CARY DERMATOLOGY CENTER, P.A.
101 S.W. Cary Parkway • Suite 210 • Cary, N.C. 27511 • (919) 467-8556

Date ________________ Patient Data No. ______________

Patients Please Complete This Section

It is our desire to reach you in the most efficient manner so we request that you provide ACCURATE information. When providing contact information please note that appointment reminder calls are made in the evening hours *two days prior to your appointment.* Other calls may be made during regular business hours.

1. **Best Phone Number to Reach You for Appointment Reminders (*Evenings*):** ______________________________
2. **Best Phone Number to Reach You Regarding Your Medical Care (*Daytime*):** _________________ **Ext.** _________
3. **Alternate Phone Number:** ______________________________

Patient Information

Social Security# ____________________________

Name ____

Address _______________________________ City_____________ State______ Zip ________

Birth date ________________Sex ____ M_____F Marital Status ______________Race______

Patient Employed by __________________________ Occupation ______________________

E-Mail Address ____

How did you hear about our office? ____

In case of emergency who should be notified? _______________________________________

Relationship _________________________________ Phone __________________________

Is there someone other than the patient who should be contacted regarding medical care?

Name_______________________________________ Phone___________________________

Relationship: Caretaker/Medical POA/Other (Please Specify) ____________________________
(Daughter, Son, Etc.)

Primary Insurance

Person Responsible for Account ____

Relation to Patient ______________ Birth Date ___________ Last 4 Digits SS# ___________

Address (if different from patient's) _______________________ Phone __________________

City _________________________________ State ___________ Zip __________________

Person Responsible Employed by________________ Occupation______________________

Business Address ___________________________ Business Phone ___________________

Insurance Company ____

Group # _______________________________ Subscriber _____________________________

Additional Insurance

Is patient covered by additional insurance? ______Yes ______No

Subscriber Name _______________ Relationship to patient________ Birth date _____________

Address (if different from patient's) _______________________ Phone __________________

City _________________________________ State ___________ Zip __________________

Subscriber Employed by __________________________ Business Phone _______________

Insurance Company ________________________ Last 4 Digits SS# ____________________

Group # ________________________________ Subscriber # __________________________

I certify that the information above is accurate and complete.

_______________________________________ ____________________
Signature Date

CHANGES TO PATIENT INFORMATION

NAME ____ DATE ____________________________

NEW ADDRESS_________________________________ NEW HOME PHONE ________________

CITY_________________ STATE_______ ZIP_______ NEW WORK PHONE ________________

NEW EMPLOYER __________________________________

NEW HEALTH INSURANCE COMPANY ____

CONTRACT# ______________________ GROUP#______________ SUBSCRIBER # _________

INSURED'S NAME (if different from patient) ____

NAME ____ DATE ____________________________

NEW ADDRESS_________________________________ NEW HOME PHONE ________________

CITY_________________ STATE_______ ZIP_______ NEW WORK PHONE ________________

NEW EMPLOYER __________________________________

NEW HEALTH INSURANCE COMPANY ____

CONTRACT# ______________________ GROUP#______________ SUBSCRIBER # _________

INSURED'S NAME (if different from patient) ____

NAME ____ DATE ____________________________

NEW ADDRESS_________________________________ NEW HOME PHONE ________________

CITY_________________ STATE_______ ZIP_______ NEW WORK PHONE ________________

NEW EMPLOYER __________________________________

NEW HEALTH INSURANCE COMPANY ____

CONTRACT# ______________________ GROUP#______________ SUBSCRIBER # _________

INSURED'S NAME (if different from patient) ____

CARY DERMATOLOGY CENTER, P.A.

MEDICAL HISTORY

Patient ____ Date: ________________________ Age_________
Referred by _______________________________ Personal Physician ____
Reason for today's visit ____
Are you allergic to any medications? ❒ Yes ❒ No If yes, list ____
____
List all Medications you are currently taking:
____
____
Preferred Pharmacy:______________________ Location:_______________________________ Phone:___________
Do you have now, or have you ever had diseases or conditions below: (please check YES or NO)

Lungs	**YES**	**NO**
Bronchitis	❒	❒
Emphysema	❒	❒
Asthma	❒	❒
Chronic Cough	❒	❒
Morning Cough	❒	❒
Vascular:		
High Blood Pressure	❒	❒
Chest Pain	❒	❒
Heart Attack	❒	❒
Heart Murmur	❒	❒
Irregular Heartbeat	❒	❒
Pacemaker	❒	❒
Heart Valve Problems	❒	❒

Other Systemic:	**YES**	**NO**
Diabetes	❒	❒
Thyroid	❒	❒
Kidney	❒	❒
Bladder	❒	❒
Stomach	❒	❒
Bowel	❒	❒
Hepatitis or Yellow Skin	❒	❒
Glaucoma	❒	❒
Arthritis/Joint Deformity	❒	❒
Convulsions, Epilepsy	❒	❒
or Seizures	❒	❒
Fainting	❒	❒
Do you bleed easily?	❒	❒
(Women) Are you Pregnant?	❒	❒
Do you have artificial joints(s)	❒	❒

Do you drink alcohol? ❒ YES ❒ NO If Yes_______ drink per day
Do you use IV drugs? ❒ YES ❒ NO If Yes, what _______________ how much? ______________
Do you smoke: ❒ YES ❒ NO If Yes, how much: __________________
Have you had or have you been exposed to HIV (AIDS)? ❒ YES ❒ NO
Have you ever had dental anesthesia (Novacaine) ❒ YES ❒ NO Any bad reaction? ❒ YES ❒ NO

Skin:
When you are exposed to sun do you: ❒ Tan only ❒ Tan and burn ❒ Burn
Have you ever had skin cancer? ❒ YES ❒ NO
Has anyone in your family had skin cancer? ❒ YES ❒ NO If YES, who? _________________
Do you have a history of any specific skin diseases? ❒ YES ❒ NO
If YES, please list: ____
List any other disease or condition we should know about: ____________________________________
List any surgical procedures you have had in the last 6 months: _________________________________

COSMETIC INTEREST(S)
Skin care issues of interest to you (please check all that apply):
❒ BOTOX® Cosmetic (Botulinum Toxin Type A)
❒ Dermal Fillers (Juvederm,Radiesse)
❒ Hair Removal
❒ Skin Rejuvenation(Facial Treatments, Product Recommendations)

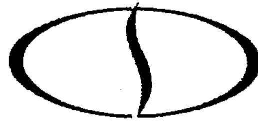
Please answer the following questions:

What is your occupation? ____
What are your hobbies? ____
Has anyone in your family been seen in our office? ❒ YES ❒ NO

If yes, please give name and relationship ____

Completed by: ❒ Patient ❒ Parent
❒ Medical Assistant _________

Signed by Physician ____ Date __________________________________



CARY DERMATOLOGY CENTER, P.A.

COMBINED CONSENT AND AUTHORIZATIONS

Consent for Release of Information

With my consent, Cary Dermatology Center, P.A./Your Touch at Cary Dermatology may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Cary Dermatology Center, P.A.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, Cary Dermatology Center, P.A. /Your Touch at Cary Dermatology may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Cary Dermatology Center, P.A/Your Touch at Cary Dermatology may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Cary Dermatology Center, P.A./Your Touch at Cary Dermatology may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Cary Dermatology Center, P.A./Your Touch at Cary Dermatology restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I understand the medical information to be disclosed may include information regarding psychological or psychiatric impairment, a communicable disease (such as sexually transmitted disease, HIV/AIDS, tuberculosis or hepatitis), mental illness, alcohol or substance abuse.

Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents, or other parties unless you object.

I understand that treatment will not be conditioned upon my completion of this authorization.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

By signing this form, I am consenting to Cary Dermatology Center, P.A./Your Touch at Cary Dermatology's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Receipt of Notice of Privacy Practices

I am a patient of Cary Dermatology Center, P. A. I hereby acknowledge receipt of Cary Dermatology Center, P. A.'s Notice of Privacy Practices.

Signature: ____ Date: ______________________________

OR

I am a parent or legal guardian of ________________________________ [patient name]. I hereby acknowledge receipt of Cary Dermatology Center, P. A, 's Notice of Privacy Practices with respect to the patient.

Name [please print]: ______________________________________

Relationship to Patient: ❒ Parent ❒ Legal Guardian

Signature: ____ Date: __________________________

FOR CARY DERMATOLOGY CENTER, P.A. USE ONLY

If acknowledgement of receipt of the Notice of Privacy Practices is not obtained from the patient or patient's representative, please explain your efforts to obtain acknowledgement and the reason you could not obtain it:

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CARY DERMATOLOGY CENTER

Alexander Chiaramonti, MD, Robert B. Johnson, MD, Catherine Hren, MD, Heidi Mangelsdorf, MD,
Christine L. Benigar, PA-C, Maybelle M. Madlock, PA-C

Payment required at the Time of Service

Payment is required at the time of service. This policy applies to applicable and estimated deductibles and co-payments under your health insurance plan. If you do not have health insurance, we require full payment at the time of service. We require full payment for all non-covered service, including cosmetic services, at the time of service.

We accept cash, personal checks, Master Card, Visa and Discover. ***There is a $25.00 charge for returned checks.***

Policy for Handling Insurance

Our office participates with the following health insurance plans: Blue Cross and Blue Shield, Aetna, Cigna, Medicare and Physicians Care. If your plan requires a referral, it is your responsibility to obtain this prior to your visit. Because each plan is different we may not have all the details of your insurance benefits. Some of your questions are best answered by a representative of your insurance company. If we are a network provider for your insurance company we will submit the claim on your behalf.

As a courtesy to our senior citizens we will file with all Medicare Advantage and supplemental plans. However, we are not in network providers with every Medicare Advantage or supplemental plan. It is best that you confirm with a representative from your insurance plan what benefits are available for a visit with us.

When you come for your visit, please bring with you a current insurance card and a photo ID. If you do not present current insurance information, we automatically consider you a self- pay patient. After we have accurate information on your insurance eligibility and coverage, we will file a claim with your insurance company. In some cases, your insurance company may not cover the medical services that we provide. In this case, you will be financially responsible for the services you receive.

If we are a participating provider with your insurance plan you are responsible for any co-payment and/or deductibles at the time of service. In some cases we are unable to confirm what that will be. If this is the case, we will swipe your credit card and ask you to sign a receipt agreeing to pay up to the authorized amount. Once we hear back from your insurance company your card will be charged only the amount your insurance company indicated is your responsibility.

Notice to Medicare Patients

The providers of care in this facility have made a commitment to the Medicare program and to you as our patients. We assure you that our providers will deliver to you medical care of the highest quality possible.
We will abide by the Medicare rules and regulations in the delivery of care.

As physician(s) contracted with your Medicare program to provide services to the Medicare patient, only services that are defined as medically necessary can be charged to the Medicare Program.

When services are requested that are defined by Medicare as not medically necessary or excluded as cosmetic, we will advise you in writing why Medicare considers the service to be noncovered. This will be done prior to your decision to schedule the procedure.

The cost of such a procedure will be discussed with you prior to your determination to schedule the procedure to be performed. The payment for the procedure will be solely your responsibility. We will not bill any medically unnecessary or cosmetic procedure to your Medicare carrier or any other insurance entity.
We are committed to you and to the Medicare program to bill for services provided to you accurately and timely. Should we fail to fulfill your expectations we would appreciate your speaking to us about your concerns. We can only serve you and meet your expectation if you let us know your needs.

Should any person in this facility fail to address your concerns you are requested to report that failure to the Compliance Officer Alexander Chiaramonti, M.D. at (919) 457-8556.

Multiple Procedures during One Visit

If you are here for multiple procedures, the provider will determine whether or not to perform all of these procedures during the same office visit or to schedule them on a future date. We cannot guarantee multiple procedures on the same day of service. Your insurance company may have one co-payment for the office visit and a deductible for a procedure. In addition, if we provide a non-covered service during the same visit as a medical visit, then you will have two separate charges.

If the Patient is a Minor

A parent or legal guardian accompanying a minor is responsible for the payment of the patient's account, regardless that holds the insurance policy. Unaccompanied minors can be denied non-emergent treatment until a parent or legal guardian is present, or until we receive written permission for the treatment and payment of the account. Unaccompanied minors must provide all co-pays and other payments on the day of service.

We require all minors to be accompanied by a parent or legal guardian for the initial visit. Following the initial visit, we will see minors without a parent or guardian if the parent or guardian has provided written permission for treatment.

Refunds

If an overpayment is made to your account, we will process refunds no later than the 15th of the month following the month in which we received the overpayment. If your treatment is ongoing, at your request, we will apply the overpayment to any future balances.

Collection Agency

Patients who have an outstanding balance of more than sixty (60) days must make arrangements for payment prior to scheduling future appointments. If payment arrangements are not made and the account is more than ninety (90) days delinquent, the account may be turned over to a collection agency.

Missed Appointments/Late Cancellations

If you need to cancel an office visit, please notify our office at least 24 hours prior to the appointment time so we can offer this time to another patient. If you fail to keep your appointment or cancel without proper notification there will be a $25.00 fee. If you are unexpectedly delayed, please contact our office.

If you need to make special arrangements, please let us know prior to your examination. We will accommodate your needs to the best of our ability.

Assignment of Benefits and Guaranty of Payment

I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act, for any government benefits or for any insurance benefits is correct. I hereby authorize payment of health insurance, government of other third party benefits directly to Cary Dermatology Center, P. A.

I understand that I am financially responsible for, agree to pay and guarantee payment in full of any and all charges for services provided to me by Cary Dermatology Center, P. A. even if such treatment is not covered by insurance. I understand that my bill will be sent to my address on file unless I complete a request for my bill to be sent to alternate address.

I understand and agree to the financial policies of Cary Dermatology Center, P. A.

Signature:

____Date:__________

Name [please print]:

____

Relationship to Patient: ❒ Parent ❒ Legal Guardian

Signature:

____Date:______________

CARY DERMATOLOGY CENTER, P.A., 101 SW CARY PARKWAY, SUITE 210, CARY, NC 27511
PHONE: 919-467-8556 - FAX: 919-380-1480

Consent for Treatment of Minor Child

I, being the parent or guardian of ___________________________, do hereby request and authorize the physicians and staff of **Cary Dermatology Center, P. A**. to perform necessary services for my child which are deemed advisable by the physician, whether or not I am present at the actual appointment.

Below is a list of individuals who have permission to bring my child in for treatment:

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______________________________________	______________________
Signature of Parent or Guardian	Date and Time
______________________________________	______________________
Witness	Date and Time

THIS FORM SHOULD BE WITNESSED BY A MEMBER OF THE CARY DERMATOLOGY STAFF. IF YOUARE UNABLE TO ACCOMPANY YOUR CHILD TO HIS/HER INITIAL APPOINTMENT, YOUR SIGNATURE MUST BE NOTARIZED.