Dermatology
of North Asheville

APPT DATE: _____ / _____ / _____

PATIENT NAME: _____ DATE OF BIRTH: _____ / _____ / _____

Reason for Visit:

_____

_____

1. **Location:** □ Head/neck □ Arms □ Chest/abdomen □ Back □ Genitals □ Legs
2. **Symptoms:** □ Itching □ Pain □ Bleeding
3. **Severity:** □ Mild □ Moderate □ Severe
4. **How long has the condition been present?** _____

CURRENT MEDICATIONS Please list current PRESCRIPTION medications (doses NOT needed; use reverse side if needed)

_____ _____ _____

_____ _____ _____

DRUG ALLERGIES □ No known medication allergies □ Yes, list below and indicate reaction (use reverse if needed)

Medication/Allergen	Reaction
	□ Unknown □ Rash □ Nausea □ Other _____
	□ Unknown □ Rash □ Nausea □ Other _____
	□ Unknown □ Rash □ Nausea □ Other _____

Check if allergic to any of the following: □ Tape □ Latex □ Topical Iodine

PERSONAL MEDICAL HISTORY (Please be sure to check all that apply - past or present)

□ Acne (severe/cystic)
□ Arthritis
□ Asthma
□ Cancer: _____
□ Crohn's disease
□ Depression
□ Diabetes
□ Eczema
□ Gastric reflux
□ Heart attack (yr ___)
□ Heart failure
□ Hepatitis
□ High blood pressure
□ HIV
□ Lupus
□ Migraine
□ Mitral valve prolapse
□ MRSA infection
□ Psoriasis
□ Seizure disorder
□ Skin Cancer
□ Stroke
□ Thyroid disease
□ Tuberculosis
□ Ulcerative colitis
□ Other: _____

SOCIAL HISTORY:

Do you currently use nicotine products?	□ No □ Yes
Do you have a history of severe sunburns as a child?	□ No □ Yes
Have you used tanning beds in the past?	□ No □ Yes
As an adult, have you had severe sun exposure?	□ No □ Yes
Do you take aspirin?	□ No □ Yes
Do you take prescription blood thinners?	□ No □ Yes
Do you have a pacemaker or defibrillator?	□ No □ Yes
Have you seen a dermatologist before?	□ No □ Yes
Do you have any of the following:	□ Light, fair skin □ Blue eyes □ Red hair

DERMATOLOGY OF NORTH ASHEVILLE, PA

PATIENT REGISTRATION SHEET

(***PLEASE PRINT ALL INFORMATION)***

Patient Name: _____
First *Middle Initial* *Last*

Mailing Address: _____ Apt.: #:_____

City: _____ **State**: _____ **Zip**: _____ **Sex**: ☐ M ☐ F **Date of Birth**: _____/_____/_____

Age: _____ **Marital Status:** _____

☐ **Cell Phone**: (_____)_____ ☐ **Home Phone**: (_____) _____ ☐ **Work Phone**: (_____)_____

***** NOTE: Please place check mark beside the number you would like to list as your MAIN contact *****

Email: _____ Do you wish to be emailed about cosmetic specials? ☐ Yes ☐ No

IF PATIENT IS A MINOR, NAME OF PERSON RESPONSIBLE FOR ACCOUNT: _____

RELATIONSHIP TO PATIENT: _____

Employer Name and Address: _____

Work Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Disabled **Full-Time Student**: ☐ Yes ☐ No

Emergency Contact: _____ **Relationship**: _____

Emergency Contact Phone: (_____)_____ ☐ Cell ☐ Home

Primary Care Physician (Name / City, State) _____

Did they refer you to our office? ☐ Yes ☐ No

How did you hear about our office? ☐Family Member ☐Friend ☐Internet ☐Yellow Pages ☐Other _____

Pharmacy Name & Location (*intersection*):_____

***My signature below authorizes my pharmacy to provide my medication list to Dermatology of North Asheville.*

INSURANCE INFORMATION

Are you insured through someone else for your *PRIMARY* insurance? ☐ Yes ☐ No

If yes, what is name of that person: _____ **Their date of birth:** _____

Their relationship to you: ☐ Spouse ☐ Parent ☐ Other_____

Are you insured through someone else for your *SECONDARY* insurance? ☐ Yes ☐ No

If yes, what is name of that person: _____ **Their date of birth:** _____

Their relationship to you: ☐ Spouse ☐ Parent ☐ Other_____

NOTE: Please do not provide Social Security # unless requested by staff as required by certain insurance companies

Office use only: _____

By signing below, I certify that the information provided above is up-to-date and complete.

SIGNATURE: _____ **DATE**: _____

Dermatology
of North Asheville

HIPAA DISCLOSURE FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). Please specify your privacy preferences below.

Dermatology of North Asheville, PA assumes that patients do not give permission for relevant health information to be shared on any answering machine/voicemail or with any person unless otherwise indicated. If you wish to share medical information, please indicate your preferences below.

☐ I GIVE PERMISSION for Dermatology of North Asheville, PA to leave messages concerning relevant health information (biopsy reports, lab results, etc.) on my answering machine/voicemail at the following phone numbers. *(If you prefer that we do not leave messages, then leave this section blank.)*

☐ **Cell phone** ☐ **Home phone** ☐ **Work phone**

☐ I GIVE PERMISSION for Dermatology of North Asheville, PA to disclose relevant health information (my health status, treatment, payment arrangements, etc.) to the individual(s) I have listed below. *(If you prefer that we do not disclose your information to anyone, then leave this section blank.)*

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

PATIENT INFORMATION CONSENT:

I have read and understand Dermatology of North Asheville, PA's Notice of Privacy Practices Summary and Financial Policies, and have been given the opportunity to obtain complete copies of these documents upon request. I understand that Dermatology of North Asheville, PA will use and/or disclose my personal health information (PHI) for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any related administrative operations. I understand that I have the right to restrict how my PHI is used if I notify the practice of my wishes. I understand that Dermatology of North Asheville, PA will consider requests on a case-by-case basis, but is not legally bound to agree to requests for restrictions. I understand that Dermatology of North Asheville, PA does not allow the use of PHI for the purposes of marketing, fund raising, solicitation, or for research studies.

I hereby consent to the use and disclosure of my personal health information for the provision of treatment, payment, evaluation of service quality, or administrative operations. I understand that I am financially responsible for all charges, including those not covered by my insurance company, as well as co-pay and deductible amounts.

_____ **Patient Date of Birth: ____/____/____**
Patient Name (please print)

_____ **Date of Signature: ____/____/____**
Signature of Patient
(or Patient's Qualified Personal Representative)

_____
Relationship to Patient

Dermatology
of North Asheville

FINANCIAL AND PRACTICE POLICIES

Thank you for choosing Dermatology of North Asheville, PA (DNA). Our goal is to focus on providing healthcare services to our patients and to avoid any miscommunication or concern regarding financial matters.

1. **Payment**: **Payment is expected at the time of service**. This includes copays, coinsurance, and deductibles. Copays will be collected at check-in (prior to the visit). Coinsurance and deductibles will be collected at check-out, as final charges will be determined after the patient has been seen.
2. **Payment Types Accepted:**
   - Cash
   - Check (check must be dated for date of service; postdated checks not accepted)
   - Money order
   - American Express
   - Discover
   - MasterCard
   - Visa
3. **Returned Check Fee:** Returned checks will result in a $25 fee.
4. **Insurance** :
   a. **Insurance Card** – Patients must provide a copy of their insurance card at each visit, or as requested by office staff.
   b. **Insurance Claims** – Charges will vary according to the patient's insurance plan and any contractual relationship that may exist between DNA and the patient's insurance company. DNA will file insurance for the patient under most circumstances, assuming the patient provides DNA with current insurance information. Patients are responsible for understanding the details of their insurance coverage as well as required payments. Not all insurance policies cover all services; if the patient's insurance coverage denies payment for services rendered, the patient will be responsible for all remaining charges. Complete and ultimate responsibility for the timely payment of the patient's bills rests with the patient.
   c. **Calendar Year Deductibles** – If DNA has determined that the patient's annual deductible has not been met, we will determine the portion expected to be applied to the patient's deductible, and that amount will be collected at check-out. The insurance claim will then be filed with the insurance company.
   d. **Unpaid Insurance Claims** – If the insurance company has not responded to DNA within 90 (ninety) days of filing an insurance claim, DNA will send charges to the patient and the patient will be responsible for their payment, including any other charges incurred pursuant to this financial policy.
   e. **Non-Participating Insurance –** DNA does not participate with Medicaid; therefore, no claim will be filed with this insurance plan. Patients that have Medicaid as their primary insurance may be seen, however they must pay the full charge at the time of service, understanding that their insurance will not be filed. If Medicaid is secondary to Medicare or other insurance, the patient will be expected to pay the amount not covered by Medicaid at time of checkout.
   f. **Specialist Prior Authorization –** DNA is a specialist provider; some insurance plans require prior authorization for specialist care. If prior authorization is required, it is the sole responsibility of the patient to obtain prior authorization before being seen at DNA. If the patient fails to obtain prior authorization and care is provided, DNA will be unable to file the patient's insurance and the patient will be responsible for the full charge of all services as a Self Pay patient. Failure to obtain prior authorization will not be considered extenuating circumstances for rescheduling, and a patient who fails to give 24-hour notice of cancellation will be subject to any deposits, restrictions or fees pursuant to this financial policy.

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5. **The Release of Medical Records Information** – DNA and the physicians supplied by DNA are authorized to disclose all or any part of the patient's medical record and protected health information for the purposes of treatment, payment, and healthcare operations, including but not limited to disclosures to other healthcare providers, and to such insurance companies, organizations, or agencies as may be concerned with payment of the cost of treatments by physicians and other individuals engaged by DNA.
6. **The Assignment of Benefits** – If the patient is a Medicare beneficiary, the undersigned requests that payment of authorized Medicare benefits be made to DNA, as applicable, and authorizes DNA to submit claims to Medicare for payment . If the patient is not a Medicare beneficiary, the undersigned expressly authorizes payment directly to DNA for healthcare benefits otherwise payable to the patient under the terms of the patient's policy. In making such assignment, the undersigned agrees that in consideration for service to be rendered to the patient by DNA, the patient individually obligates himself or herself to promptly pay to DNA any amounts charged by DNA for the services provided by its physician or other professionals that are not paid under the patient's insurance policies. The undersigned also agrees that if the nature of the patient's illness or injury is not covered at all by his or her Medicare or other insurance policies, the patient will be responsible to DNA for payment of the entire amount due.
7. **Minor Patients** :
   a. **Minors must be accompanied** - A parent or legal guardian must accompany underage patients.
   b. **Charges** – Charges for services rendered to minors are the responsibility of the parent or guardian who seeks treatment for the minor.
   c. **Minor Children of Divorced Parents** – Charges including applicable copays and deductible amounts are due at the time of service from the parent or guardian who seeks treatment for the child, regardless of any court-ordered responsibility for medical costs.
   d. **Financial Responsibility of Both Parents** – The stated terms of this Financial Policy shall not modify the duty of both parents to provide for the welfare of their minor children. We expressly reserve the right to hold either or both parents responsible for any and all reasonable and necessary medical expenses.
8. **Self-Pay**: Patients who have no health insurance are expected to pay in full at the time of service.
9. **Account Balances**:

   Balances – Statements showing patient responsibility are mailed to the patient's address on file. The patient is responsible for promptly paying any balance due. Delinquent accounts will be turned over to a third-party collection agency, which may affect the patient's credit standing. DNA reserves the right to deny scheduling of future appointments until outstanding account balances have been paid, or payment arrangements set up. Account balances which are not paid until reaching a delinquent status will require that all future visits be paid in full at time of service.

   Payment Agreements – DNA accepts and processes debit/credit payments through Easy Pay Solutions, Inc., a secure off-site Cardholder Information Security Program (CISP) member. A one-time authorization can be signed which will allow DNA to charge up to $100.00 to the patient's debit/credit card after the insurance pays their portion. An email can be automatically sent to the patient with the transaction information on the day posted. (NOTE: This same process can be used for monthly payment plans, for which a separate agreement is signed authorizing an approved monthly payment.)

   Overpayments - Patient overpayments on accounts will be processed and refunded on a monthly basis. Balances of $5.00 or less will be written off as a courtesy. Likewise, overpayments of $5.00 or less will be adjusted, and no refund processed.

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10. **Restricted Service**: Old balances on patient accounts are to be paid in full prior to receiving additional routine services. Patients are responsible for contacting DNA if they are unable to pay an old balance or need to set up payment arrangements.

11. **Cancellations:**. Cancellations must be made by the patient (or authorized person) and will only be accepted during business hours, Monday through Thursday from 7:15 AM to 4:30 PM. Exceptions will be made at the sole discretion of Dr. Hutchin on an individual basis for illness and extenuating circumstances.
    a. **No Show for Office Visits:** Patients who fail to give 24-hour notice of cancellation for an appointment will be subject to a rescheduling fee of $50.00. This fee will be assessed on the next appointment or after 12 months of the canceled appointment, whichever is sooner. This fee is non-refundable, and may or may not be applied to the co-pay/charges for the next visit at the discretion of the DNA. Patients that routinely fail to give 24-hour notice of cancellation may be discharged from DNA.
    b. **No Show for Procedures:** Patients who fail to give 24-hour notice of cancellation for a procedure will be required to pay the full cost of the procedure as a deposit prior to rescheduling.

12. **Prescription Prior Authorization Requests:** If a Prescription Prior Authorization is required, the patient is responsible for requesting that the required authorization forms be faxed or sent to DNA. The forms will then be completed and submitted by DNA on behalf of the patient.

13. **Clinical Photography:** Digital photography may be used for coordination of care. Photographs are part of the medical record and are treated as personal health information maintained in a secure, confidential, regulated environment. By signing the HIPAA Disclosure Form, the patient consents to allow clinical photography for the reasons mentioned above. The patient may withdraw this consent at any time.

14. **Collection Costs, Court Costs, and Attorney Fees:**
    a. Accounts will be **turned over to a third party for collection if past due 90 days** or more.
    b. Should a patient account become delinquent and be referred to a third party for collection, the patient will be responsible for all collection costs, court costs, and reasonable attorneys' fees as defined by N.C. GEN. STAT. § 6-21.2.

15. **The non-patient guarantor (parent/legal guardian, etc.) specifically acknowledges that:**
    a. The non-patient guarantor accepts and undertakes this obligation in consideration of their relationship to the patient and in consideration of DNA rendering of services to the patient.
    b. Their obligation under this agreement is an original, direct, independent and positive promise to pay and is not a contingent promise simply to answer for the debt of another. The non-patient guarantor waives presentment, demand, protest and notice of every kind respecting this agreement.
    c. DNA may grant extensions of time for payment at any time and without notice to or without the consent of the non-patient guarantor at the sole discretion of Dr. Hutchin.

By signing the* HIPAA Disclosure Form*, the patient understands, and agrees to the above Financial and Practice Policy outlined above and that the insurance information provided to DNA is correct and complete. The patient agrees to be financially responsible for all charges. The patient had an opportunity to ask any questions prior to signing. This agreement supersedes any previous or subsequent oral or written agreements. The patient understands that charges not covered by their insurance company, as well as fees, co-pays, and deductibles are the patient's responsibility.

PLEASE SIGN THE SEPARATE HIPAA DISCLOSURE FORM

PLEASE DO NOT SIGN THIS PAGE

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SUMMARY OF NOTICE OF PRIVACY PRACTICES

(effective 9/23/2013)

Dermatology of North Asheville, PA has a legal responsibility to protect the privacy of your personal health information (PHI). In addition, we are required by law to provide you with this notice, and to follow the information practices that are described herein. This is a summary statement of how medical information about you may be used and disclosed. A full document is available for your review upon request.

Generally, PHI consists of all information gathered in the course of a patient's treatment in our office, including medical records, lab reports, and insurance information. We use your PHI in all aspects of routine patient care and in the billing process. For example, we may use your PHI to remind you of an appointment, to send a copy of your record to another physicians involved in your care, or to submit information to your insurance carrier about services performed.

Our policy is to obtain your written authorization prior to disclosing your PHI. You will be asked to provide us with a list of persons whom you authorize to obtain your PHI, such as your spouse, child, or friend. In the event that the patient is a minor, the legal guardian will be asked to provide consent for the use of the patient's PHI. Be aware that any authorization you provide can be revoked by you at any time, but must be requested in writing. Under certain circumstances, Dermatology of North Asheville may be required to disclose your PHI as mandated by law, with or without prior authorization. You are entitled to the updates of Dermatology of North Asheville's privacy practices as revisions are made.

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