ADVANCED DERMATOLOGY & SKIN SURGERY, P.A.

Thank you for scheduling an appointment with Advanced Dermatology. We are committed to your treatment and well being and will work hard to serve your needs. In order to make your visit as pleasant and productive as possible, please review our office and financial policies, which we require you read and sign prior to any treatment.

- Complete the **Patient Registration** and **Medical History** prior to your arrival.
- If applicable bring your current insurance card(s).
- Bring a photo ID.
- Bring all medical records, list of current medications and/or other tests related to your visit.
- If your insurance company requires a pre-authorization for this visit, you must obtain the authorization form and present it at your time of visit.
- All new patients are asked to arrive 15 minutes prior to the scheduled appointment time.

Providing a pleasant environment that is conducive to the delivery of excellent patient care as well as one that promotes a positive employment experience for our staff is a priority for us. We hope that your experience with us meets or exceeds your expectations. We make every attempt to accommodate our patients to the highest standard with respect and dignity. We ask our patients to respond to our staff in the same manner. Behavior by any patient that is disruptive to the business operations will not be tolerated.

Office Policies

Appointments

Appointments may be made Monday through Friday by calling (828) 274-4880, press 5. When scheduling an appointment, the receptionist will gather information to ensure enough time is allocated for your visit. Please arrive for your scheduled appointment on time. Patients who arrive late may have to be worked in, or if you are more than 15 minutes late we will have to reschedule. If you are unable to keep an appointment please call us at least 24 hours in advance so we may use those times for other patients. If you do not keep your appointment, or if you cancel the same day of your appointment, there will be a $50 charge.

Office Hours

The office is open Monday-Friday 8 AM-5 PM. On days of inclement weather please call the office before leaving for your appointment to hear a recorded message concerning whether the office will be closed or opening late.

Emergencies

Emergencies will always be given priority. During office hours, call (828) 274-4880; after hours call (828) 259-5008. Should a true emergency arise after office hours call 911.

Prescriptions and Refills

Prescriptions and refills are only issued during regular office hours before 4:00 PM. Calls received after 4:00 PM for routine refills will be handled the next business day. Pain medications are not refilled after hours. We want to process requests for prescription refills as quickly as possible. When a prescription needs to be refilled, please call the pharmacist to check and see if there are refills authorized. If there are no refills, call our office. We may call in a refill or request that the patient first be seen by a provider. When you call for refills please have available the patient's name, address, date of birth, name of medication, the pharmacy name and phone number. Please contact the office before any medication has completely run out.

Fees, Payment Policy and Insurance

For each visit to our office, we will ask you to provide the information needed to verify your insurance coverage and file your insurance claim. If you are unable to provide adequate insurance information, we will require that you pay in full for services rendered at the time of the visit. **Depending on your insurance plan, a deposit may be required to schedule certain procedures with the balance due in full at the time the procedure is performed. Deductibles (including HSA plan deductibles), and coinsurance are due at the time that medical services are rendered**. **Prior balances and copayments may be collected at check-in. All past due balances are required to be paid in full before new services are rendered.**

Advanced Dermatology & Skin Surgery accepts cash, personal checks, debit cards, Visa and MasterCard. CareCredit financing is available. The office will not accept post-dated checks. There is a $25 charge for all returned checks and you will then be asked to pay cash or money order for all future appointments. Delinquent accounts will be charged an additional administrative fee of $50.

We participate with many insurance carriers and it is your responsibility to insure that we participate with your particular plan. Because your insurance policy is a contract between you and your insurance company, it is your responsibility to know and understand your plan's requirements and policies regarding co-payments, co-insurance, deductibles, and benefits. Should your insurance carrier deny a claim, we will make a reasonable attempt to help you resolve the disputed issues. In the event your health plan determines a service to be "not covered"; you will be responsible for the complete charge. In that event we will bill you, and payment is due upon receipt of the statement. Please keep copies of all billing information so that you can follow-up with claims with your insurance company if it becomes necessary. If your insurance carrier has not paid in FULL within 45 days the balance due may become your responsibility.

If an overpayment occurs, your account will be credited, you may either leave that amount on your account as a credit or request a refund providing there is no outstanding balance owed on your account. Please allow 10-14 business days for refunds to be processed and mailed to you.

Lab Billing

If a biopsy is performed please be aware of the diagnosis notification and billing process:
Advanced Dermatology is pleased to be able to have a dermatopathology lab and a qualified dermatopathologist as part of our practice. This enchances the care that we are able to provide to you and simplifies the billing process. Advanced Dermatology will file an insurance claim for each biopsy or excision processed in our on-site lab. These services will be billed under the names of the laboratory physicians, Dr. Zivony and Dr. Swick, for the portion of services they provide to process your biopsy. Once insurance processes your claim, if there is a patient balance, you will receive a statement from Advanced Dermatology. You will see Drs. Zivony and Swick as billing providers on your statement for the services they provided in the lab even if you did not see these providers during your recent office visit.

Medicaid

Medicaid patients must present a current Medicaid card and be prepared to pay any applicable co-payments. If you do not bring your current Medicaid card and applicable co-payment, your appointment will be rescheduled.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determinate of usual and customary rates.

Minor patients

A parent or guardian must accompany a patient under the age of 18 and are responsible for consent of treatment and full payment. Unaccompanied minors will not be treated.

Medical Records

The authorization for release of medical records will be provided to you upon request. A signed authorization is needed to release medical records and a new release is required every 12 months. **Please allow 72 hours to process medical record requests after we have received your signed form.**

In Closing

Good medical care results from mutual understanding, respect and trust. Our goal is to provide you with the highest quality care possible. Should you have any questions, comments or suggestions on how we may improve our service, please let us know.

Rev. 2015

Advanced Dermatology & Skin Surgery

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THIS NOTICE IS REQUIRED UNDER FEDERAL MANDATE OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by our physicians and medical staff.

Payment. Your health information may be used to seek payment from your health plan, or from other sources of coverage such as an automobile insurer. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Advanced Dermatology and Skin Surgery. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Appointment reminders. Your health information may be used or disclosed to provide a reminder to you about an upcoming appointment.

Treatment Options. Your health information may be used to send you information regarding new treatment or management options for your medical condition.

Workers Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information (Advanced Dermatology and Skin Surgery is not required to honor, and withholds the right to deny, any such request).
- the right to receive confidential communications concerning your medical condition and treatment

- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed (such an accounting will not include disclosures for treatment, payment, health care operations and disclosures made based upon an authorization).
- the right to receive a printed copy of this notice

Advanced Dermatology and Skin Surgery Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our front office staff or our privacy officer. We may charge you a reasonable fee for copying and mailing of protected health information.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Patti Cummings, Privacy Officer
Advanced Dermatology & Skin Surgery
16 Medical Park Drive
Asheville, NC 28803

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also send a written complaint to the U.S. Secretary of the Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Patti Cummings, Privacy Officer
Advanced Dermatology & Skin Surgery
16 Medical Park Drive
Asheville, NC 28803

Effective Date: This Notice is effective on or after April 14th, 2003.

ADVANCED DERMATOLOGY & SKIN SURGERY, P.A.

PATIENT REGISTRATION **(Please Print)** **Today's Date** ____/____/____

Name _____
Last First M.I.
Mailing Address _____ _____
City State Zip Code
Home Phone_____Cell Phone_____Work Phone_____
(Area Code) (Area Code) (Area Code)
Date of Birth ____/____/____ Age_____ Sex_____ Marital Status _____ Email_____

Race (circle) Caucasian African American Asian American Indian Native Alaskan Hawaiian Pacific Islander

Ethnicity (circle) Non-Hispanic/Latino OR Hispanic/Latino

Language (circle) English Spanish French German Vietnamese Italian Mandarin

PARENT OR RESPONSIBLE PARTY *(if different from patient*)

Name _____
Last First M.I.
Address_____
City State Zip Code
Home Phone _____Cell Phone_____Work Phone_____
(Area Code) (Area Code) (Area Code)
Date of Birth____/____/____ Sex_____

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

Primary Insurance Name _____
Ins. Address _____
Name of Insured _____
Insured's ID#_____
Insured's SSN _____
Group # _____
Insured's Date of Birth _____
Employer Name _____
Employer Address _____
Employer Phone (_____)_____
Relationship of patient to the Insured _____

Secondary Insurance Name_____
Ins. Address _____
Name of Insured _____
Insured's ID# _____
Insured's SSN _____
Group _____
Insured's Date of Birth _____
Employer Name _____
Employer Address _____
Employer Phone (____)_____
Relationship of patient to the Insured _____

Pharmacy of choice _____ Phone _____
Referred by _____
Primary Care Physician _____

Please see other side.

Advanced Dermatology & Skin Surgery

I have read and understand the financial and office policy of the practice and I agree to be bound by its terms. I hereby authorize Advanced Dermatology & Skin Surgery to collect financial information arising from my treatment. This includes, but is not limited to, hospital and laboratory services. I also understand and agree that such terms may be amended from time-to-time by the practice.

Patient/responsible party signature _____Date___/___/_____

Please **print** the name of the patient_____

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. I also authorize payment of medical benefits to the physician.

Patient/responsible party signature _____Date___/___/_____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected at the time of service in some instances, prior to your visit. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. Deposits may be required prior to scheduling certain procedures. Delinquent accounts will be charged an administration fee of $50. Your signature below signifies your understanding and willingness to comply with this policy.

Patient/responsible party signature _____Date___/___/_____

NAME:_____ TODAY'S DATE:__/__/____ Office use-Reviewed___

DATE OF BIRTH: __/__/____ Name I prefer to be called: _____ Entered: ___

PAST MEDICAL HISTORY (Please **circle** all that apply) Scanned: ___

Anxiety	End Stage Renal Disease	Leukemia or Lymphoma
Depression	Hearing Loss	Radiation
Arthritis	Heart Attack/Stroke	Cancer: _____
Artificial Joints	Hepatitis B or C	Other: _____
Diabetes	HIV/AIDS	None

PAST SKIN DISEASE HISTORY (Please **circle** all that apply)

Actinic Keratoses	Melanoma	Other:_____
Basal Cell Carcinoma	Squamous Cell Carcinoma	None

PAST SURGICAL HISTORY (Please **circle** all that apply)

Heart Valve Replacement	Other: _____
Joint Replacement	None

□ Do you have an immediate family history of melanoma? **Yes** or **No**. If yes, Mother Father Sister Brother or Child
□ Are there any pertinent or major skin problems that run in your family? _____

MEDICATIONS (Please **list** all your medications, including vitamins and supplements, doses & frequencies, tablet or liquid)

			SEE LIST

ALLERGIES TO MEDICATIONS (Please **list** any medication allergies and the **type of reaction** that occurred)

_____

PHARMACY (Please provide the pharmacy name and general location)

_____

PRIMARY CARE DOCTOR: _____REFERRING DOCTOR:_____

DERMATOLOGY ALERTS (Please **circle** any of these important alerts if they apply to you)

Allergy to lidocaine	Artificial heart valve	Defibrillator
Rapid heartbeat with epinephrine	Artificial joints within last 2 years	Pacemaker
Allergy to adhesive	Premedication prior to procedures	Pregnant, planning or nursing
Allergy to topical antibiotics	Blood thinners	Other_____

□ What is your current and/or former occupation? _____
□ What type of outdoor activities, if any, do you participate in? _____
□ Do you have any other hobbies or activities you would like us to know about? _____
□ Do you have any children or pets? _____
□ With whom, if anyone, do you live? _____
□ Where do you live (generally speaking: what town or city or county, assisted living facility)? _____

PLEASE DETAIL THE REASON FOR TODAY'S VISIT

	Problem 1	Problem 2
Problem (e.g. growth(s) or rash or follow-up for a skin condition?)		
Location (site on body?)		
Quality (stable, asymptomatic, itch, bleed, tender, scaly, rough, darker, enlarging?)		
Severity (mild, moderate, or severe?)		
Duration (how long?)		
Previous treatments (OTC, prescriptions or other?)		
What makes it better or worse?		

Do you have any other rashes? YES or NO
Do you have any problems with allergy or your immune system? YES or NO
Are you under significant stress? YES or NO
Do you have problems with scarring? YES or NO
Do you have problems with healing? YES or NO
Do you have problems with bleeding? YES or NO

Advanced Dermatology & Skin Surgery
Daniel Zivony, MD●Todd Wilkinson, MD●Elise Rackoff, MD●Stephanie Myracle, MD
Adriane Barlow, PA-C● Chris Lyon, PA-C
16 Medical Park Drive●Asheville, North Carolina 28803●Phone: 828-274-4880●Fax: 828-274-6868

Advanced Dermatology & Skin Surgery ASHEVILLE

HIPAA Notice of Privacy Practices Authorization

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices which provides a more complete description of such uses and disclosures. I also understand that this practice has the right to change its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Advanced Dermatology and Skin Surgery Privacy Officer at: 16 Medical Park Drive, Asheville, NC 28803.

●May we call your home or other alternative location and leave a message in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations (TPO), such as appointment reminders, insurance items and any calls pertaining to your clinical care including lab results, among other. □**YES** □**NO**
If yes, please provide phone number:_____

●May we phone you at work and leave a message to call our office? □**YES** □**NO**
If yes, please provide phone number:_____

●May we mail appointment reminders/patient statements to your home or alternate address? □**YES** □**NO**
*Our office will mail benign lab results to the patient. These results are in the form of a postcard, addressed to the patient. Unless told otherwise, these results will be mailed to your home address. Please notify our office if you want these results mailed to an alternate address:_____

●Do we have your permission to talk to family members or other individuals regarding your PHI? □**YES** □**NO**
If yes, please provide their name, phone number, and relationship to you.

Name:_____Phone:_____Relation:_____

Name:_____Phone:_____Relation:_____

Patient Information: I understand that I have the right to revoke this authorization at any time in writing. I understand that a revocation is not effective in cases where the 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 or state law.

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

Authorization Signature of patient:_____, or

Signature of Legal Guardian:_____(if patient is under 18 years of age)

Note: A signed authorization must be updated annually. This form does not authorize the release of actual medical records to you or your representative(s). An authorization for the release of medical records is available upon request.

Consent I hereby give my consent for Advanced Dermatology and Skin Surgery to use and disclose my protected health information (PHI) to carry our treatment, payment, and healthcare operations.

Signature of patient:_____ Print patient name:_____, or

Signature of Legal Guardian:_____ (if patient is under 18 years of age)