



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 a.

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 # \_\_\_\_\_



## 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 herbs:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

<b>Cardiovascular</b>			<b>Constitutional</b>			<b>Gastrointestinal</b>			<b>Neurological</b>		
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						
<b>Musculoskeletal</b>			<b>Lymphatic/Hematologic</b>			<b>Genitourinary</b>			<b>Respiratory</b>		
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
<b>Skin</b>			<b>Eyes</b>			<b>Ear/Nose/Throat</b>					
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) \_\_\_\_\_

Patient Name: \_\_\_\_\_

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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, Aspirin) 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 \_\_\_\_\_



## 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:

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Patient Printed Name

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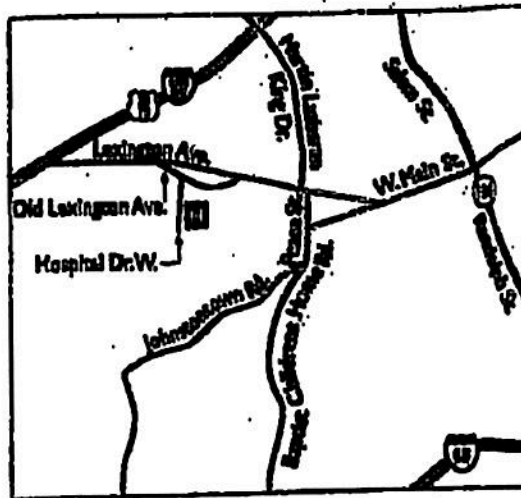
Date

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Patient/Guardian Signature



## Directions to Our Clinic



Thomasville Medical Center is conveniently located off I-85 and business 29/70 in Thomasville, NC. Following are written driving directions that will assist you in getting to the Thomasville Medical Center campus.

**From the High Point/Greensboro (North) or Lexington (South):**

1. Take Interstate 85 to Exit 102 - Lake Rd.
2. Turn right at the top of the exit.
3. Left at the second stoplight onto Lexington Rd.
4. Turn left onto Old Lexington Road at the Fire Station
5. The Center is on the left.

**From Winston-Salem:**

1. Take "New" Interstate 40 East to Hwy. 109 South.
2. Get onto Business 85/29/70 South to Mount Calvary Church Rd.
3. Look for the blue hospital sign - it is a left exit.
4. At the stop sign, cross Lexington Ave. onto Old Lexington Ave.
5. The Center is on the right.

\*\* Our office is located inside Thomasville Hospital.

Go in the Ambulatory Care Discharge Entrance. This entrance is to the left of the Main Entrance when you are facing the hospital. You will then go in the 4th wooden door on the right.