Central Dermatology Center

(Please print legibly, and complete all fields)

Patient Name_____
Last First Middle

Address_____
Street & Apartment # City State Zip

Home Phone (_____) _____- _____ **Cell** (_____) _____- _____ **Work** (_____) _____-_____

Email _____@_____ To be used for clinical communication (appointment & care reminders, medical information & test results) and practice communication (announcements, newsletters, specials & events). We will never share or sell your email address. At any point, you may unsubscribe or opt-out of one or both types of communication.

Communication Preferences: Check ONLY one box for each type of communication

Appointment & Care Reminders (Check ONLY one)**:** □ Call Home □ Call Cell □ Text □ Email

Medical Information or Test Results (Check ONLY one)**:** □ Call Home □ Call Cell □ Call Work

Date of Birth ____/_____/_____ **Age** _____ **SS#** _____-___-_____ **Gender**_____

Marital Status: Single Married Divorced Separated Widow/er

Ethnicity: (Please circle) Hispanic Non-Hispanic **Preferred language**_____

Race: (Please circle) African American/ Caucasian /Asian/American Indian /Alaska Native/Native Hawaiian/ Pacific Islander/Mixed Race/Other

Patient's Employer _____

Emergency Contact (Name) _____ **Relationship** _____

Emergency Contact: Home/Cell Phone _____ **Work Phone** _____

Primary Care Physician (First AND Last Name) _____

How did you hear about Central Dermatology Center? (Please circle)

Established Patient Physician Friend/Family Google Other _____

Facebook Instagram Insurance Company Digital Ad/Email

If you were referred by a physician, please list their name _____

Primary Health Insurance Company _____
Policy/ID # _____ **Group/ Plan #** _____
Policy Holder Name: _____ **Policy Holder DOB:** _____

Secondary Health Insurance Company _____
Policy/ID # _____ **Group/ Plan #** _____
Policy Holder Name: _____ **Policy Holder DOB:** _____

I understand that office visit charges are payable on the day the service is rendered. I authorize Central Dermatology Center to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Central Dermatology Center and myself.

Signature _____ **Date** _____

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby consent to the use or disclosure of my identifiable health information ("protected health information") by Central Dermatology Center, P.A. in order to carry out treatment, payment, or health care operations. I have been given the opportunity to review Central Dermatology Center, P.A.'s Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information. I have the right to review such Notice prior to signing this consent form

Central Dermatology Center, P.A. reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If Central Dermatology Center, P.A. does changes the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice by requesting the Notice from the Front Office Staff of Central Dermatology Center, P.A.

I retain the right to request that Central Dermatology Center, P.A. further restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. Central Dermatology Center, P.A. is not required to agree to such requested restrictions; however, if Central Dermatology Center, P.A. does agree to my requested restriction(s), such restriction(s) are then binding on Central Dermatology Center, P.A.

At all times, I retain the right to revoke this Consent. Such revocation must be submitted to the Central Dermatology Center, P.A. in writing. The revocation shall be effective *except* to the extent that the Central Dermatology Center, P.A. has already taken action in reliance on the Consent. *Central Dermatology Center, P.A. may refuse to treat you if you do not sign this Consent Form* (except to the extent that Central Dermatology Center, P.A. is required by law to treat individuals). If you (or authorized representative) sign this Consent Form and then revoke consent, then Central Dermatology Center, P.A. has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Facility is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT, OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENTER TO THE ABOVE STATED TERMS.

Date _____ Time _____AM/PM _____/_____
Signature of Patient Date of Birth

_____
Please Print Name

_____
Person Signing on Behalf of Patient/ Relationship

_____
Please Print Name

Phone Consent: I authorize the physicians and staff of Central Dermatology Center, P.A. to:
(Please circle to indicate your preference, and list the preferred phone number)

- Leave a message on my answering machine on Home/Cell Phone? **NO YES Tel #**_____
- Leave a message at my place of employment? **NO YES Tel #** _____
- Discuss my medical condition with a member of my household **NO YES Tel #** _____
  - **If yes, whom** _____ **Relationship** _____

Signature _____**Date** _____
(If the patient is under 18, a parent or guardian must sign. If the patient is over 18, the patient must sign for themselves.)

CONSENT FOR MINOR TO PRESENT THEMSELVES FOR TREATMENT

I, _____, give my consent for my son/daughter _____ **to bring himself/herself** to the office for routine health care, which may include diagnosing and the treatment of presenting problems. This consent shall be effective from the date of my signature until the date I terminate it in writing or at the time a minor consent for treatment is no longer needed.

Parent's Signature _____ **Date** _____

Witness _____ **Date** _____

Central Dermatology Center

Patient Rights

As a patient in our practice, Central Dermatology Center, P.A., we would like to share with your rights as a patient, outlined by the American Medical Association's Council on Ethical and Judicial Affairs Code of Medical Ethics.

1. You have the right to get information and guidance from the provider on the benefits, risks, and costs of the correct treatment options.
2. You have the right to obtain copies or summaries of your medical record and have questions answered.
3. You have the right to be made aware of possible conflicts of interest that your provider may have.
4. You have the right to make decisions about health care recommendations by the provider, accepting or refusing those recommendations.
5. You have the right to be treated with courtesy and respect, and to receive timely attention to your needs.
6. You have the right to confidentiality, except when the law provides otherwise.
7. You have the right to available adequate health care. This is a goal toward which physicians and all providers along with society should strive.

Please confirm that you have received and reviewed this information by signing below.

Thank you for allowing us the privilege of providing your care.

Signature_____ **Date** _____

Central Dermatology Center

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any medical services being rendered.

1. FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS WE HAVE A CONTRACT WITH YOUR INSURANCE COMPANY.
2. WE ACCEPT CASH, CHECKS, VISA, AMERICAN EXPRESS, MASTERCARD AND DISCOVER.
3. WE OFFER AN EXTENDED PAYMENT PLAN FOR SURGERIES WITH PRIOR APPROVAL FROM OUR OFFICE MANAGER.

Regarding Insurance:

We may or may not accept assignment of your insurance benefits. If assignment is taken, you will still be responsible for any deductibles or copayments at the time services are rendered. Your insurance policy is a contract between you and your company; we are not a party to that contract unless we also have a contract with your company. If your insurance company has not paid on your claim within 45 days, you will automatically be responsible for the balance.

Please be aware that some, and perhaps all, of the services provided may be deemed non-covered services or not medically necessary under Medicare and/or other medical insurance programs.

Regarding insurance plans where we are a participating provider, all copayments and deductibles are due at the time services are rendered. In the event your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraphs.

Usual and Customary Rates:

Our practice is committed to providing the best treatment to our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. The only exception to this policy is a plan where we are a contracted participating provider.

Missed Appointments/ No-Shows:

Unless cancelled at least 24 hours in advance, missed routine appointments will be charged a no-show rate of $50.00 and missed surgical appointments will be charged a no-show rate of $150.00 for the second no-show, and any no-show after.

Minor Patients:

The adult parent accompanying the minor is responsible for payment of the minor's patient's account regardless of who the insurance policyholder is. For unaccompanied minors, non-emergency treatment will be denied unless the minor is prepared to pay when services are rendered.

I authorize Central Dermatology Center, P.A. to release my information, including the diagnosis and records of any treatment(s) or examination(s) rendered to me or my child, to my insurance company(s) necessary to process claims. I also authorize and request my insurance company(s) to make payment of any medical benefits directly to the physician or Central Dermatology Center, P.A.

THANK YOU FOR UNDERSTANDING THE NECESSITY OF OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING THE ABOVE FINANCIAL POLICY.

I HAVE READ, UNDERSTAND, AND AGREE TO THIS FINANCIAL POLICY.

_____ _____

Signature of patient (If patient is under 18, a parent or guardian must sign. If the patient is over 18, they may sign for themselves.) **Date**

Updated 09/09/2020

Central Dermatology Center

History and Intake Form

Patient Name: _____ Date of Birth: _____ Date: _____

(FOR PATIENTS 18 YEARS AND YOUNGER) Height: _____ Weight: _____

Primary Care Physician: (name, location) _____

Preferred Pharmacy: (name, city) _____

REASON FOR VISIT:_____

Past Medical History: (circle all that apply)

Anxiety	Depression	Hepatitis	Breast Cancer
Arthritis	Diabetes	High Cholesterol	Colon Cancer
Asthma	End-stage Renal Disease	Hyperthyroidism	Prostate Cancer
Atrial Fibrillation	Epilepsy	Hypothyroidism	Pacemaker
Stroke	GERD	Immunosuppression	Radiation Therapy
COPD	High Blood Pressure	Liver Disease	Bone Marrow Transplant
Coronary Artery Disease	Hearing Loss	Leukemia	Seizures
Chemotherapy treatment	HIV/AIDS	Lymphoma	Valve Replacement
Other:		Lung Cancer	**NONE**

Past Surgical History: (circle all that apply)

Breast Implants	Tubal Ligation	Ovaries removed (cyst, ovarian cancer)	Hip Replacement (R, L, bilateral)
Breast Reduction	Heart Valve replacement	Pancreas removed	Knee replacement (R, L, bilateral)
Coronary Artery Bypass	Hysterectomy	Prostate removed (cancer)	Heart Transplant
Kidney Transplant	Lumpectomy (R, L, bilateral)	Spleen removed	Liver Transplant
Colostomy	Mastectomy (R, L, bilateral)	Kidney removed	

Other: **NONE**

Skin Disease History: (circle all that apply)

Acne	Dysplastic (atypical) mole	Hay fever/Allergies	Squamous Cell Skin Cancer
Actinic Keratosis (pre-cancers)	Eczema	Malignant Melanoma	Rosacea
Basal Cell Skin Cancer	Asthma	Psoriasis	

Other: **NONE**

Do you have **family** history of Malignant Melanoma? Yes / No If **yes**, which relative? (please circle) Parent / Sibling / Child

Do you have a **family** history of a non-melanoma skin cancer? Yes / No

Medications: Please list your current prescription and over the counter medications. *You may skip this section if providing a printed list to our rooming staff.*

_____ _____ _____

_____ _____ _____

_____ _____ _____

Drug Allergies: _____

Cigarette Smoking Never Smoker Former Smoker Current Every day Smoker Current smoker (less than daily)

Alcohol Use None Less than 1 drink a day 1-2 drinks a day 3 or more drinks a day

FOR PATIENTS 65 AND OLDER (circle yes or no):

Have you received a Pneumonia Vaccination? Yes / No

Do you have a health care proxy in the event you are unable to make your own medical decisions? Yes / No

Central Dermatology Center

Review of Systems:

Are you currently experiencing any of the following?

(please check yes or no for the following).

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
Immunosuppression		
Chest pain		
Shortness of breath		
Rash		
Changing mole		
Dry skin/lips		
Nosebleeds		
Unintentional weight loss		
Change in appetite		
Headaches		
Ringing in the ears		
Blurry vision		
Abdominal pain		
Bloody stool		
Joint aches		
Anxiety		
Depression		
Thoughts of hurting yourself or others		
Fever/chills		
Night sweats		
Sore throat		
Cough		
Muscle weakness		
Nausea or vomiting		
Irregular periods		
Seizures		
Dizziness		
Heat or cold intolerance		
Loss of taste/smell		
Body/muscle aches		
Bipolar Disorder		
Hidradenitis Suppurativa		

Other Symptoms:

_____

Alerts:

Are any of the following true for current health?

(please check yes or no for the following)

Alert	Yes	No
Pregnancy or planning a pregnancy		
Defibrillator		
Pacemaker		
Blood thinners		
Artificial heart valve		
Premedication prior to procedures		
Artificial joints in past two years		
Taken isotretinoin in the last year		
Immunosuppression		
HIV		
Hepatitis B or C		
History of Cancer		
History of Melanoma		
Allergy to lidocaine		
Allergy to adhesive		
Allergy to topical antibiotic ointments		
Rapid heartbeat with epinephrine		
Yeast infections with antibiotics		
Gastrointestinal upset with antibiotics		
Breastfeeding		

Central Dermatology Center

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU REQUIRE MORE INFORMATION, PLEASE CONTACT OUR HIPAA COMPLIANCE OFFICER AT THE CONTACT INFORMATION AT THE END OF THIS NOTICE.

At CDC we understand that your medical information about you and your health is personal. Our practice is committed to protecting your medical information. We are required by federal and state laws to maintain the privacy of your Protected Health Information (**PHI**) and to give you this notice explaining our privacy practices with regard to that information. This notice explains your rights and our legal obligations regarding the privacy of your **PHI**. Protected Health Information is information that individually identifies you. It may be used and disclosed by your physician, our office staff, another health care provider, your health plan, your employer, or a healthcare clearing house that relates to (1) your past, present, or future physical conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information.

For your Treatment: Your **PHI** may be provided to a physician or healthcare provider (a specialist or laboratory) to whom you have been referred, to ensure they have the necessary information to diagnose, treat or provide you a service.
For Payment: Your **PHI** may be used and disclosed to enable us to bill and either collect payment from you, a health plan or a third party for the treatment and services you receive from us. As an example, we may need to give your health plan information of your treatment in order for your health plan to agree payment for that treatment.
For Health Care Operations: We may use and disclose your **PHI** in order to support the business activities of your physician's office. These activities include, but are not limited to, the evaluation of our team members in caring for you, quality assessment, the disclosure of information to physicians, nurses, medical technicians, medical students and other authorized personnel for educational and learning purposes. We participate in Organized Health Care Arrangements with providers in the UNC Health Alliance and the UNC Senior Alliance. We may use your PHI for our own health care operations and for those of the Organized Health Care Arrangements in which we participate.
Appointment Reminders/Treatment Alternatives/ Health-Related and Services: We may use and disclose your **PHI** to contact you to remind you that you have a scheduled medical appointment or to advise you of treatment options or alternatives or health related benefits and services which may be of interest to you.
As required by Law: We will disclose your **PHI** about you when required to do so by international, federal, state, or local law.
Marketing & any purposes which require the sale of your information: These disclosures require your written authorization.
Any other uses and Disclosures not recorded in this Notice will be made only with your written authorization. You may revoke the authorization at any time by submitting a written revocation and we will no longer disclose your **PHI**, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION.
The Right to Inspect and Copy: Under federal law you have the right to inspect and copy you **PHI** (we have up to 30 days to make your **PHI** available to you, fees may apply). You have a right to a Summary of your **PHI** instead of the entire record, or an explanation of the **PHI** which has been provided to you so long as you agree to this alternative form and agree to pay the associated fees.

The Right to an Electronic Copy of Electronic Medical Records: You have the right to request to be given to you or have transmitted to another individual or entity, an electronic copy of your medical records, if they are maintained in an electronic format. We will make every effort to provide the electronic copy in the format you request however if it is not readily producible by us we will provide it in either our standard format or in hard copy form (fees may apply).

Central Dermatology Center

NOTICE OF PRIVACY PRACTICES

The Right to Request Restrictions: You have the right to request a restriction or limitation on the **PHI** we use or disclose for treatment, payment, or health care operations. You may ask us not to use or disclose any part of your **PHI** and by law we must comply when the **PHI** pertains solely to a health care item or service which the health care provider involved has been paid out of pocket in full. You also have the right to request a limit on the **PHI** we disclose about you to someone involved in your care or payment of your care. Your request must be made in writing to our HIPAA Compliance Officer with specific instructions. If we agree to the restriction, we may only be in violation of that restriction for emergency treatment purposes. By law, you may not request that we restrict the disclosure of your **PHI** for treatment purposes.

The Right to Get Notice of a Breach: You have the right to be notified upon a breach of any of your unsecured **PHI**.

The Right to Request Amendments: If you feel that the **PHI** we have is incorrect or in complete, you may ask us to amend the information. A request and the reason for the requested amendment must be made in writing to the HIPAA Compliance Officer at the information at the end of this Notice. In certain cases we may deny your request. If we deny your request you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy.

The Right to an Accounting of Disclosures: You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred six years prior to the date of request. Your request must be made in writing and you must indicate in what form you want the list, for example on paper or electronically. The first accounting of disclosures in any 12 month period will be free. Any additional requests within that same time period we may charge reasonable costs. You may withdraw or modify your request before the costs are incurred.

The Right to Request to Receive Confidential Communications: You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you on a specific telephone number. Your request must be made in writing with specific instructions on how and where we contact you. We will accommodate all reasonable requests and will not ask the reason for your request.

Complaints:

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with us you must make it in writing to our HIPAA Compliance Officer at the information at the end of this Notice. Complaints must be submitted within 180 days of when you knew of or suspected the violation. **There will be no retaliation against you for filing a complaint.**

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W. Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hippa/ for more information. **There will be no retaliation against you for filing a complaint.**

If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer, Chris Bullock, in person or by phone at the number listed at the bottom of this Notice. You have the right to request a paper copy of this Notice at any time even if you have agreed to receive this Notice electronically. A copy of this Notice may also be found on our website

Please sign below to acknowledge you have received or have been given the opportunity to receive a copy of our Notice of Privacy Practices.

Signature _____ **Date** _____