WESTGATE
DERMATOLOGY & LASER CENTER

Please bring this form with you to your appointment.

Patient Information: *(please complete using your name as listed on your insurance card)*

Last Name: _____ First Name: _____ Middle Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: M F

Home Phone: (____) _____ Work Phone: (____) _____ Cell: (____) _____

Social Security Number: _____

Which Provider are you going to see? _____

Did a Physician refer you to our clinic? Y N Name of Referring Physician: _____

Referring Physician Practice Name: _____ Phone #: _____

Status: *Please Circle* Single Married Divorced Widow/Widower Student

Employer: _____ Occupation: _____

Employer Address: _____ Employer Phone Number: _____

Insurance Information: *All Patients must provide a copy of their insurance card at their visit*

Who is Responsible for Bill? _____

Address of Responsible Party: _____

Phone Number of Responsible Party: (____) _____

Social Security Number: _____ Date of Birth: _____ Sex M F

Primary Insurance: _____ _____ Relationship to Patient: _____

Policy #: _____ Group #: _____

Secondary Insurance: _____ _____ Relationship to Patient: _____

Policy #: _____ Group #: _____

Additional Patient Information: Email Address: _____

Were you referred by a patient seen in our practice? Y N If yes, name of Patient: _____

Emergency Contact Information

Name: _____ Phone Number: _____ Relationship: _____

Pharmacy Information

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Street/City: _____ Pharmacy Fax Number: _____

Primary Care Physician All referring and consulting physicians will receive a copy of our findings regarding your visit. If your primary care physician did NOT refer you to our clinic, but you would like a copy of your records faxed to their office, please check this box ☐.

Primary Care Physician: _____ Phone # _____

I have read and filled out the above information to the best of my knowledge.

_____

Patient's Printed Name

→ _____

Patient's Signature *Date*

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as describe below but not to exceed the reasonable and customary charge for those services.

→ _____ **SIGNED (Insured Person)**

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment to specific insurance carriers, third party payers or others involved in processing and collection of this claim.

→ _____ **SIGNED (Patient, or Parent if Patient is a Minor)**

I am legally authorized to provide consent on behalf of the patient. My relationship to the patient is best described as ☐ Parent or Guardian ☐ Health Care Power of Attorney, or other (Please specify:_____)

→ _____

Signature of Authorized Individual *Printed Name* *Date*

*Please note that minors **unaccompanied** by a parent or legal guardian will not be seen on their initial visit. Follow up visits of minors unaccompanied by a parent or legal guardian require a pre-authorized consent to treat the patient. More information can be obtained by contacting our office.*

For Office Use

Date of Initial Visit: _____ Medical Record #_____

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PATIENT'S AUTHORIZATION REQUEST FORM

Please bring with you to your appointment

You may give the providers and staff of Westgate Dermatology and Laser Center, P.A. written authorization to disclose your protected health information (PHI) to anyone you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the following information below. Completion of this form will not change the way Westgate Dermatology and Laser Center, P.A. communicates with you as a patient. For example, we will send statements, appointment reminders, give path results, etc. when appropriate.

Patient's Name: _____ Date of Birth: _____

Responsible Party (if the patient is a minor) _____

Patient's Social Security Number: _____

At my request, I authorize Westgate Dermatology and Laser Center, P.A. to disclose my Protected Health Information to: (enter name of person/entity who will receive PHI):

(1) _____ (2) _____

Name Relationship to Patient Name Relationship to Patient

I would like this authorization to expire on ___/___/_____. If no date entered, this authorization will **NOT** expire.

I understand that I may revoke this authorization at any time by giving the Westgate Dermatology and Laser Center, P.A. written notice. However, if I revoke this authorization, I also understand that the revocation will not affect any action Westgate Dermatology and Laser Center, P.A. took in reliance of this authorization before Westgate Dermatology and Laser Center, P.A. received my written notice. I understand that the practice will not condition the way medical treatment will be given because of this authorization. I also understand that if the persons or entities I authorize to receive my PHI are not health plans, covered health care providers, or health care clearing houses subject to the Health Insurance Portability and Accountability Act (HIPAA) or other federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by HIPAA or federal health information privacy laws. A copy of Westgate Dermatology's Notice of Privacy Practices has been made available to me.

Should we need to speak with you concerning lab results, pathology reports, appointments or general information, and cannot reach you, may we leave a message? Yes or No (circle). If yes:

Authorization to leave a telephone message: _____
Signature

Please list telephone number(s): _____

Email address for future cosmetic announcements and specials: _____

Signature: _____ Date: _____

This form has two (2) pages
Please bring this with you to your appointment

Patient Name: _____ **Birth Date:** _____ **Height:** _____ **Weight:** _____
Please answer all of the questions as accurately as possible.

Primary Care Doctor: _____

Doctor Requesting Consultation: _____

Drug Allergies: _____

Past Medical History: Have you ever had the following:

AIDS/HIV	Yes	No	Easy Bleeding/Bruising	Yes	No	Kidney Disease	Yes	No
Anemia	Yes	No	GI/Bowel Disease	Yes	No	Mitral Valve Prolapse	Yes	No
Arthritis	Yes	No	Glaucoma	Yes	No	Rheumatic Fever	Yes	No
Asthma	Yes	No	Heart Disease/Attack	Yes	No	Stomach Ulcer	Yes	No
Breast Disease	Yes	No	Hepatitis	Yes	No	Stroke	Yes	No
Cancer	Yes	No	High Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Diabetes	Yes	No	High Cholesterol	Yes	No	Tuberculosis	Yes	No

List previous surgeries or major illnesses requiring hospitalization and dates:

_____

_____

List any medications you are taking, including non-prescription drugs, vitamins, and herbals:

_____

_____

_____

_____

Review of Systems: Mark any of the following which you have had in the past year.

Cardiovascular			**Constitutional**			**Gastrointestinal**			**Neurological**	
Chest pain	Y	N	Fever	Y	N	Abdominal pain	Y	N	Numbness	Y N
Leg swelling	Y	N	Weight loss	Y	N	Nausea/Vomiting	Y	N	Weakness	Y N
Heart failure	Y	N	Night sweats	Y	N	Blood in stool	Y	N		
Blood clots in legs	Y	N	Chills	Y	N					
Musculoskeletal			**Lymphatic/Hematologic**			**Genitourinary**			**Respiratory**	
Arthritis	Y	N	Enlarged lymph nodes	Y	N	Blood in urine	Y	N	Cough	Y N
Joint pain	Y	N	Easy bleeding	Y	N	Pain with urination	Y	N	Wheezing	Y N
Skin			**Eyes**			**Ear/Nose/Throat**				
Keloid scars	Y	N	Tearing	Y	N	Mouth ulcers	Y	N		
Non-healing lesions	Y	N	Blurred vision	Y	N	Sore throat	Y	N		

Family History: Has any blood relative ever had the following:

Breast Cancer	Yes	No	Heart Disease	Yes	No	Melanoma	Yes	No
Depression	Yes	No	High Blood Pressure	Yes	No	Skin Cancer	Yes	No
Diabetes	Yes	No	Kidney Disease	Yes	No	Stroke	Yes	No

Social History:
Do you use tobacco? (Type & Amount Per Day)_____ Date quit:_____

Do you drink alcohol (Type & Amount Per Week) _____

Do you use a tanning bed? (How often)_____

Female Patients: Are you pregnant (Yes or No) _____

Do you have anyone in household that can help you with wound care Y N if yes, who?
_____

Have you ever had Skin Cancer? (If yes, list type, date and location):_____
_____

Do you take any medications that thin the blood (e.g. Coumadin, Plavix, Asprin) or do you have any known problems with proper blood clotting? Y N If yes, please explain:_____
_____

Have you had hepatitis Y N If yes, was it hepatitis A, B, or C? (Circle one)

Do you have an implantable defibrillator? Y N

Do you have a pacemaker? Y N

Have you had a joint replacement (e.g. knee or hip) pins in broken bones, artificial heart valves or cosmetic implants? Y N If yes, please explain what and when it was done? _____
_____

Do you have a history of a heart murmur? Y N

Do you have any immune system problems? (e.g. HIV/AIDS, leukemia, current chemotherapy, lupus, previous organ transplant? Y N If yes, please explain_____
_____

Do you have any psychological or emotional problems? (including anxiety, depression or significant claustrophobia) Y N If yes, please explain _____
_____

Have you ever had cold sores on the lips? Y N

Do you form excessively large scars or keloids? Y N

Do you require antibiotics before procedures or dental work? Y N

Have you been exposed to significant amounts of arsenic in medications or pesticides, or have you been exposed to other carcinogens in large amounts? Y N If yes, explain _____

Have you been exposed to radiation or had radiation therapy? Y N If yes, explain_____
_____

Do you have any history of memory loss? Y N If yes, please ask for a separate sheet to fill out.

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X_____ _____
Signature of patient or parent if minor Date

Provider Initials _____ **Clinical Staff Initials** _____

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PATIENT FINANCIAL RESPONSIBILITY

The providers and staff of Westgate Dermatology and Laser Center, P.A. appreciate the confidence you have shown in choosing us to provide for your health care needs. We recognize the need for our patients to have a clearly stated policy regarding payment for medical services. The following is our Patient Financial Responsibility Policy:

Your agreeing to receive services at Westgate Dermatology and Laser Center, P.A. implies a financial responsibility on your part. This responsibility obligates you to payment in full of our fees. As a courtesy, we will bill your primary and secondary insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. Please remember that an insurance contract is between the patient and his or her insurance company, not between the Provider and the insurance company. This office does not accept responsibility for collecting your insurance claim or for negotiating a disputed claim.

As a patient, it is in your best interest to know and understand your responsibility for any co-payment, deductible and/or co-insurance as determined by your contract with your insurance carrier prior to your visit. Not all services are covered in all insurance contracts. If your insurance plan does not cover a service or procedure, you may be liable for full payment of the bill.

There are no "free" visits. Any time you are seen by one of our providers there will be a charge for their services. There are limited exceptions to this rule. Your insurance contract specifies what services are considered no charge.

Your insurance company should provide an Explanation of Benefits (EOB) which shows the amount you are responsible for. Your insurance benefits determine this amount. We only bill you for what your insurance benefits do not cover. This may be listed on the EOB as a co-pay, co-insurance and/or deductible.

For all patients with a co-payment we expect your co-payment portion to be paid at the time of service. Failure to pay your required co-pay will result in your appointment being rescheduled. We do not set your co-pay amount, your insurance company does. This amount should be listed on your insurance card or benefits summary. Your insurance company requires that we collect the co-payment at time of service. Insurance contracts obligate patients to pay co-pays and doctors to collect them.

All surgical patients are expected to pay their portion (patient responsibility) of the surgical bill before having surgery. You will be notified of the amount due before your surgery appointment. If you cannot pay, your surgery will be rescheduled. The amount we collect is an ESTIMATE and is based on information that your insurance carrier(s) provide to us. The final amount that you will be responsible for may be different. Any balance due must be paid in full within 30 days after claim settlement. Any overpayments will first be applied to unpaid balances; any remaining credit will be refunded by company check within 30 business days.

Surgical Missed Appointments: Patients scheduled for surgery that miss their appointments will be required to pay a $200.00 deposit when rescheduling their surgery. This payment will be credited to your account and will remain until your insurance claim is paid. If there are any funds remaining from your deposit, they will be applied to any past due balance. Any credit amount remaining on your account after your insurance pays and past due amounts are paid will be refunded to you by company check within 30 business days.

You are responsible for providing proof of insurance at each visit to our office and to notify us if your insurance, benefits, address or phone number(s) change. You will be asked to provide a Picture ID, Social Security # and your insurance card. This is for your protection against insurance fraud and for proper filing of claims.

Patients who want our office to file their insurance claims for them must provide their Social Security Number (in the case of a minor, the policy holder's SSN). Patients who do not provide their SSN must pay in full for all services at their time of appointment. We will provide you with a copy of your billing sheet so that you can file a claim with your insurance company.

If your insurance company requires a referral and/or prior authorization, contact your primary care physician prior to your appointment at our office. Failure to provide a referral and/or prior authorization when necessary may result in your appointment being canceled, rescheduled or your being responsible for the full payment of your bill. Referrals and prior authorizations from some insurance companies can take several days. Please allow ample time before your appointment to secure these authorizations.

For patients with health insurance, once your insurance company has responded to our claim we will bill you accordingly. Payments are due upon receipt of your statement. Accounts over 90 days past due may be turned over to collections and our clinic may cease providing services to you. If you receive a statement that your insurance company has not paid for a claim, you should contact your insurance company to ask why a payment was not made.

Responsibility for payment for services rendered to the child(ren) of divorced or separated parents rests with the parent who seeks treatment. Any court ordered judgment must be between the individuals involved without including our facility. We will not send duplicate statements.

In the event your payment is returned to us unpaid, we may elect to resubmit your payment to your financial institution. We may also collect a return processing charge in an amount not to exceed that permitted by North Carolina state law.

Missed Appointment Policy: In order to provide the best service to all of our patients, we require 24 hours advance notice if you are unable to keep your appointment. A $25.00 Missed Appointment charge may be assessed if your appointment is not canceled within the required time frame. These charges are not payable by your insurance company and must be paid prior to making another appointment. Patients with two consecutive Missed Appointments or those who accrue three Missed Appointments in one calendar year may be dismissed from our practice.

For patients that do not carry health insurance (Self Pay) and those for whom we do not participate in their insurance health plan, payment by cash or credit card is expected when you check in for your appointment. If you are here for an exam the following fees will be collected:

Level 4 Exam - NEW Patient $192.00 ESTABLISHED Patient $128.00.

If your exam is less than a Level 4 the difference will be refunded to you at check out. If you are here for a procedure (including surgery) the fee for that procedure will be collected before services are rendered.

For your convenience, we accept cash, check (established patients), debit and credit cards (Visa, Master Card, Discover). Care Credit financing is also available.

I have read the above and understand the statement of Patient Financial Responsibility:

Patient Printed Name	Date	Patient/Guardian Signature