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 attempt to 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. 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 **(REQUIRED)**	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 ( )

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:

As a courtesy, we will bill your primary and secondary insurance and help you receive the maximum allowable benefit. **However, if North Carolina Medicaid, or any umbrella thereof, is your secondary insurance we will not bill them as part of your insurance coverage and YOU will be responsible for charges not reimbursed with your primary insurance.** Before appointments, our Billing Coordinator will attempt to contact your insurance company to verify your insurance benefits. Please remember that your insurance policy is a contract between you and your insurance carrier. It is your responsibility to know and understand your benefits and the limitations of your policy and your deductible and co-insurance amounts. It is also your responsibility to notify our office of any insurance changes at least one week prior to your appointment. We will try and provide you with an estimate of your responsibility for surgical procedures. This estimate is never a guarantee of the final amount that you may owe. We will know the final amount until your insurance company processes the claim. The amount that the insurance company says the will cover during eligibility can be different that the amount that they actually pay. You are responsible for any services not covered by your plan.

When insurance is involved, we are contractually obligated to collect co-payments co-insurance and deductibles as outlined by outlined by your insurance carrier. It is our office policy to collect any unmet deductibles, co-pays, estimated coinsurance and non-covered services at the time of service.

Financial Responsibility: I agree to pay for all medical services provided. I understand that I may need to call my insurance company to see if they will approve and pay for the medical care. Please bill my health insurance plan as a service to me. I am aware that this does not mean they will agree to pay for any services. I agree to pay whatever amount is not covered. Please apply for any health insurance coverage that may be available to me. I agree to help in this process. I assign all of my rights and claims for payment under any health insurance plan to Carolinas Skin Center. I appoint Carolinas Skin Center as my "authorized representatives" to act for me in getting payment for services provided. If I pay more than what I owe for this medical visit, I agree that it can be used to pay for any unpaid bill I have with Carolinas Skin Center. I give permission to be called on any of the telephone numbers I have given. This includes calls with a pre-recorded message, automatic dialing system or artificial voice. Calls may be made by businesses helping Carolinas Skin Center collect money that I owe.

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.

We accept payment in the form of cash, check (certified or banker's may be required), debit or credit card.

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, in addition to your bank charges, will apply to all checks returned to our office as "unpaid" or "returned" or "non-insufficient funds."
- Medical Records: A fee may be charged for providing copies of medical records. Please inquire with the Office Manager. There is $25.00 charge per request to file or fill out any forms such as disability, FMLA, etc, related to your treatment. Outstanding attorney's fees will become the responsibility of the patient.

It is our office policy to only send three patient statements. Patient statements are sent out at the end of each month to include all outstanding charges, fees or penalties once your insurance company has processed you claim. **If payment in full is not received within 30 days after your third statement's mail date, your account will incur a penalty charge and will be turned over to collections *without additional notice.*** We do not offer payment plans. In the event that your account must be turned over to collections, a 25% collection fee (subject to change) will be added to your account. If a collection agency is utilized to collect outstanding charges and penalty fees you agree to allow for any HIPPA protected health information to be shared in the pursuit of debt collection. Your signature below signifies your understanding and willingness to comply with this policy. In the event of disputed credit/debit or bank charges or violation (default, closing of account) of above terms, patient agrees to allow Carolinas Skin Center to use HIPPA and/or protected health information/demographics/patient information to settle, investigate or pursue collection and settling of debt or financial responsibilities. Please note that once collection agency is involved this office will no longer be able to settle your account and your credit score/rating/report may be affected.

Patient refunds will not be processed until all active or past due accounts for patients or dependents are paid in full. **We request that you provide us with a 48-hour cancellation notice for any appointments you are unable to make and failure to do so will result in a $50 no-show fee for an office visit and $75 no-show fee for a missed surgical appointment. These charges will be sent to you directly for payment and/or may be added to any future office visits, procedures or services.** Patients will be dismissed from the practice/office after three missed appointments without further notification.

I have read and understand this financial policy statement and 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. This form serves as formal notification of our financial policy for our patients. I understand updates to office policy may not be listed. Your signature represents your understanding and acceptance of these policies.

Signature (Patient or Responsible Party)	Date

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 or other testing. 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

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. I authorize the assignment of benefits to Carolinas Skin Center.

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

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

Signature (Patient or Responsible Party)	Date