CAROLINAS SKIN CENTER

PLASTIC & DERMATOLOGIC SURGERY

Hello and Welcome to Carolinas Skin Center. We are excited about your upcoming visit and look forward to meeting you. Please fill out the following information forms prior to your visit.

Please bring the enclosed completed forms with you on your appointment day.

- **Patient Demographic and Information Form**
- **Authorization to Disclose Protected Health and or Billing Information**
- **Patient Intake and History Form**
- **Any appropriate Referral forms or letters**
- **Recent lab or pathology reports**

At Carolinas Skin Center we are committed to providing excellent medical care and personalized attention for your needs. Please contact our warm and friendly staff at 704 997-7070 should you have any questions about your upcoming visit, your particular insurance coverage or any other general questions.

Along with the enclosed forms, please bring the following to your upcoming appointment:
• **Insurance card** (Dr. Nowicky cannot see you without verifying your insurance with your insurance card)
• **Co-pay or Deductible** (We will verify this with you prior to your appointment time)

Completing these forms with their required signatures and having your insurance card and co-pay/deductible can dramatically decrease the time required for check-in, so we appreciate your assistance and we look forward to your visit.

Please take the time and effort to ensure scheduling considerations for you and all the patients of Carolinas Skin Center. Thanks so much…

Patient Demographic and Insurance Form

Patient Name (Last, First, M)		Date of Birth	Date
Address		City/State/Zip	Male ____ Female ____
Email		Social Security Number	Ethnicity: Race:
Home Phone ( )	Cell Phone ( )	Employer	
Marital Status	Spouse Name	Referring Doctor	Primary Doctor
Adult Emergency Contact	Relationship	Home Phone ( )	Cell Phone ( )
Responsible Party If Not Self	Relationship	Date of Birth	Social Security Number
Responsible Party Address (if different from patient above)		City/State/Zip	Phone ( )

INSURANCE INFORMATION

Primary Insurance	Employer	**Secondary Insurance**	Employer
Insurance ID #	Insurance Group #	Insurance ID #	Insurance Group #
Insurance Address		Insurance Address	
City/State/Zip		City/State/Zip	
Name of Policy Holder	Relationship to patient	Name of Policy Holder	Relationship to patient
Policy Holder Date of Birth	Policy Holder Social Security #	Policy Holder Date of Birth	Policy Holder Social Security #

Adult Emergency Contact: Name Relationship:	Pharmacy Information Name:
Adult Emergency Contact Address	Pharmacy Address
Adult Emergency Contact Phone: ( )	Pharmacy Phone ( )

How did you hear about us? __Family __Friend __Patient __Employee __Physician __Internet Search __Insurance Provider List

__Magazine __Newspaper __Facebook __Twitter __Instagram Other_____

By signing below I authorize Carolinas Skin Center to leave messages in reference to any items that assist in carrying out healthcare operations.

Home Phone: Yes No **Cell Phone:** Yes No **Work Phone:** Yes No **Patient Portal:** Yes No

Please list any persons to whom your protected health information can be disclosed to:

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Patient or Responsible Party Signature:_____ Date: _____

Financial Policy and Assignment of Insurance Benefits:
Payment is required for all services at the time they are rendered unless the patient is in an insurance plan with which we participate. **An estimate of ALL co-payments, deductibles, co-insurances not covered by your insurance carrier will be collected up front and due on the date of service.** Failure on our part to collect these from patients may be considered insurance fraud. **When calling to confirm your appointment, we will notify you of the amount due at the time of service – this is only an ESTIMATE.** Due to the possible extensive nature of some dermatologic procedures, there may be instances where additional procedures may be necessary in order to fully remove or treat your condition and/or lesion. This would result in additional fees.
To provide the best care possible, Carolinas Skin Center may, on occasion, send specimens to an outside source for processing. Examples of these services are pathology and laboratory testing. Should we send specimens to other providers, you will receive a separate billing statement from the outside pathologist and/or laboratory; these charges will be in addition to those for services rendered by Carolinas Skin Center.

Insured Patients
• Copays, Co-Insurance and Deductibles are due at the time of service. For your convenience, we accept cash, check, debit and most major credit cards.
• In the event that your insurance carrier determines a service to be "non-covered", you will be responsible for the complete charge(s).
Non-Insured Patients
• Non-Insured patients will be required to pay for an office visit prior to being seen. There may be additional charge(s) depending upon the procedure(s) performed. Payment for additional services is due prior to leaving the office. Please see the Office Manager if you have any questions.
All Patients
• Returned Checks: A $35.00 fee will apply to all checks returned to our office as "unpaid". Payment for future services may be required by cash or credit card.
• Medical Records: A fee may be charged for providing copies of medical records. Please inquire with the Office Manager.

We accept payment in the form of **cash, check, debit or credit**. In the event that your account must be turned over to collections, a $25.00 collection fee will be added to your account. There is a $35 fee for any returned check. Your signature below signifies your understanding and willingness to comply with this policy.
I have read and understand this financial policy statement. I agree to make in-full prompt payment to Carolinas Skin Center when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered.

In addition to the above, if I am a Medicare patient, 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 to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Be advised that completing preliminary health and insurance questionnaires does not establish a physician---patient relationship with this practice. An initial evaluation is required to determine whether you are a suitable candidate and whether the practice will accept you as a patient.
I hereby authorize and direct my insurance carrier to issue payment check directly to Carolinas Skin Center (CSC) for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance. Payment and credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding charges. I agree that if my insurance carrier sends payment to me for the medical services instead of to Carolinas Skin Center, I will immediately pay the amount due to CSC. I agree it is my responsibility to understand my insurance benefits and to notify Carolinas Skin Center immediately of any changes to my insurance coverage. I understand that it is my responsibility to obtain insurance authorization if it is required and the payment is still my responsibility. **Please remember that insurance is a contract between the patient and the insurance company and ultimately you are responsible for payment in full to Carolinas Skin Center.** I agree for Carolinas Skin Center to service my account or to collect any amounts I owe, I may be contacted by telephone at any number associated with my account, including wireless telephone numbers, which could result in charges to me. I may also receive text messages or emails, using any email address I provide. Methods of contact may include using pre--- recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I authorize review, recording and downloading of my prescription history records from the internet and/or other doctors' data. I also authorize photography of my medical/surgical conditions. Patients whose accounts have been turned over to a collection agency will be responsible for the account balance and all costs associated with collection, including attorney fees. There will be a charge for form completion: disability, FMLA, supplemental insurance, etc. The forms require office staff time and time away from patient care for the physicians. We require 3 business days to complete the forms and requests. I authorize Carolinas Skin Center to use and disclose the health and medical information for the purposes of Treatment, Payment and Health Care Operations. You may review Carolinas Skin Center's "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent.

Signature (Patient or Responsible Party)	Date

Financial Policy for All Patients, including Medicare:

Carolinas Skin Center (CSC) is considered a specialist office. Some insurance policies require that prior to your office visit; you must obtain a referral from your primary care physician. If this is not acquired prior to your visit, you may be asked to reschedule your appointment or pay for your visit in full.

Payment is required for all services at the time they are rendered unless you are covered under an insurance policy in which we participate. For those patients, applicable co-payments, deductibles, and/or coinsurance will be collected at the time of service. The patient is responsible for any/all charges not paid for by their insurance company.

I have read and understand the financial policy statement. I agree to make prompt payment in full to CSC when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered (i.e. cosmetic services). Further, I authorize payment directly to CSC for medical insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed for my treatments. This authorization is valid until revoked in writing.

Signature (Patient or Responsible Party)	Date

Privacy Practices (HIPAA):

Receipt of Privacy Practices

By signing below, I acknowledge that I have the right to review a copy of the Notice of Privacy Practices prior to signing this consent. I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications and prescriptions.

Signature (Patient or Responsible Party)	Date

Permission to Treat a Minor- Only for Patients age 18 or younger:

A parent or guardian must be present with a patient under the age of 18 for the first visit and any subsequent visit in which a procedure is performed. The parent/ guardian grants permission for Carolinas Skin Center to see the minor without their presence for standard medical office visits. This authorization is valid until revoked in writing. I have legal right to select and authorize health care services for this minor child.

Signature	Relationship to Patient	Date

General Consent: I consent to medical care at Carolinas Skin Center. This includes needed lab work and HIV testing. By law, I understand that if there is an at-risk exposure to my blood or body fluids, I may be tested for HIV, Hepatitis B or C virus. Those test results will be shared with the healthcare worker who was exposed. I am aware that healthcare is not an exact science. No guarantees have been made. If I am hospitalized, I agree to send any valuables home. I agree that Carolinas Skin Center is not responsible for any loss or damage to my property.

Signature	Relationship to Patient	Date

IF YOU HAVE MEDICARE PLEASE COMPLETE THE FOLLOWING

Please Sign So We May Have On File Your Medicare Authorization and Supplement Authorization

I authorize as the holder of medical or other information about me to release to the Social Security Administration and health care Financing Administration 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.

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

Signature (Patient or Responsible Party)	Date

Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% copayment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.

Are you in a Medicare HMO or other Senior Medicare Plan? ____Yes ____No

If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers.

Name of Insurance Company

Policy Number Group Number

Name Policy Holder (Insured) ____Male ____ Female Date of Birth

Supplemental Insurance or Medicare Advantage Plans

In the event of a major procedure or hospitalization, we request secondary insurance information for our records (supplemental Medicare insurance information). Please fill out below if you are covered by a plan, which covers the 20% NOT covered by Medicare.

Name of Insurance Company

Policy Number Group Number

Name Policy Holder (Insured) ____Male ____ Female Date of Birth

Signature (Patient or Responsible Party)	Date

Please present your Medicare and insurance card(s) and a photo ID to the receptionist along with this completed form.