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**: ______________

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**

History & Intake Form Name:_________________________ Date: ________

Cell Phone #:______________ Home Phone #:_____________ Primary Care Physician: ____________________

Past Medical History: (please circle all that apply)

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

Past Surgical History: (please circle all that apply)

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

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

Melanoma	Acne	Flaking or Itchy Scalp
Squamous Cell Carcinoma	Blistering Sunburns	Hay Fever/Allergies
Basal Cell Carcinoma	Dry Skin	Psoriasis
Actinic Keratoses	Eczema	NONE
Atypical Moles	Excessive Sweating	Other ___________________________

Do you wear sunscreen? Yes No If **yes**, what SPF? ____ Do you have a family history of Melanoma? Yes No

Do you tan in a tanning salon? 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:	**Alcohol use:**	**Women:** How many times in the past year have you had 4 or more drinks in a day? _____
Currently smokes	NONE	**Men:** How many times in the past year have you had 5 or more drinks in a day? _____
Former smoker	less than 1 drink per day	**over 65:** How many times in the past year have you had 4 or more drinks in a day? _____
Has smoked in the past	1-2 drinks per day	
Never smoker	3 or more drinks per day	

If over 19, have you had a flu shot this flu season? Y / N When?_____________ Last DT (tetnus) shot: _____________	If over 50, have you received the shingles (herpes zoster) vaccine? Y / N	If over 65, did you receive 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)

Are you experiencing an itch? Y / N

On a scale of 0 – 10, 10 being the worse, how would you rate the itch? ____

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