INTEGRATED DERMATOLOGY OF NORTH RALEIGH

Integrated Dermatology of North Raleigh
Willis Martin, M.D. • Angela Macri, D.O.
3809 Computer Drive, Suite 200 Raleigh, NC 27609 / Telephone: (919) 782-3782 / Fax: (919) 782-3788

Patient Information (Please Print) **Account Number:**

Patient Name:_____ **Sex:** ☐ M ☐ F **Marital Status:** ☐ S ☐M ☐D ☐W
First Name M.I. Last Name

Address:_____ **Date of Birth:** ____/____/_____ **SSN:**_____-_____-_____

City: _____ **State:**_____ **Zip Code:** _____ **Email:** _____

Telephone Numbers: Home:_____ **Mobile:** _____ **Work:** _____
☐ Preferred ☐ Preferred ☐ Preferred

We attempt to contact the "Home" number for appointment reminders. If you would prefer us to contact you at another number, please check the box below the appropriate number. We will leave a message on the voicemail/answering machine if you are unavailable.

Other Information

Primary Care Provider: _____ **Phone:** _____ **Fax:** _____

Practice Name & Address:_____

Referring Provider:_____ **Phone:** _____ **Fax:**_____
*If different from above
Practice Name & Address:_____

In case of emergency, notify Name:_____ **Phone:** _____

Insurance Information

Primary Insurance Plan Name: _____ **Issuing Employer:**_____

Policy Holder's Name:_____ **Policy Holder's Date of Birth** ____/____/_____

Patient's Relationship to Policy Holder: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

Secondary Insurance Plan Name: _____ **Issuing Employer:**_____

Policy Holder's Name:_____ **Policy Holder's Date of Birth** ____/____/_____

Patient's Relationship to Policy Holder: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

Medical Information

DRUG ALLERGIES ☐ YES ☐ NO Please List:

Current Medication List: _____

_____

PLEASE INFORM THE DOCTOR IF YOU ARE PREGNANT OR NURSING.

Please check all of the following that apply:

☐**Cancer—Type/Location:**_____ ☐**High Blood Pressure** ☐ **Liver disease** ☐**Diabetes**

☐**Heart Disease** ☐ **Heart Surgery** ☐**Heart Valve Replacement** ☐**Pacemaker** ☐**Tuberculosis/Positive TB Test**

☐**HIV/AIDS** ☐**Hepatitis B** ☐**Hepatitis C** ☐**Glaucoma** ☐**Joint Replacement—Location:**_____

Other Health Problems & Surgeries:_____

Reason for Visit: _____/_____/_____

Signature of Patient or Representative **Date**

ASSIGNMENT OF BENEFITS

WE ARE REQIURED BY LAW TO HAVE YOUR SIGNED CONSENT TO FILE YOUR INSURANCE

COMMERCIAL INURANCE PLAN PATIENTS

I agree to allow Integrated Dermatology of North Raleigh to file my insurance on my behalf. I understand that I am responsible for paying any balance not paid by my insurance including my copay, annual deductible, coinsurance, non-covered, and cosmetic charges. I can find further details about Integrated Dermatology of North Raleigh's Financial Policy on their website and by asking the receptionist for a copy. There is also a copy posted in the waiting room.

Patients covered by private commercial insurance plans which our providers are not contracted with are required to pay at the time of service. We will provide an itemized statement for your use in filing a claim to your insurance company.

***I have read and agree to adhere to the payment policies described above.**

Signature of Patient/Patient Representative: _____ Date:_____

TRADITIONAL MEDICARE PATIENTS

We are a participating provider with the standard Medicare Program, accepting assignment on all claims. Any coinsurance or deductible associated with your plan is due at the time of service. For any services not traditionally covered by Medicare you will be asked to sign an Advance Beneficiary Notice (ABN). The ABN will explain the service; ask if you want us to file it with Medicare, and explains that you understand the balance will be your responsibility should it not be covered by Medicare.

Our office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and acknowledge your agreement by providing your signature.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Integrated Dermatology of North Raleigh's providers for any services furnished to me by that provider. I authorize release to Centers for Medicare and Medicaid Services and its agents any medical information about me needed to determine the payments for related services.

Signature of Patient/Patient Representative: _____ Date:_____

If you have a supplemental Medicare insurance policy, also known as a MediGap plan, Medicare will generally cross the claims over automatically. We are required to keep a signature on file for these plans authorizing us to file on your behalf.

I request authorized Medicare supplemental benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to my Medicare supplemental carrier any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient/Patient Representative: _____ Date:_____

MEDICARE ADVANTAGE PLAN PATIENTS

Medicare Advantage plans take the place of traditional Medicare. These plans usually have a copayment which is due at the time of service. There is more information on the Medicare Advantage plans we accept in our Financial Policy which can be found online, posted in the waiting room, and at the reception desk.

I authorize Integrated Dermatology of North Raleigh to file my Medicare Advantage plan on my behalf. I also authorize them to release any medical information needed to my plan to help determine benefits payable for related services.

Signature of Patient/Patient Representative:_____
Date:_____

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Patient Financial Responsibility Form

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the patient, to check with your insurance company regarding your coverage. It is your responsibility to know your individual coverage. Failure to comply could result in you, the patient, being responsible for all costs incurred. Please remember, your insurance policy is between you and your insurance company, not between your doctor and your insurance company.

To assist you in finding out what coverage you have, feel free to ask for assistance in finding phone numbers or addresses of your insurance company. Many insurance companies today need referral forms from a primary care physician or group. If your insurance meets this requirement it will be your responsibility to furnish this referral at the time of service. Failure to do so may require you to reschedule your appointment and/or accept full responsibility for payment. Some insurances state you cannot go out of network. Many companies have instituted a mandatory second opinion program, and these are changing day by day. We cannot keep up with the changes and are often unaware of them until it is too late.

Please call your insurance company and learn about your coverage, it may save a lot of confusion in the long run. Thank you.

This Consent was signed by: _____

Patient Name – Patient Representative

_____ / / /

Signature Date

Relationship to Patient (if other than patient) _____

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE
I hereby authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance, and other health plans to Integrated Dermatology of N. Raleigh, LLC of any medical benefits payable to me for the services provided at Integrated Dermatology of N. Raleigh, LLC. I also authorize the release of all medical information necessary to process insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claims processing or as long as dictated by payor. I understand It is my responsibility to pay any deductible amount, co-insurance, or any other balance deemed patient responsibility by the insurance company. I understand it is my responsibility to pay the balance in full if the insurance information provided proves false or otherwise ineffective. I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to appointment. I will be responsible for the unpaid balance due on any bills if this is not done. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection.
X
Patient Signature or Signature of Guardian or Parent Date
MEDICARE PATIENTS ONLY -Lifetime Signature on File and Lifetime Consent
I request that payment of authorized Medicare benefits be made on my behalf to Integrated Dermatology of N. Raleigh, LLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services. I request that payment of authorized Medigap or secondary insurance benefits be made on my behalf to Integrated Dermatology of N. Raleigh, LLC. I authorize any holder of medical Information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.
X
Patient Signature or Signature of Guardian or Parent Date

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HIPPA 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. This 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: _____

Patient Name – Patient Representative

_____ / / /

Signature Date

Relationship to Patient
(if other than patient) _____

Witness: _____

Patient Name – Practice Representative

_____ / / /

Signature Date

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HIPAA Release of Information

Messages regarding office appointments may be left on my:

☐ Cell phone ☐ Home phone ☐ Work phone
☐ Email ☐ Sent as text to cell

Messages regarding information related to my care may be left on my:

☐ Cell phone ☐ Home phone ☐ Email

It is okay to discuss my health information with:

_____

_____

_____

This HIPPA Release of Information was signed by:

_____
Printed Name – Patient or Representative

_____ _____
Signature Date

Relationship to Patient
(if other than patient):_____

_____

Preferred Pharmacy

Pharmacy Name _____

Address _____

City, State, Zip Code _____

Phone Number _____

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HEALTH QUESTIONNAIRE

Date: _____

Name: _____ Age: _____ Date of Birth: _____

Referred By: _____

Primary Care Physician: _____ Phone: _____

Primary Reason for Your Visit: _____

_____

Duration of Problem: _____

Treatment: _____

Aggravating Factors: _____

Current Medications (please include over-the-counter, herbs, vitamins, supplements): _____

_____

_____

Allergies to Medication: ☐None ☐ _____

Other Allergies: ☐None ☐Latex ☐Bandages/Adhesive

☐Topical Antibiotic (Neosporin or other) _____

Have you ever had a bad reaction to local anesthesia? ☐No ☐Yes ☐Never had anesthesia

FOR WOMEN ONLY:

Are you currently pregnant, trying to become pregnant, or are you nursing? _____

Are you on a contraceptive, and if so, what form? _____

SKIN CONDITIONS:

Have you ever had skin cancer? ☐No ☐Yes

If Yes, ☐Basal Cell Cancer ☐Squamous Cell Cancer ☐Melanoma

Where? _____ When? _____

Treatment? _____

Has anyone in your family ever had skin cancer? ☐No ☐Yes

If Yes, ☐Basal Cell Cancer ☐Squamous Cell Cancer ☐Melanoma

Who? _____

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Do you have any history of skin problems or diseases? ☐No ☐Yes

If Yes, ☐Psoriasis ☐Eczema ☐Keloid ☐Other _____

SUN EXPOSURE:

When you are exposed to the sun do you:

☐ always burn
☐ usually burn, tan minimally
☐ sometimes mild burn, tan uniformly
☐ rarely burn, always tan well
☐ very rarely burn, tan very easily
☐ never burn, tan very easily

Where did you grow up? _____

Did you: ☐ sunburn every summer in childhood
☐ get at least one blistering sunburn, how many _____
☐ ever use a tanning bed, how many times/how often _____

Do you: ☐ Use sunscreen regularly, SPF _____

PAST SURGERIES (Type and Date): _____

_____

_____

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS:

Allergic/Immunologic: ☐Normal ☐Seasonal allergies ☐Immunosuppression ☐Autoimmune problem

Constitutional: ☐Normal ☐Weight loss/weight gain ☐Fever/Night sweats ☐Fainting

Cancer: Type _____

Cardiovascular: ☐Normal ☐Artificial Heart Valve ☐Pacemaker ☐Implanted Defibrillator ☐Irregular Heartbeat ☐Chest Pain/Heart attack ☐Mitral Valve Prolapse ☐Other _____

Ears/Eyes/Nose: ☐Normal ☐Glaucoma ☐Glasses/Contacts ☐Other _____

Endocrine: ☐Normal ☐Diabetes ☐Thyroid Disease ☐Other __ Gastrointestinal: ☐Normal ☐Reflux ☐Liver Problem ☐Nausea ☐Diarrhea ☐Other _____

Genital/Urinary: ☐Normal ☐Enlarged Prostate ☐Prostate Cancer

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Hematologic: ☐Normal ☐Anemia ☐Bleeding Problems ☐Other _____

Infections: ☐Normal ☐HIV ☐Hepatitis ☐Tuberculosis/+PPD Skin Test

☐Other _____

Musculoskeletal: ☐Normal ☐Arthritis ☐Artificial Joint ☐Other _____

Neurological: ☐Normal ☐Stroke ☐Seizures/Epilepsy ☐Multiple Sclerosis

☐Other _____

Respiratory: ☐Normal ☐Asthma ☐Emphysema ☐Other _____

Psychiatric: ☐Normal ☐Depression ☐Anxiety Attacks ☐Other _____

Others: ☐Kidney Problems ☐Cold Sores ☐Varicose Veins

☐Require Antibiotics Prior to Dentistry

Any other medical problems: _____

FAMILY HISTORY: ☐Eczema ☐Psoriasis ☐Other _____

COSMETIC HISTORY: ☐BOTOX Injectable Fillers ☐Laser Treatments

SOCIAL HISTORY:

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow/Widower

Occupation:

_____

Smoking: ☐No ☐Former ☐Yes, packs/day _____

Alcohol: ☐No ☐Yes, how much/often _____

By signing, I am acknowledging that I have disclosed all of my health information known to me at this time, and all of my other personal information is accurate. I understand that it is my obligation and responsibility to notify Integrated Dermatology of North Raleigh of any changes in my medical information during the course of my medical treatment.

SIGNATURE _____ Date _____

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