PATIENT REGISTRATION FORM

Social Security Number_____-_____-_____ Age: _____ Race: _____

Name: _____
(Last) (First) (M.I.)

Address_____

City_____State _____ Zip Code_____

Home Phone (___)_____ Cell Phone (___)_____Drivers License # _____

Date of Birth_____/_____/_____ Male_____Female_____ Single_____Married_____Other_____

Employer _____Work Number (___)_____

Name of Referring Physician/Facility_____

Insurance Policy Holder(s)

Name (If other than patient) _____Relationship to Patient_____

Full Address (If different than patient's)_____

Policy Holder's Date of Birth _____/_____/_____ SS # _____/_____/_____

Policy Holder's Employer _____Work Phone (____)_____

Emergency Contact

Name _____Relationship to Patient_____

Address_____ Phone # (____)_____

ALL THE ABOVE INFORMATION MUST BE COMPLETED IN FULL

I authorize the release of any medical records necessary to process claims and payment of medical benefits. I understand that I am financially responsible for the full cost of any procedure(s) performed by the physician. I give the attending physician my permission to examine and treat me performing any necessary procedures and dispensing any necessary medications to treat my condition(s). My signature signifies that I understand these policies and that the above information is accurate and true to the best of my knowledge.

Signature _____ Date _____

North Carolina Center for Dermatology
Medical History Form

Patient Name _____ Date of Birth____/____/____ Age____

Primary Care Physician_____
Are you allergic to any medications? Yes No (circle one)
If "yes" please list_____
Medications currently taking (please list name, dosage and directions): _____
_____
_____

Current medical conditions: (check all that apply)

____Diabetes ____High Cholesterol ____Hepatitis B
____Lung Cancer ____Arthritis ____Hepatitis C
____Skin Cancer ____Asthma ____HIV/AIDS
____Prostate Cancer ____Migraines ____Other (please list)
____Heart Disease ____High Blood Pressure _____
____Liver Problems ____Anemia _____

Recent changes in health: (check all that apply)

____Weight Change ____Irregular Heart Rhythm ____Hair Loss ____Shortness of Breath
____Special Diet ____Bone Fractures ____Dry Skin ____Unusual Bleeding
____Vision Problems ____Osteoporosis ____Rashes ____Urinary Problems
____Hearing Problems ____Arthritis (aching) ____Heartburn ____Hypertension
____Vertigo ____Muscle Weakness ____Swollen Glands ____Dizziness
____Diarrhea ____Numbness in limbs ____Difficulty Swallowing ____Anxiety
____Chronic Coughing ____Nose Bleeds ____Depression
____Constipation ____Other (please describe) _____

Social History:

Do you work? Yes No If yes, where do you work? _____
What are your activities at work? _____
What do you do for recreation? _____
Are you around animals? Yes No If yes, what kind? _____
Do you travel? Yes No Overseas_____ Domestic_____
Has any family member ever had Skin Cancer or a chronic skin condition? Yes No (circle one)
If yes, describe _____
Marital status: Single Married Widowed Divorced
Do you have children? Yes No
Do you smoke? Yes No If yes, how many packs a day? _____
Do you consume alcohol? Yes No If yes, how many drinks a week? _____
Is your mother still living? Yes No (circle one)
If no, please list cause of death_____
Medical condition(s) she had_____
Is your father still living? Yes No (circle one)
If no, please list cause of death_____
Medical condition(s) he had_____
Do you use sunscreen/sun block?
Level of sun exposure: Frequent Occasional Rare

Cosmetic Interest: (Please check all that apply)

____Acne ____Skin care advice
____AHA and Glycolic Peels ____Skin care products
____Birthmarks ____Skin rejuvenation
____BOTOX Cosmetics ____Spider vein treatment
____Liver spots/ Age spots ____Sunscreen advice
____Removing leg veins ____Other, please specify: _____

Physicians or Nurse Signature_____Date_____

THE NORTH CAROLINA CENTER FOR DERMATOLOGY, PA

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

The patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") by the North Carolina Center for Dermatology in order to carry out treatment, payment, or health care operations. The patient should review the Facility's Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosure of such information, and the patient has the right to review such notice prior to signing this consent form.

Facility reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If the facility does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice.

Patient retain the right to request that the Facility further restrict his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Facility is not required to agree to such requested restrictions; however, if the Facility does agree to Patient's requested restriction(s), such restrictions are then binding on the Facility.

At all times, Patient retains to revoke this Consent. Such revocation must be submitted to the Facility in writing. The revocation shall be effective *except* to the extent that the Facility has already taken action in reliance on the Consent.

The Facility may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that the Facility is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consents, the Facility has the right to refuse to provide further treatment to Patient 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 SEALED [SEALED SIGNATURES ARE OPTIONAL] DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date: _____Time_____AM/PM _____
Signature of Patient

_____
Please Print Name

_____ _____
Signature of Witness Person Signing on behalf of Patient*

_____ _____
Please Print Name Please Print Name

PATIENT FINANCIAL POLICY

Thank you for choosing the North Carolina Center for Dermatology. We are committed to your treatment being successful. Please take a minute to understand your financial obligations.

FULL PAYMENT OF PATIENT OBLIGATIONS SUCH AS CO-PAYS, CO-INSURANCES, DEDUCTIBLES, OR COSMETIC PROCEDURES IS DUE ON DATE OF SERVICE. PLEASE BE ADVISED THAT ALL LABS ARE A SEPERATE CHARGE THAT WILL BE BILLED BY EITHER GREENSBORO PATHOLOGY OR LABCORP.

We accept:
Cash, Checks, Visa, MasterCard, & American Express
(There is a $25 return check fee.)

You must cancel your appointment within 24 hours. There is a **$25 "NO SHOW"** fee for all regular appointments and a **$50 "NO SHOW"** fee for all surgery and cosmetic appointments missed that are not cancelled or rescheduled at least 24 hours before the appointment time. This must be paid before your next visit. **MULTIPLE NO SHOWS MAY RESULT IN TERMINATION FROM THE CLINIC!!!!**

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits please be aware that some or perhaps all of the services provided may not be covered. These will be 100% payable by you. It is up to you to make sure that we participate with your carrier, that you know your benefit coverage, and you obtain all necessary pre-certifications. **HAVING INSURANCE BENEFITS, REFERRALS, AND PRE-AUTHORIZATIONS IS NOT A GUARANTEE OF PAYMENT FROM YOUR INSURANCE COMPANY.**

All balances not paid within 90 days will be turned over to collections.

I have read and agree to this financial policy:

_____ Date: _____
Signature of patient or responsible party

The North Carolina Center for Dermatology

Notice of Privacy Practices

WE ARE COMMITTED TO PROTECTING THE PRIVACY OF YOUR HEALTH INFORMATION. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of our privacy practices explains:

1. How we may use and disclose your health information in the course of providing treatment and services to you.

2. What rights you have with respect to your health information. These include the right:

    - To inspect and obtain a copy of your health information.
    - To request that we amend health information in our records
    - To receive an accounting of certain disclosures we have made of your health information.
      To request that we restrict the use and disclosure of your health information.
    - To request how and where we contact you about medical matters.
      To receive a copy of this Notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We are committed to protecting the privacy of health information about you and that can identify you, which we call "protected health information". Protected health information includes information about your past, present or future health, healthcare we provide you and payment for your healthcare contained in the record of care and services by The North Carolina Center for Dermatology. Our privacy practices concerning your protected health information are as follows:

We will safeguard the privacy of protected health information that we have created or received.

We will explain how, when and why we use and/or disclose your protected health information.
We will only use and/or disclose your protected health information as described in this notice.

WHO WILL FOLLOW THIS NOTICE?

Any healthcare professional authorized to enter information into your medical record at The North Carolina Center for Dermatology.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION:

The following categories describe different ways that we may use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within at least one of the categories.

For Treatment. We may use your protected health information to provide, coordinate or manage your health care treatment and related services. This may include communication with other health providers regarding your treatment and coordinating and managing your health care with others. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. The doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. We may also disclose your protected health information to people, such as home health providers, who may be involved in your medical care after you leave our care.

For Payment. We may use and disclose your protected health information to other providers so they may bill and collect payment for treatment and services they provided to you. Before you receive scheduled services, we may share information about these services with your health plans) to obtain prior approval or to determine whether your insurance will cover the treatment. We may also share your medical information with billing and collection departments or agencies, insurance companies and health plans to collect payment for services, departments that review the appropriateness of the care provided and the costs associated with that care and to consumer reporting agencies (e.g., credit bureaus). For example, if you have a broken leg, we may need to give your health plans) information about your condition, supplies used (medications or crutches), and services you received (x-rays or surgery). This information is given to our billing agency and your health plan so we can be paid or you can be reimbursed.

For Health Care Operations. We may use and disclose your protected health information for health care operations. These uses and disclosures allow us to improve the quality of care we provide and reduce health care operations to include the following:

- Reviewing and improving the quality, efficiency and cost of care that we provide to you and other patients.
- Evaluating the skills, qualifications, and performance of healthcare providers taking care of you.
- Providing training programs for students, trainees, health care providers or non-health care professionals (for example, billing clerks) to help them practice or improve their skills.
- Cooperating with outside organizations that assess the quality of care we provide.
- Cooperating with outside organizations that evaluate, certify or license health care providers, staff or facilities n a particular field or specialty. For example, we may use or disclose protected health information so that one of our nurses may become certified in a specific field of nursing.
- Assisting various people who review our activities. Protected health information may be seen by doctors reviewing services provided to you, and by accountants, lawyers and others who assist us in complying with applicable laws.
- Conducting business management and general administrative activities related to our organization and service that we provide.
- Resolving grievances within our organization.
- Complying with this Notice and with applicable laws.

Appointment Reminders. We may use and disclose health information to provide a reminder to you about an appointment you have for treatment.

Treatment Alternatives. We may use and disclose your protected health information to manage and coordinate your health care and inform you of treatment alternatives that may be of interest to you. This may include telling you about treatments, services, products and/or other health care. providers.

Business Associates. There are some services provided in our organization through contacts with business associates. For example, we may use a copy service to make copies of your medical record. When we hire companies to perform these services, we may disclose your health information to these companies so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your protected health information.

Individuals Involved in Your Care or Payment for Your Care. We may share your information with a family member or other person identified by you or who is involved in your care or payment of your care. If you do not want health information about you released to those involved in your care, please call 1-800-688-1867. We will comply with additional state law confidentiality protections if you are under the age of 16 and receive treatment for pregnancy, drug and/or alcohol abuse, venereal diseases or emotional disturbances.

SPECIAL SITUATIONS.

We may use and disclose protected health information about you for a number of circumstances in which you do not have to consent, give authorization or otherwise have an opportunity to agree or object. Those circumstances include:

As Required by Law. We will disclose your protected health information when required to do so by federal, state or local law or other judicial or administrative proceedings. For example, we may disclose your protected health information in response to an order of a court or administrative tribunal.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent or reduce the threat.

Public Health Risks. We may disclose your health information to appropriate government authorities for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability To report deaths and births.
- To report child care abuse or neglect.
- To report reactions to medications or problems with products. To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading the disease
- To notify the appropriate government authority if we believe an adult patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required by law.
- To support public health surveillance and combat bioterroism.

Health Oversight Activities. We may. disclose your health information to a federal or state oversight agency that is authorized by law to oversee our operations.

Law Enforcement. We may release health information if asked to do so by a law enforcement official and such release is required or permitted by law. For example, we may disclose your protected health information to report a gunshot wound. However, if you request treatment and rehabilitation for drug dependence from us, your request will be treated as confidential and we will not disclose your name to any, law enforcement officer unless you give consent. .

Lawsuits and Disputes. If you are involved' in a lawsuit or a dispute, we may disclose your health information in response to a court or an administrative order. We may also disclose your health information in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. All research projects, however, are subject to a special approval process. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We may, however, use medical information about you in preparing to conduct a research project, for example, to look for patients with specific needs, so long as the medical information reviewed dots not leave our entity.

Specialized Government Functions. We may disclose protected health information about you if it relates to military and veterans' activities, national security and intelligence activities, protective services for the President, and medical suitability or determinations of the Department of State.

Workman's Compensation. We may release your health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your health information to the correctional institution or law enforcement official. This release is required: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; and (3) for the safety and security of the correctional institution.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. Also, when consent to disclosure is required by state law, your consent will be obtained prior to such disclosure. If you provide us permission to use or disclose your health information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your health information for the reasons covered by your written authorization. We are unable to take back any disclosures that we have already made with your permission. We are required to retain records of the care that we provided to you.

North Carolina Law. In the event that North Carolina Law requires us to give more protection to your health information than stated in this Notice or required by Federal Law, we will give that additional protection to your health information. For example, we will comply with additional sate law confidentiality protections relating to communicable diseases, such as HIV and AIDS. We will also comply with additional state law confidentiality protections relating to treatment for mental health and drug or alcohol abuse. Those laws generally require that we obtain your written consent before we disclose information related to your mental health, developmental disabilities or substance abuse services, subject to certain exceptions permitted by law, such as disclosure to other facilities or professionals when necessary to coordinate your care or treatment or to a health care provider in an emergency. Also, state law permits a hospice, home health, ambulatory surgery or outpatient cardiac rehabilitation patient to object in writing to having state licensing inspectors review their health information during a licensure survey, and we will comply with such written objection.

Right to Request Restrictions. You have the right to request that we restrict the use and disclosure of your protected health information. We are not required to agree to your requested restrictions. And, if we agree to your request, there are certain situations when we may not be able to comply with your request. These situations include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services and uses and disclosure that do not require your authorization.

Right to Request Alternative Ways of Communication. You have the right to request how and where we contact you about your medical matters. For example, you may request that we contact you at your work address or phone number. Your request must be in writing. We will accommodate reasonable requests, but when appropriate, may condition that accommodation on your providing us with information regarding how payment, if any, will be handled and your specifications of an alternative address or other method of contact.

Right to Paper Copy this Notice. We will provide a paper of this notice to you no later than the date you first receive service from us.

Contact for Questions or Complaints. Please call our office at (919) 484-9551 .

Changes to this Notice. We reserve the right to change the terms in this Notice and to make new notice provisions effective for all protected health information that we maintain by:

- Posting the revised notice at our facilities.
- Making copies of the revised notice available upon request.