WAKE
SKIN CANCER CENTER

Name: _____ DOB: _____

PAST MEDICAL HISTORY
Select any of the following medical conditions:

- ☐ None
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Bone Marrow Transplantation
- ☐ BPH (Benign Prostatic Hyperplasia)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension (High Blood Pressure)
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia (High Cholesterol)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other _____

PAST SURGERIES
Have you had any surgeries on the following organs?

- ☐ None
- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Both, Left or Right)
- ☐ Breast: Mastectomy (Both, Left or Right)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Both, Left or Right)
- ☐ Joint Replacement: Knee (Both, Left or Right)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate: Prostate Biopsy
- ☐ Prostate: Prostatectomy
- ☐ Prostate: TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ Other: _____

SKIN

Have you had any of the following skin conditions?

- ☐ None
- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking of Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Other: _____

Do you wear Sunscreen?

☐ Yes ☐ No

If yes, what SPF?

_____ SPF

Do you tan in a tanning salon?

☐ Yes ☐ No

FAMILY HISTORY

Do you have a family history of Melanoma?

☐ Yes ☐ No

If yes, which relative?

- ☐ None
- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother (Maternal or Paternal)
- ☐ Grandfather (Maternal or Paternal)
- ☐ Grandson
- ☐ Granddaughter
- ☐ Other: _____

MEDICATIONS

Please list any current medications, their dosage and frequency.

- ☐ None
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

ALLERGIES

Please list any allergies and their reactions. (e.g. anaphylaxis, hives, rash, etc.)

☐ No known allergies

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

SOCIAL HISTORY DETAILS

Smoking Status

☐ Current every day smoker

☐ Current some day smoker

☐ Former smoker

☐ Never smoker

☐ Cigar smoker

☐ Other _____

Month/Year Started Smoking _____

Month/Year Quitted Smoking _____

Number of packs per day _____

Total years smoking _____

Drug Use (Other than prescribed medications.)

☐ None

☐ If yes, what drug(s)? _____

Alcohol Use

☐ None

☐ EtOH less than 1 drink per day

☐ EtOH 1-2 drinks per day

☐ EtOH 3 or more drinks per day

☐ Other: _____

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65? _____

VACCINATION STATUS

For all patients: Have you received an Influenza (flu) vaccination?

☐ Yes ☐ No

For patients 65 and older: Have you received a Pneumococcal (pneumonia) vaccination?

☐ Yes ☐ No

For patients 65 and older: Have you received a Zoster (shingles) vaccination?

☐ Yes ☐ No

ADVANCE CARE

Do you have a health care proxy in the event you are unable to make your own medication decisions?

☐ Yes ☐ No

Do you have a living will?

☐ Yes ☐ No

Which statement(s) best reflect your wishes on advanced care recommendations?

☐ DO NOT Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

☐ DO NOT Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.

☐ FULL Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Effective Date: August 1, 2019

**IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:**

Privacy Officer: Practice Administrator
Mailing Address: 11640 Northpark Drive, Suite 200
Telephone: 919-436-4124
Fax: 919-439-9645

## About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights - and we have certain legal obligations - regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

## What is Protected Health Information?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for this health care.

## How We May Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information in the following circumstances:

- **For Treatment.** We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate needed medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to determine a diagnosis or treatment or provide you with a service.

- **For Payment.** We may use and disclose your Protected Health Information so that we can bill for the treatment and services received from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order to obtain payment.

- **For Health Care Operations.** We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of

our team members providing this care. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational purposes.

**Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

- **Minors.** We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

- **Research**. We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

**As Required by Law.** We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

- **Business Associates.** We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.

- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation - such as an organ donation bank - as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of an armed forces family, we may disclose Protected Health Information as required by military command authorities.

- **Workers' Compensation.** We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

  **Abuse, Neglect, or Domestic Violence.** We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

- **Health Oversight Activities.** We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.

- **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.

- **Military Activity and National Security.** If you or your family members are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.

- **Coroners, Medical Examiners, and Funeral Directors**. We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

**Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out**

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

- **Fundraising Activities.** We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. If you do not want to receive these materials, please submit a written request to the Privacy Officer.

**Your Written Authorization is Required for Other Uses and Disclosures**

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

- Most uses and disclosures of psychotherapy notes or evaluations by psychologists;
  Uses and disclosures of Protected Health Information for marketing purposes; and
- Disclosures that constitute a sale of your Protected Health Information.
- Any information related to diagnosis or treatment of HIV, Alcohol and Substance Abuse information, Mental Health Information or Genetic Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

**Your Rights Regarding Your Protected Health Information**

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy.** You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for this care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with this request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

- **Right to a Summary or Explanation.** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agree to this alternative form and pay the associated fees.

- **Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

- **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.
- **Right to Request Amendments.** If you feel that the Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of

your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.

**Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

**How to Exercise Your Rights**

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

**Changes To This Notice**

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

**Complaints**

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: The U. S. Department of Health & Human Services Office of Civil Rights, 61 Forsyth Street, SW, Suite 3B70 , Atlanta, GA 30303-8909, Telephone (404)562-7886; (404) 331-2867 (TDD), FAX: (404) 562-7881.

www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintpackage.pdf

There will be no retaliation against you for filing a complaint.

WAKE
SKIN CANCER CENTER

**Patient Acknowledgement Form for**

**Patient Name:** _____
**(Please Print)**

The Health Insurance Portability and Accountability Act ("HIPAA") rules require that the Practice provide our patients with the attached Notice of Privacy Practices on their first visit. The Notice describes how the medical information we receive from you may be used or disclosed by the Practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of our Notice to review. If you have any questions about our Privacy Practices, please feel free to contact our Privacy Officer. Thank you for your cooperation.

***I acknowledge that I have received a copy of the Practice's Notice of Privacy Practices and have been given an opportunity to ask questions.***

**Signature of Patient or Personal Representative:**

_____ **Date:**_____

**If Personal Representative, give relationship to patient:**

_____

**Please Tell Us How to Contact You to Discuss Your Medical Care**

***I authorize the Wake Skin Cancer Center, P.A. to leave medical information pertaining to my care by the following methods and will assume responsibility to notify the Practice, in writing, whenever this information changes.***

Please list names of people with whom we can discuss your medical care:
Spouse Name_____
Parent Name_____

Other Name (s) & Relationship(s)
_____
_____

Please list a "unique identifier" as a way to confirm your identity when calling the office. This "unique identifier" must be given before any information can be disclosed.

**Unique Identifier:**_____
(last four digits of your social security number or mother's maiden last name)

WAKE
SKIN CANCER CENTER

# Authorization for Use/ Disclosure of Protected Health Information/Medical Records

**PATIENT NAME**_____
**LAST** **FIRST** **MI**

**DATE OF BIRTH:** ___/_____/_____ **SS#:** _____ **MEDICAL RECORD #** _____

_____
**ADDRESS** **CITY** **STATE** **ZIP**

**DAY PHONE:** _____ **EVENING PHONE:** _____

o I authorize the Wake Skin Cancer Center, P.A. to use or disclose my protected health information as indicated below to:

_____
**Name of entity to receive this information**

_____
**ADDRESS** **CITY** **STATE** **ZIP**

_____
**PHONE NUMBER** **FAX NUMBER**

o authorize_____
**Name of entity to release this information**

To release my protected health information to the Wake Skin Cancer Center, P.A as indicated below.

| **INFORMATION TO BE RELEASED:** | **PURPOSE OF DISCLOSURE:** |
|---|---|
| o From & To Dates _____<br>o History and physical exam<br>o Office notes<br>o X-ray reports<br>o Lab reports<br>o Hospital records (op notes, discharge summary)<br>o Medication records<br>o Other: _____ | o Changing physicians<br>o Continuing care<br>o At patient request<br>o Second opinion<br>o Legal<br>o Insurance/Workers' Compensation<br>o School<br>o Other: _____ |

I understand that this authorization will expire: _____
**Expiration Date or Defined Event**

I understand that I may revoke this authorization at any time by notifying Wake Skin Cancer Center, P.A in writing. This authorization will cease to be effective on the date notified except to the extent that the Practice has acted in trust upon this authorization.

_____ _____
Signature of Patient or Legal Guardian Date

Effective Date:_____

**11640 Northpark Drive, Suite 200** **Wake Forest, NC 27587-3302**
**Phone: 919-436-4124** **Fax: 919-439-9645**


## CONSENT TO OBTAIN PRESCRIPTION HISTORY

This consent form authorizes Wake Skin Cancer Center, P.A. to obtain and review my prescriptions history. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names or dosages.

By signing this consent form, you agree that Wake Skin Cancer Center, P.A. can request and use your prescription medication history from other healthcare providers, pharmacies, and benefit payors (such as your insurance company) for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Wake Skin Cancer Center, P.A. to request, view, and use my external prescription history for treatment purposes. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

PATIENT NAME (Printed): _____

PATIENT DATE OF BIRTH: _____

PATIENT SIGNATURE: _____

DATE OF SIGNING CONSENT FORM: _____

Elias E. Ayli, D.O.
Wake Skin Cancer Center, P.A.
11640 Northpark Dr
Suite 200
Wake Forest, NC 27587-3302
Phone: 919-436-4124
Fax: 919-439-9645

Patient Name: _____

Date of Birth: _____


## PRACTICE FINANCIAL POLICY

Please review and acknowledge below.

- Co-payments for office services are required at the time you check-in.
- As a courtesy, we will process and file your insurance claims for services at no cost to you.
- For services that are covered by insurance, the practice requires payment of approximately 20% of the total estimated charges or the co-payment specified by your insurance.
- For services that are <u>not</u> covered by insurance, the practice requires payment of 100% of total charges unless payment arrangements have been worked out.
- Returned checks are subject to a handling fee of $20.00. In the event your account must be turned over for collection, you will be billed and are responsible for all fees involved in that process.

You must realize that:

1. Your insurance is a contract between you and your employer and/or the insurance company. While we may be a provider of services, we are not a party to that contract. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.

2. Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. We will make every effort to ascertain your coverage for our services before treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. We will allow you 90 days to pay any balance remaining after insurance payment. After that time, your account will accrue interest at the rate of Prime plus 2%. Our staff will make arrangements for you to make monthly payments over an approved term. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, please do not hesitate to ask us. We are here to help you.

**PLEASE READ THE ABOVE CAREFULLY <u>BEFORE</u> SIGNING.** By signing below, I acknowledge that I have read and understand this policy.

Signature:_____ Date:_____

(Patient and/or Responsible Party)

Elias E. Ayli, D.O.
Wake Skin Cancer Center, P.A.
11640 Northpark Dr
Suite 200
Wake Forest, NC 27587-3302
Phone: 919-436-4124
Fax: 919-439-9645

Patient Name: _____

Date of Birth: _____


# INSURANCE INFORMATION RELEASE CONSENT FORM

## MEDICARE AUTHORIZATION

_____ _____
Initials Date

I authorize the holder of medical or other information to release to the Social Security Administration and Health Care Financing Administration, its intermediaries or carrier, any information needed to file a Medicare claim. I permit a copy of this authorization form to be used in place of the original and requested payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. DEDUCTIBLE AND CO-INSURANCE (20% IF NO SUPPLEMENT) IS DUE AND EXPECTED AT THE TIME OF SERVICE.

## TRICARE INSURANCE

If you have Tricare or Tricare Prime, please READ CAREFULLY:

_____ _____
Initials Date

We are currently certified providers with Tricare and in Network with Tricare Prime; however, Tricare Prime (Active Duty members) does require a referral and/or prior authorization for which the patient is responsible for acquiring from their primary care physician.

I authorize the release of medical information for services rendered to my insurance company, and also authorize payment of medical benefits to the physician. I understand that I am responsible for any amount not covered by insurance. I also consent to the taking of photographs for medical, teaching purposes and office use.

_____ _____
PATIENT SIGNATURE DATE

Elias E. Ayli, D.O.
Wake Skin Cancer Center, P.A.
11640 Northpark Dr
Suite 200
Wake Forest, NC 27587-3302
Phone: 919-436-4124
Fax: 919-439-9645

Patient Name: _____

Date of Birth: _____


## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

**If you are 18 years of age or older; we must have your permission to discuss your treatment, medical, or financial information, etc. with anyone other than yourself. If a person's name is not listed on the consent form, we cannot discuss your information with them.**

**<u>***PLEASE SIGN IN ONLY ONE OF THE AREAS BELOW***</u>**

I hereby give my consent for Wake Skin Cancer Center, P.A. and staff to review or discuss my medical treatment, lab results, pathology reports, and/or financial information with the following persons, <u>other than myself</u>. I understand that I must submit a written request to amend this list.

1. _____ Relationship: _____
   (FIRST & LAST NAME) (Date of Birth)

2. _____ Relationship: _____
   (FIRST & LAST NAME) (Date of Birth)

3. _____ Relationship: _____
   (FIRST & LAST NAME) (Date of Birth)

Signature: _____ Date:_____

## OR

If there is no one that you wish your information to be released to, other than yourself, please sign below:

**DO NOT RELEASE ANY INFORMATION ABOUT MY MEDICAL RECORDS OR FINANCIAL INFORMATION TO ANYONE OTHER THAN MYSELF.**

Signature: _____ Date:_____

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Patient Name: _____

Date of Birth: _____


**PATIENT ACKNOWLEDGEMENT Health Insurance Portability and Accountability Act (HIPAA)**

Our ***Notice of Privacy Practices*** provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this acknowledgement. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

The Summary of our Notice of Privacy Practices is posted in our main lobby. The complete Notice of Privacy Practices in also available in our main lobby for your review. If you would like to receive a copy of the Summary and complete Notice, we have one available for you at the front desk.

If you wish for persons other than those released under normal operations as indicated in the Notice to receive confidential information that is now protected under this law, you must release them in writing. Please indicate on your patient registration form spouse, or any family or friends whom you wish to be able to receive information about you. You may of course choose not to release anyone. You may also be more specific in your restrictions for the persons you have released, just provide that request in writing. Parents or Guardians of minor children do not need to be released.

We have found that the easiest way to identify persons who are inquiring about your information is for you to assign a security password to your account. Persons who call will be asked this password instead of your social security information. Please be aware that our staff has to follow federal law on information that we release by phone and we may at any time choose not to release information of any kind by phone if we feel that the person requesting information is not authorized or we feel the information may be too sensitive to release by phone.

By signing this form, you are acknowledging that the Wake Skin Cancer Center, P.A. has made our Notice of Privacy Practices available to you for review and that we have offered you a personal copy

Signature: _____

This acknowledgement was signed by: _____

Printed Name - Patient or Representative: _____

Relationship to Patient (if other than patient): _____

Date: _____

In front of: _____

(Practice representative)

**HIPAA AUTHORIZATION FORM**

Elias E. Ayli, D.O.
Wake Skin Cancer Center, P.A.
11640 Northpark Dr
Suite 200
Wake Forest, NC 27587-3302
Phone: 919-436-4124
Fax: 919-439-9645

Patient Name: _____

Date of Birth: _____


I authorize Wake Skin Cancer Center, P.A. to use and disclose my protected health information (PHI) listed below upon my request. This includes faxing this information to designated entities or persons.

_____ Appointments _____ Restrictions _____ Medications _____ Diagnosis

_____ Date of Visit _____ Reason for visit _____ Released from care

Entity or person(s) authorized to receive this information:

_____ Camp _____ Social Worker _____ School/Daycare/Preschool

_____ Employer _____ Family/Friends _____ Parole Officer

_____ Personal Representative's Employer

This PHI is being used or disclosed for the following purposes:

_____ Verify return to work/school _____ Work/School Excuse

_____ To verify restrictions

This authorization shall be in force and effect until the time or event specified below, at which time this authorization to use and disclose PHI expires.

_____ No longer in school _____ Employment terminated

_____ Released from Care _____ Child is no longer a minor

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at (office address or e-mail address). I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of Patient or Personal Representative Date

Elias E. Ayli, D.O.
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