PLEASE FILL OUT AND BRING TO APPOINTMENT

Patient Name ____
Last First M.I.

Mailing Address ____
Address City State Zip

Home Phone ____________ Work Phone____________ Cell Phone ____________
Best daytime number to reach you? ☐ Home ☐Work ☐Cell

Email Address ______________________ SS#______________
We provide information about the practice, newsletters and special announcements via email. We do not share information with third parties.

Date of Birth ___/___/___ Sex ☐ M ☐ F

PARENT/GUARDIAN and/or FINANCIALLY RESPONSIBLE, If Applicable *(if different from patient)*

Patient Name ____
Last First M.I.

Mailing Address ____
Address City State Zip

Home Phone ____________ Work Phone____________ Cell Phone ____________
Best daytime number to reach you? ☐ Home ☐Work ☐Cell

Email Address ______________________ SS#______________
We provide information about the practice via email. We do not share information with third parties.

Date of Birth ____/____/____ Sex ☐ M ☐ F Marital Status ____________

INSURANCE INFORMATION *(Please present insurance card at time of check in.)*

Primary Insurance Name ______________
Name of Policy Holder______________
Policy Holder Date of Birth______________
Insured's ID#__________ Group #________

Secondary Insurance Name______________
Name of Policy Holder ______________
Policy Holder Date of Birth______________
Insured's ID#__________ Group #________

EMERGENCY CONTACT

Primary Contact (Name and Number)______________ Relationship__________
Secondary Contact (Name and Number)______________ Relationship__________

OTHER INFORMATION

Other family members that are patients ______________________
Pharmacy of choice ______________________ Phone__________

REFERRAL INFORMATION

How did you hear about North Carolina Dermatology Associates?

☐ Insurance Company
☐ Newsletter
☐ Community Event
☐ Fifteen 501 Magazine
☐ Post Card
☐ Internet
☐ Patient
☐ Brier Creek Magazine
☐ Saathee Magazine
☐ Clipper Magazine
☐ Yellow Pages
☐ Friend
☐ Wake Living Magazine
☐ Skin Sense
☐ Other __________ (specify)

☐ Referring Physician/Practice ______________________ Phone ____________

Mailing Address ____
Address City State Zip

PATIENT PAYMENT/RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize my insurance company to send all payments for medical services rendered to me (or my dependents) directly to NORTH CAROLINA DERMATOLOGY ASSOCIATES, PLLC. With my signature, I confirm the above demographic and insurance information is true and correct, and for any future services this authorization applies to. If the information is found to be inaccurate, I agree to be personally responsible for payment in full for services provided. I further authorize the release of any information (including medical information) to my insurance company, primary care, referring or consulting physicians if needed and as necessary to process insurance claims, insurance applications and prescriptions as well as coordinating care. I confirm I have received a copy of North Carolina Dermatology Associates' Financial Policy and Notice of Privacy Policy (PDF available online for download).

I acknowledge it is the policy of this office that payment is required at the time of service. An insurance claim submission on my behalf is a *courtesy* extended to me, or the party I represent, unless mandated by the health plan in which this practice participates. I understand I am financially responsible for all services not covered by my health plan. Should my insurance plan not forward notice of payment and/or a benefits statement within 60 days from the date of service, I will be responsible for payment in full. I also understand that should I be covered by a health plan North Carolina Dermatology Associates, PLLC is participating with at the time services are provided, I shall only be responsible for those services authorized and approved by my plan.

I am financially responsible for any uncovered services, deductibles, and co-payments due to North Carolina Dermatology Associates, PLLC.

A COPY OF THIS AUTHORIZATION MAY BE CONSIDERED AS AN ORIGINAL FOR INSURANCE PURPOSES.

______________________________	______________________	____________
Patient Signature (or authorized representative)	**Relationship, if not patient**	**Date**

At North Carolina Dermatology Associates, we have implemented a patient portal, which allows for secure electronic communication regarding your medical care. This will be able to use to request appointments, prescription refill requests, labs results and other functionality.

I understand giving my email address to North Carolina Dermatology Associates will be interpreted as my consent to receive secure electronic communication via the patient portal regarding my medical care. I understand that electronic communication occurs only through the patient portal. At no time will you ever receive a direct email regarding your medical care. In your email box you will receive a message that a secure message is waiting on your patient portal account in which you will login in order to receive the message (this is similar to the way financial institutions securely communicate). I understand the terms and I consent to the use of the patient port in addition to the other methods of communication with North Carolina Dermatology Associates

I understand that message via the patient portal or any form of electronic communication is never appropriate for urgent or emergency situations.

______________________________	______________________	____________
Patient Signature (or authorized representative)	**Relationship, if not patient**	**Date**

RELEASE OF INFORMATION

Do we have your permission to discuss your medical conditions with any member of your household? Yes ☐ No ☐

If Yes, Whom: ______________________________ Relationship: ______________________________

FOR MEDICARE PATIENTS ONLY

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

______________________________	______________________
Signature as it appears on Medicare Card	**Date**

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

______________________________	______________________
Signature as it appears on Medicare Card	**Date**