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, PA

140 Leaning Oak Dr., Ste 101, Mooresville, NC 28117 704-658-9730

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities - 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.**

Your Rights - When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you, and/or have it transmitted to another person. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (IE: home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices - For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures - How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

  Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

  Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

  Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see:www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your info.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date of Notice: October 1, 2005 Revised: April 5, 2021

Privacy Officer: Valerie Plaska, vplaska@lakenormanderm.com, or write to 140 Leaning Oak Dr, Ste 101, Mooresville, NC 28117

LAKE NORMAN DERMATOLOGY, P.A.

Phone: 704-658-9730 140 Leaning Oak Drive, Suite 101, Mooresville, NC 28117 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 PCP (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:**

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.

140 Leaning Oak Drive, Suite 101, Mooresville, NC 28117

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)
- We will file the insurance claim(s) on your behalf.
- 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.

140 Leaning Oak Drive, Mooresville, NC 28117
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 THIS REQUEST: ❒ Health care ❒ Insurance Coverage ❒ Personal ❒ 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: _____