: To comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object. We may share your information:

- with friends or family members, or other persons directly identified by you at the level they are involved in your care. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information. If you are not present or able to agree /object, the healthcare provider will use professional judgment to determine if it is in your best interest to share relevant information.
- to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- All other uses and disclosures not recorded in this Notice

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights: You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. Written requests should be directed to the privacy officer designated on this Notice.

You have the right to see and obtain a copy of your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information. You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment. **There is one exception**: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations. We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information. You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us. This applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures for the previous six years or a shorter time frame. If you request more than one list within a 12 month period you may be charged a fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints: If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Valerie Plaska, HIPAA Officer, lakenormanderm.com or in writing to 20808 N. Main St, Cornelius, NC, 28031 Attn: HIPAA

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us. If you file a complaint we will not retaliate against you for filing a complaint.

LAKE NORMAN DERMATOLOGY, P.A.

Phone: 704-658-9730 20808 N. Main St, Cornelius, NC 28031 Fax: 704-658-1457

ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE

I. I have received a copy of the HIPAA Privacy Practices for Lake Norman Dermatology and have been provided the opportunity to review it.

Print Name: _____ **DOB:** _____ **Please initial here** _____

Who is your Primary Care Provider _____

DESIGNATION OF DISCLOSURE

Lake Norman Dermatology is authorized to release my protected healthcare information as indicated below. Appointment reminder messages will be left on answering machines/VM, unless we are informed otherwise at the time of each scheduling.

II. **Communication:** **email address:** _____

Home #: _____ Cell #: _____

May leave detailed message with path/lab results:	☐ Home	☐ Cell	☐ with Spouse
Message with call back # only:	☐ Home	☐ Cell	☐ with Spouse
General message (insurance, financial, other)	☐ Home	☐ Cell	☐ with Spouse

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FOR YOUR INFORMATION: Relevant information regarding your medical care, including but not limited to test results, surgeries and procedures will be shared with any physician that has referred you to us; that we have referred you to; home caregivers; or any persons that you have designated in your medical record, as involved in your treatment / medical care.

III. Please list **anyone you WOULD LIKE TO DESIGNATE as persons involved with your health care** or payment relating to health care for disclosure of pertinent medical information. You are not required to list anyone.
DO NOT LIST YOUR PRIMARY CARE PHYSICIAN OR THE DR. THAT REFERRED YOU HERE

Name: _____ Relationship:_____ Phone #: _____

Name: _____ Relationship:_____ Phone #: _____

V. Is there anyone that **IS NOT AUTHORIZED** to receive your patient health information?

Name: _____ Relationship:_____

I understand that I have the right to revoke this authorization at any time and have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where information has already been disclosed, but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____

Signature of Patient / Guardian **Date**

LAKE NORMAN DERMATOLOGY, P.A.

20808 N. Main Street, Cornelius, NC 28031

Phone: 704-658-9730 **Fax: 704-658-1457**

Financial Policy

Lake Norman Dermatology believes that part of a good healthcare practice- patient relationship is to establish and communicate our financial policy to our patients. We are dedicated to providing you with the best possible care, and we want you to completely understand our billing policy.

Payment

- Payment is expected at the time of your visit.
- We accept cash, personal checks, Discover, Visa and MasterCard.
- Payment will include any co-insurance or co-payment amounts that you are responsible for.
- If you do not carry insurance or if your coverage does not include pre-existing conditions, payment is required at the time of service.
- You will be billed separately for biopsy (pathology) and laboratory charges from the facility in which your specimen was submitted. They will also submit the charges to your insurance company.

Insurance

- We are participating providers with most insurance plans (In Network), and must send a claim for every visit.
- We will file the insurance claim(s) on your behalf, and are obligated to file a claim for each visit.
- Your insurance information will be forwarded, with any path or lab tests, to the appropriate facility to be filed.
- You will be billed if your insurance company does not pay within a reasonable period of time. Please remember, insurance is a contact between you, the patient, and the insurance company. Ultimately, the patient is responsible for payment. We will always do what we can to assist you.
- If we receive payment from your insurance after you have paid, we will refund any over-payment accordingly.

Out of Network (If we do not participate with your plan):

- We will prepare and submit the claim for you.
- You may be responsible for payment or partial payment at the time of service.
- The insurance company will most likely send the payment directly to you.

Due to the many different insurance companies, and the variety of plans, we can not guarantee your eligibility and coverage. It helps you to know your coverage.

Referrals

- You are responsible for obtaining a properly dated referral if your insurance policy requires one.
- Referrals are not a guarantee of payment. If the service provided is “not covered” by your plan, they will not cover the charges even if you have obtained a referral.
- Not all plans cover all services.
- If you are seen without a referral and a referral was required by your insurance plan, you will be responsible for the payment. Coverage limits are set by your plan.
- Payment is due upon receiving a statement from our office for all services not covered by insurance.

Returned Checks

- A $35.00 service fee will be charged for every check returned by the bank for insufficient funds.
- You will be required to bring cash or a money order to cover the amount of the check, PLUS the fee.

Accounting

Payments and credits are applied to the oldest balance first, except for insurance payments which are applied to the corresponding dates of service. Accounts with unpaid personal balances will be turned over to a collection agency.

If you have any questions regarding a billing statement, our billing staff will be available to assist you.

I have read and understand this financial policy for Lake Norman Dermatology, and agree to be bound by its terms. I understand that these terms may be amended by the practice from time to time.

_____ _____

Signature of Patient / Responsible Party (if minor) Relationship (if not the patient)

_____ _____

Printed Name of Patient **Date**

LAKE NORMAN DERMATOLOGY, P.A.

20808 N. Main Street, Suite 103, Cornelius, NC 28031
PHONE 704-658-9730 www.lakenormanderm.com FAX 704-658-1457

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of birth: _____
Address: _____
City, State, Zip Code: _____
SS #: _____ Patient's phone #: _____

Date of Request: _____ **Date Needed:** _____

I authorize Lake Norman Dermatology to: OBTAIN INFORMATION / RELEASE INFORMATION
(CIRCLE ONE)

Name of provider or facility: _____
Address: _____
City, State, Zip Code: _____
Phone: _____ Fax: _____

PURPOSE FOR REQUEST: ❒ PCP ❒ Insurance ❒ Relocating ❒ Second Opinion ❒ Changing Provider
❒ Other _____

TYPE OF RECORDS REQUESTED:

- ❒ Immunization history
- ❒ All medical history related to a specific condition: _____
- ❒ All medical history from the dates: _____
- ❒ Treatment summary (includes history/physical, laboratory tests, radiology reports, operative reports, pathology)
- ❒ Specific information
  - ❒ Procedure report ❒ History and Physical ❒ Physical Therapy ❒ Laboratory/Pathology test results
  - ❒ X-ray reports ❒ Other: _____

AUTHORIZATION VALID FOR:

- ❒ This request only
- ❒ One year from the date of this authorization ***OR*** for all records prior to the date _____
- ❒ This request and for medical records of any future treatment of the type described until _____

I understand that:

- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment **information requires additional authorization.**

Charge for this service is as follows, according to North Carolina Law:
.75 per page 1 to 25, .50 per page 26 to 100, .25 per page 101 and over
with a $10.00 minimum plus postage fees

_____ _____
Patient/Legal Guardian Signature Date

_____ _____
Witness Date

For Office Use Only:

Date sent: _____ by: _____
via: ❒ mail ❒ fax
❒ picked up by: _____