

Atlantic Dermatology, P.A.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____ have been offered a copy of Atlantic Dermatology, P.A. Notice of Privacy.

Signature of Patient or Guardian

Date

If you would like a copy of our HIPAA guidelines, they are in our lobby

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. We will continue to make reminder calls for patient's appointments.

I wish to be contacted in the following manner (check all that apply):

Home Phone

_____ Okay to leave a message with detailed information.

Cell Phone

_____ Okay to leave a message with detailed information.

*Cell number that you can be reached at _____

Work Phone

_____ Okay to leave a message with detailed information.

Spouse/other & relation

Okay to leave a message with detailed information and disclosing Confidential Medical Information.

Name: _____ Relation: _____

Name: _____ Relation: _____

Patient Signature

Date

Signature of Parent or Guardian

Date

Atlantic Dermatology, P.A.

PATIENT INFORMATION

Please answer all questions

Last Name: _____ First: _____ MI: _____

Birthdate: _____ Sex: _____ Marital Status: _____ SS# _____

Preferred contact (please circle): Home Cell Work | **Consent to text?** Y N | **Email:** _____

Home Phone: _____ Cell: _____ Work: _____

Address: _____ City/State: _____ Zip: _____

Employer: _____

Primary Care Physician: _____ How were you referred: _____

EMERGENCY CONTACT

Name: _____ Phone: _____ Relation: _____

INSURANCE INFORMATION

1. Primary Insurance: _____ Insured's Name: _____ DOB: _____

Relation to Patient: _____ Insured's SS#: _____ Employer: _____

2. Secondary Insurance: _____ Insured's Name: _____ DOB: _____

Relation to Patient: _____ Insured's SS#: _____ Employer: _____

RESPONSIBLE PARTY

****This person must be present and sign this form****

Name: _____ Relation: _____ DOB: _____

SS#: _____ Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Address: _____

(1) Payment is required for all services at the time they are rendered; this may include but not be limited to a co-payment, co-insurance, or your bill in full if your insurance is one we do not file. Some cosmetic procedures may require prepayment.

(2) I authorize the release of medical and personal information which may include but is not limited to; processing of medical claims and referring to other physicians.

(3) I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the cost of the interest, collection and legal action (if required).

(4) My right to payment for all procedures, tests, and nursing/ physician services including major medical benefits are hereby assigned to Atlantic Dermatology, P.A. This assignment covers all benefits under Medicare, and other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will ensure such payment to Atlantic Dermatology, P.A.

(5) I agree to indemnify, defend and hold Atlantic Dermatology, P.A. harmless from any loss, damages, costs, or expenses in connection with false insurance information provided by patient.

(6) I understand that I am responsible for obtaining authorization if required by my insurance.

Patient Signature _____ Date _____

Responsible Party Signature _____ Relation _____ Date _____

OFFICE POLICIES

APPOINTMENTS AND CANCELLATIONS: Patients are seen by appointment. For urgent and acute situations, we often schedule "work-in" appointments. Work-in appointments are made to address one acute problem, only so that patients with scheduled appointments are not kept waiting. Except in emergencies, patients with scheduled appointments will be seen before "work-in" patients.

We work very hard to keep our appointment schedule. However, because we see emergencies in the office there will inevitably be delays. We apologize in advance.

We will call to confirm most appointments two days in advance. If you are more than 15 minutes late by our clock, you will be asked to reschedule your appointment. Cancellations must be made 24 hours prior to your appointment. We charge \$25.00 for missed appointments.

Cancellations for surgical appointments including MOHS surgery must be made 48 hours prior to your appointment. A fee of \$200.00 may apply if a 48-hour notice is not given.

PERSONAL INFORMATION: We handle patient's personal information in a confidential manner, but we may release personal and medical information to another doctor's office in the event of a referral.

INSURANCE: Insurance is a contract between you and your insurance company. We are not involved in that contract. Therefore, we cannot become involved in disputes between you and your insurance company regarding deductibles, co-payments, labs, or other charges. Currently, we file claims for Aetna, BCBS plans that can be filed through NC, Cigna, Coventry National, First Health, Inclusive Health, Humana, Medicare, Medcost, PMCS, United Health Care, and Tricare. For all other insurances, we will provide you with the required information, so you can file your claim with your insurance company. If we are non-participating with your insurance plan, then you will be responsible for payment at the time the services are provided. You will be expected to pay any co-pay, co-insurance and/or deductible required by your insurance at the time of your visit. If there is a change in your insurance carrier, it is your responsibility to inform us prior to your appointment.

To ensure proper filing of your insurance, we require a copy of your current insurance card. If you do not have your current insurance card at the time of your appointment, you will be expected to pay in full. Otherwise, your appointment will be rescheduled.

MINORS: All children under the age of 18 must be accompanied by a parent or guardian. If the parent or guardian is not present, the appointment will be rescheduled. Please do not leave children unattended in the waiting area.

PAYMENT: Payment is due from each patient at the time of service. Some cosmetic procedures may require prepayment. We accept the following payment options cash, check, Visa, Master Card, Discover, and Care Credit. With our Care Credit option, we offer 6 months interest free (with no minimum charge), and 24 months at 14.90% interest with a required minimum charge of \$1000.00. If you are interested in applying for Care Credit, we can do the application process here in our office. It only takes a moment of your time, and we can get your application results within a few minutes. We do not bill parents or guardians not present in the office at the time of their appointment. Patients that are 18 years of age or older, will be responsible for their balance. We will not bill a parent or guardian, you will be responsible for the amount due at the time of service. Patients with co-pays, deductibles, percentages, etc. are due at the time of their appointment. There will be a \$35.00 service fee on all returned checks.

PHONE CALLS: Please be sure to keep us updated with any phone number changes that you may have. We do our best to answer calls in a timely manner. However, there may be times where you will need to leave a message. If you need to leave a message, we will return your call as soon as possible. In an emergency dial 911 first.

REMINDER CALLS: As a courtesy we send out reminder calls the day before your scheduled appointment. However, it is the patient's responsibility to know the date, time and location of their appointment.

AFTER HOURS: We are on call 24 hours a day, available only for urgent issues that cannot wait for the office to open the next business day. To contact us, please call the office number.

ACKNOWLEDGEMENT: I have read, understand, and agree to follow the above office policies.

Patient/Guardian Signature: _____ Date: _____

Printed name of patient: _____

Printed name of guardian and relationship to patient if applicable: _____

Atlantic Dermatology, P.A.

HISTORY AND INTAKE FORM

Patient Name: _____ DOB: _____ Age: _____ Today's Date: _____

Primary Care Physician: _____ Referring Physician: _____

****Referring Physicians & possibly other physicians will be updated of your care unless you circle: Do Not Update**

Please circle "Yes" or "No" for each question

<u>PAST MEDICAL HISTORY</u>					
Anxiety	Y/N	Genital Herpes	Y/N	Lymphoma	Y/N
Arthritis	Y/N	Guilain-Barre	Y/N	Lung Cancer	Y/N
Asthma	Y/N	High Blood Pressure	Y/N	Breast Cancer	Y/N
Atrial Fibrillation	Y/N	Hearing Loss	Y/N	Colon Cancer	Y/N
BPH/Benign Prostate Enlargement	Y/N	Hepatitis B or C (circle one)	Y/N	Prostate Cancer	Y/N
Stroke	Y/N	Crohn's Disease / Ulerative Colitis	Y/N	Multiple Sclerosis	Y/N
COPD	Y/N	Multiple Myeloma	Y/N	Parkinsons Disease	Y/N
Coronary Artery Disease	Y/N	Cold Sores (HSV)	Y/N	Polycystic Ovarian Disease	Y/N
Ovarian Cysts	Y/N	HIV	Y/N	Radiation Treatment	Y/N
Depression	Y/N	High Cholesterol	Y/N	Lupus	Y/N
Diabetes	Y/N	Hyperthyroidism	Y/N	Bone Marrow Transplantation	Y/N
End Stage Renal Disease	Y/N	Hypothyroidism	Y/N	Other _____	
Endocarditis	Y/N	Seizures	Y/N		
GERD/Acid Reflux	Y/N	Leukemia	Y/N		

<u>PAST SURGICAL HISTORY</u>					
Defibrillator	Y/N	Heart Valve Replacement	Y/N	Spleen Removed	Y/N
Breast Biopsy (Right/Left/Bilateral)	Y/N	Year _____ Mechanical or Biological		Skin Biopsy	Y/N
Prostate Biopsy	Y/N	Appendix Removed	Y/N	Kidney Removed (R / L)	Y/N
Gallbladder Removed (Cholecystectomy)	Y/N	Colon Removed	Y/N	Hip Replacement (R / L)	Y/N
Coronary Angioplasty	Y/N	Mastectomy (Right/Left/Bilareral)☐	Y/N	Year _____	
Coronary Artery Bypass	Y/N	Bladder Removed (Cystectomy)	Y/N	Knee Replacement (R / L)	Y/N
Deep Brain Stimulator	Y/N	Hysterectomy	Y/N	Year _____	
Skin: Basal Cell Cancer Surgery	Y/N	Kidney Biopsy	Y/N	Organ Transplant	Y/N
Skin: Melanoma	Y/N	Kidney Stone Removal	Y/N	Year _____ Organ _____	
Skin: Squamous Cell Cancer Surgery	Y/N	Lumpectomy (Right/Left/Bilateral)	Y/N	Other _____	
Tubal Ligation	Y/N	Ovaries Removed (Oophorectomy)	Y/N		
		Pacemaker	Y/N		

<u>SKIN DISEASE HISTORY:</u>					
Acne	Y/N	Eczema	Y/N	Squamous Cell Skin Cancer	Y/N
Actinic Keratoses (Pre-Cancers)	Y/N	Asthma	Y/N	Blistering Sunburns	Y/N
Dry Skin (Xerosis)	Y/N	Hay Fever or Allergies	Y/N	Other _____	
Basal Cell Skin Cancer	Y/N	Melanoma	Y/N		
Poison Ivy	Y/N	Flaking or Itchy Scalp	Y/N		
Dysplastic Nevus (Mild / Mod / Severe)	Y/N	Psoriasis	Y/N		

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HISTORY AND INTAKE FORM (CONTINUED)

Do you wear sunscreen?	Y/N	If yes, what SPF? _____
Do you tan in a tanning bed?	Y/N	
Have any family members had Melanoma?	Y/N	If yes, which relative(s) (i.e. Mother, Nephew)? _____
Do you faint easily with procedures?	Y/N	

MEDICATIONS (Please list all current over-the-counter medications, prescriptions, herbal supplements and vitamins):

ALLERGIES (Please list all allergies and reactions experienced): _____

SOCIAL HISTORY:

Currently Smokes	Y/N	Alcohol Use	Y/N	Drug Use	Y/N
Has Smoked in the Past	Y/N	Number of Drinks per Day: _____		Sexually Active	Y/N

HEALTHCARE MAINTENANCE (most recent):

	<u>MM/YY</u>	<u>MM/YY</u>	<u>Circle One:</u>
Influenza Vaccine (Flu Shot)		Pap Smear	Normal / Abnormal
Pneumonia Vaccine		Colonoscopy	Normal / Abnormal
Shingles Vaccine		Mammogram	Normal / Abnormal

REVIEW OF SYSTEMS: Are you currently experiencing any of the following?

**If yes to any of these symptoms, please follow up with your primary care provider as we only treat dermatological conditions.*

Problems Healing	Y/N	Neck Stiffness	Y/N	Pacemaker / Defibrillator	Y/N
Scarring (Keloid/Hypertrophic)	Y/N	Night Sweats	Y/N	Artificial Joints- Year _____	Y/N
Immunosuppression	Y/N	Shortness of Breath	Y/N	Artificial Heart Valve	Y/N
Changing Mole	Y/N	Sore Throat	Y/N	Blood Thinners	Y/N
Rash	Y/N	Thyroid Problems	Y/N	Pregnant or Planning Pregnancy	Y/N
Abdominal Pain	Y/N	Unintentional Weight Loss	Y/N	Rapid Heartbeat to Epinephrine	Y/N
Bloody Stool	Y/N	Wheezing	Y/N	Yeast Infections with Antibiotics	Y/N
Bloody Urine	Y/N	Leg Discoloration	Y/N	GI Upset with Antibiotics	Y/N
Blurry Vision	Y/N	Leg Swelling or Inflammation	Y/N	Breastfeeding	Y/N
Chest Pain	Y/N	Leg Cramps	Y/N	History of Skin Cancer / DN	Y/N
Cough	Y/N	Restless Leg Syndrome	Y/N	History of Hepatitis	Y/N
Fever or Chills	Y/N	Varicose Veins	Y/N	Dementia / Memory Loss	Y/N
Headaches	Y/N	Urinary Leakage	Y/N	HIV / AIDS	Y/N
Joint Aches	Y/N	Vaginal Dryness	Y/N	Other: _____	
Muscle Weakness	Y/N	Decreased or Lack of Sensation during Vaginal Intercourse	Y/N		

OPTIONAL: Are you interested in Cosmetic or Esthetic Services (Lasers, Fillers, Injectables, Peels, Product, etc.)? Y/N

If Yes, which Specific Services? _____

PHARMACY OF CHOICE: _____

I attest that the information on this form is correct.

Patient Signature (or Guardian) Date

Physician/Nurse

Date