

# LAKE NORMAN DERMATOLOGY, P.A.

**PLEASE COMPLETE THE ENTIRE FORM AND RETURN WITH YOUR CURRENT INSURANCE CARD & PHOTO ID**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M. Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Home #: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work #: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M  F  Cell #: \_\_\_\_\_

Race: African American  Asian  Caucasian  Hispanic  Other  Martial Status: S M D W

**Employer:** \_\_\_\_\_ SS#: \_\_\_\_\_

Occupation: \_\_\_\_\_ email address: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Primary Insurance Company:** \_\_\_\_\_ **Copay amount:** \_\_\_\_\_

Policy holder's name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Policy holder's SS #: \_\_\_\_\_ Policy holder's DOB: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ (if applicable)

Policy holder's name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Policy holder's SS #: \_\_\_\_\_ Policy holder's DOB: \_\_\_\_\_

**Relative/contact that does NOT live with you:** \_\_\_\_\_ Ph: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

**If applicable:**

Physician who sent you to our office: \_\_\_\_\_ Specialty: \_\_\_\_\_

Records are sent to the referring physician. If you would like a summary of your visit sent to other physicians, please list their names and addresses here: \_\_\_\_\_

I AUTHORIZE: use of this form for all my insurance transmissions.  
release of any relevant information to my insurance company.  
my physician's office to act as my agent in assisting me obtain payment from my insurance company.  
that I am aware that I am responsible for all charges regardless of insurance coverage.  
payment of the medical benefits for services rendered to be sent directly to my physician.

I voluntarily consent to healthcare treatment from Lake Norman Dermatology. No guarantees have been made to me regarding the result of treatments by my caregivers.

I permit a copy of this authorization to be used in place of the original.

I understand that I am responsible to knowing my insurance coverage and for obtaining any referrals that may be needed.

I fully understand that I am responsible for any charges not covered by my insurance company, and that payment arrangements can be made with the billing department. If payments are not made, these balances may be transferred to a collection agency or attorney, and are subject to additional fees.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# LAKE NORMAN DERMATOLOGY, P.A.

Phone: 704-658-9730

140 Leaning Oak Drive, Suite 101, Mooresville, NC 28117

Fax: 704-658-1457

## ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE

- I. I have received a copy of the HIPAA Privacy Practices for Lake Norman Dermatology and have been provided the opportunity to review it.

Print Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Please initial here \_\_\_\_\_

Who is your PCP (Primary Care Provider)? \_\_\_\_\_

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## DESIGNATION OF DISCLOSURE

Lake Norman Dermatology is authorized to release my protected healthcare information as indicated below. Appointment reminder messages will be left on answering machines/VM, unless we are informed otherwise at the time of each scheduling.

### II. Communication:

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

May leave detailed message with path/lab results:  Home  Cell  with Spouse

Message with call back # only:  Home  Cell  with Spouse

General message (insurance, financial, other)  Home  Cell  with Spouse

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**FOR YOUR INFORMATION:** Relevant information regarding your medical care, including but not limited to test results, surgeries and procedures will be shared with any physician that has referred you to us; that we have referred you to; home caregivers; or any persons that you have designated in your medical record, as involved in your treatment / medical care.

- III. Please list **anyone you WOULD LIKE TO DESIGNATE as persons involved with your health care** or payment relating to health care for disclosure of pertinent medical information. You are not required to list anyone.

**DO NOT LIST YOUR PRIMARY CARE PHYSICIAN OR THE DR. THAT REFERRED YOU HERE**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

- V. Is there anyone that **IS NOT AUTHORIZED** to receive your patient health information?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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I understand that I have the right to revoke this authorization at any time and have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where information has already been disclosed, but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

\_\_\_\_\_  
Signature of Patient / Guardian

\_\_\_\_\_  
Date

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## Financial Policy

Lake Norman Dermatology believes that part of a good healthcare practice- patient relationship is to establish and communicate our financial policy to our patients. We are dedicated to providing you with the best possible care, and we want you to completely understand our billing policy.

### Payment

- Payment is expected at the time of your visit.
- We accept cash, personal checks, Discover, Visa and MasterCard.
- Payment will include any co-insurance or co-payment amounts that you are responsible for.
- If you do not carry insurance or if your coverage does not include pre-existing conditions, payment is required at the time of service.
- You will be billed separately for biopsy (pathology) and laboratory charges from the facility in which your specimen was submitted. They will also submit the charges to your insurance company.

### Insurance

- We are participating providers with most insurance plans. (In Network)
- We will file the insurance claim(s) on your behalf.
- Your insurance information will be forwarded, with any path or lab tests, to the appropriate facility to be filed.
- You will be billed if your insurance company does not pay within a reasonable period of time. Please remember, insurance is a contract between you, the patient, and the insurance company. Ultimately, the patient is responsible for payment. We will always do what we can to assist you.
- If we receive payment from your insurance after you have paid, we will refund any over-payment accordingly.

#### **Out of Network (If we do not participate with your plan):**

- We will prepare and submit the claim for you.
- You may be responsible for payment or partial payment at the time of service.
- The insurance company will most likely send the payment directly to you.

Due to the many different insurance companies, and the variety of plans, we can not guarantee your eligibility and coverage. It helps you to know your coverage.

### Referrals

- You are responsible for obtaining a properly dated referral if your insurance policy requires one.
- Referrals are not a guarantee of payment. If the service provided is "not covered" by your plan, they will not cover the charges even if you have obtained a referral.
- Not all plans cover all services.
- If you are seen without a referral and a referral was required by your insurance plan, you will be responsible for the payment. Coverage limits are set by your plan.
- Payment is due upon receiving a statement from our office for all services not covered by insurance.

### Returned Checks

- A \$35.00 service fee will be charged for every check returned by the bank for insufficient funds.
- You will be required to bring cash or a money order to cover the amount of the check, PLUS the fee.

### Accounting

Payments and credits are applied to the oldest balance first, except for insurance payments which are applied to the corresponding dates of service. Accounts with unpaid personal balances will be turned over to a collection agency.

If you have any questions regarding a billing statement, our billing staff will be available to assist you.

**I have read and understand this financial policy for Lake Norman Dermatology, and agree to be bound by its terms. I understand that these terms may be amended by the practice from time to time.**

\_\_\_\_\_  
**Signature of Patient / Responsible Party (if minor)**

\_\_\_\_\_  
Relationship (if not the patient)

\_\_\_\_\_  
**Printed Name of Patient**

\_\_\_\_\_  
**Date**