Dermatology
of North Asheville

APPT DATE: _____ / _____ / _____

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

1. **Reason for Visit:**

_____

_____

2. **Location:** □ Head/neck □ Arms □ Chest/abdomen □ Back □ Genitals □ Legs

3. **Symptoms:** □ Itching □ Pain □ Bleeding

4. **Severity:** □ Mild □ Moderate □ Severe

5. **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 _____

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

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

□ Other: _____

SOCIAL HISTORY:

Do you currently smoke?	□ 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 or blood thinners?	□ No □ Yes
Do you have a pacemaker or defibrillator?	□ 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: _____
Last *First* *Middle Initial*

Mailing Address : _____ Apt.: #:_____

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

Age: _____ **Marital Status**: _____ **Preferred Language**: _____

Race: ☐ Amer. Indian / Alaska native ☐ Asian ☐ Black / African-American ☐ Native Hawaiian / Other Pacific Islander ☐ White

Ethnicity: ☐ Hispanic / Latino ☐ NOT Hispanic / Latino ☐ *I prefer not to provide Race / Ethnicity information*

☐ **Cell Phone**: (_____)_____ ☐ **Home Phone**: (_____) _____ ☐ **Work Phone**: (_____)_____
***** NOTE: Please place check mark beside the number you would like listed 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 and Location: _____

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

INSURANCE INFORMATION

PRIMARY **Insurance**: _____ **Are you the subscriber/insured?** ☐ Yes ☐ No

If no, Name of subscriber: _____ **Subscriber Date of Birth:** _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other_____

SECONDARY **Insurance**: _____ **Are you the subscriber/insured?** ☐ Yes ☐ No

If no, Name of subscriber: _____ **Subscriber Date of Birth:** _____

Relationship to Patient: ☐ Self ☐ 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**: _____

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HIPAA DISCLOSURE FORM

The HIPAA (Health Insurance Portability and Accountability Act of 1996), a federal law privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI).

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

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

☐ I ALSO GIVE PERMISSION for messages regarding relevant health information (appointment reminders, biopsy reports, lab results, etc) to be left on my answering machine / voice mail at the following phone numbers:

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

☐ I **DO NOT** GIVE PERMISSION for Dermatology of North Asheville, PA to disclose relevant health information to anyone other than my healthcare providers. I also prefer that health information (other than appointment reminders) not be left on my answering machine / voice mail.

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

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

Personal representative information (if applicable):

Patient is a minor (____ years of age), I am patient's Healthcare Power of Attorney
OR
Patient is unable to give permission because:_____

_____ _____
Printed Name of Qualified Personal Representative **Relationship to Patient**

_____ **Date of Signature: ____/____/____**
Signature - Authority to act as Patient's Representative

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FINANCIAL AND PRACTICE POLICIES

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

1. **Payment**: **Payment is expected at the time of service**. This includes co-pays, co-insurance, and deductibles. Co-pays will be collected at check-in (prior to the visit). Co-insurance and deductible amounts will be collected at check-out, as they will need to be determined after charges have been posted to your account. (Please note that failure to pay patient portion of charges represents a breach of contract with your insurance company, and future coverage may be denied by your carrier.)
2. **Payment Types Accepted:**
   - Cash
   - Check (must be dated for date of service; no postdated checks will be accepted)
   - Money order
   - American Express
   - Discover
   - MasterCard
   - Visa
3. **Insurance** :
   a. **Insurance Card** – I will provide a copy of my insurance card at each visit, or as requested by office staff.
   b. **Insurance Claims** – I understand that charges will vary according to my insurance plan and any contractual relationship that may exist between DNA and my insurance company. (DNA will file insurance for you under most circumstances as long as you provide us with current information on your insurance plan.) I acknowledge that I am responsible for understanding the details of my insurance coverage as well as required payments. Not all insurance policies cover all services; if my insurance coverage denies payment for services rendered, I will become the responsible party. I understand that my insurance company may not cover all charges and I accept complete and ultimate responsibility for the timely payment of my bills.
   c. **Calendar Year Deductibles** – I understand that if DNA has determined that my calendar year deductible has not been met that DNA will determine the portion expected to be applied to my deductible, and that amount will be collected at check-out. The claim is then filed for processing.
   d. Unpaid Insurance Claims – If my insurance company has not responded to DNA within 90 (ninety) days of filing an insurance claim, DNA will directly send charges to me and I will be responsible for their payment, as well as for payment of any other charges incurred consistent with this financial policy.
   e. **Non-Participating Insurance:** DNA does not participate with Aetna Insurance; therefore, no claims will be filed for Aetna insurance. If primary coverage, the patient may opt to pay at the time of service as self-pay, understanding that insurance will not be filed. If secondary to Medicare or other insurance, the patient will be expected to pay the coinsurance amount at time of checkout.
4. **Consent to release medical records information** – I acknowledge and agree that DNA and the physicians supplied by DNA are hereby authorized to disclose all or any part of my medical record and protected health information for the purposes of treatment, payment, and healthcare operations, including but not limited to disclosures to other treating providers and to such insurance companies, organizations, or agencies as may be concerned with the payment of the cost of treatments by the physicians and other individuals engaged by DNA.

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5. **Consent to treat and assignment of benefits** – If the patient is a Medicare beneficiary, the undersigned requests that payment of authorized Medicare benefits be made on behalf of the patient to DNA, as applicable, and authorizes DNA to submit claims to Medicare for payment to the patient. If the patient is not a Medicare or Medicaid 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, Medicaid or other insurance policies, the patient will be responsible to DNA for payment of the entire amount due.

6. **Minor Patients** :
   a. **Must be accompanied** - A parent or legal guardian must accompany patients who are minors.
   b. **Charges** – Charges for services rendered to minors are the responsibility of the parent who seeks treatment for the minor and applicable co-pays and deductible amounts are due at the time of service.
   c. **Minor Children of Divorced Parents** – Charges including applicable co-pays and deductible amounts are due at the time of service from the parent 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.

7. **Self-Pay**: Patients who have no health insurance are expected to pay in full at the time of service.

8. **Account Balances**:

   Balances – Statements showing patient responsibility are mailed to the patient address on file. Please make prompt payment of any balance due to avoid the account being turned over to a third party collection agency which may affect your credit standing. DNA reserves the right to deny scheduling of future appointments until outstanding account balances have been paid, or payment arrangements set up.

   Payment Agreements – DNA accepts and processes debit/credit payments through Easy Pay Solutions, Inc., a secure off-site CISP (Cardholder Information Security Program) member. A one-time authorization can be signed which will allow DNA to charge approved balances to your debit/credit card after the insurance pays their portion. An email can be automatically sent to you with the debit/credit 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 a monthly debit/credit to your account for an approved amount.)

   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.

9. **Restricted Service**: Old balances on your account are to be paid in full prior to receiving additional routine services. Please contact DNA Billing Office if you are unable to pay an old balance or need to set up payment arrangements.

10. **Cancellations of Scheduled Procedures or Office Visits:** Cancellations must be made by the patient (or authorized person) and will only be accepted during business hours, Monday through Thursday from 7:45 AM to 4:30 PM, and Friday from 7:45 AM to 11:30 AM. Exceptions will be made at the sole discretion of Dr. Hutchin on an individual basis for illness and extenuating circumstances.

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11. **No Show for Scheduled Procedures of Office Visits:** Patients who do not show for their appointments will be subject to a rescheduling fee. This fee will be assessed after the third appointment which you do not call to cancel or reschedule, or after the second such instance within the same month. A $50.00 fee will be required to reschedule the appointment. This fee will be non-refundable, but can be applied to the co-pay/charges for the next visit for which you are seen.

12. **Prior Authorization Requests:** If a Prior Authorization request is required, it is the patient's responsibility to request that the specific forms required be faxed or sent to DNA at which point we will complete and submit.

13. **Cancer Policy Forms:** Effective August 1, 2012, there is a $10 charge (per form) for the completion of all cancer policy forms. This fee must be paid at the time of form submission. DNA requires 7-10 business days for form completion.

14. **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 below you give consent to allow clinical photography for the reasons mentioned above. You may withdraw this consent at any time.

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

16. **The non-patient guarantor (parent/legal guardian, etc.) specifically acknowledges that:**
    a. The non-patient guarantor accepts and undertakes this obligation in consideration of his/her relationship to the patient and in consideration of Dermatology of North Asheville's rendering of services to the patient.
    b. His/her 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. He/she waives presentment, demand, protest and notice of every kind respecting this agreement.
    c. Dermatology of North Asheville, PA, may grant extensions of time for payment at any time and without notice to or without the consent of the non-patient guarantor.

By signing this sheet, I certify that I have read, understand, and agree to the above Financial and Practice Policy outlined above and that the insurance information given by me to DNA is correct and complete . I agree to be financially responsible for all charges. I have had an opportunity to ask any questions prior to signing. This agreement supercedes any previous or subsequent oral or written agreements. I understand that charges not covered by my insurance company, as well as fees, co-pays, and deductibles are my responsibility.

_____ Patient Date of Birth**:** ____/____/_____
Patient Printed Name

_____ Date of Signature: ____/____/_____
Patient Signature or Authorized Person

_____
Relationship to Patient

Failure to sign and accept financial responsibility for services rendered may result in cancellation of your appointment/denial of service.

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