

ADVANCED DERMATOLOGY & SKIN SURGERY, P.A.

OFFICE POLICIES

Thank you for scheduling an appointment with Advanced Dermatology & Skin Surgery. We are committed to your treatment and wellbeing 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. **Your initials and signature are required prior to any treatment.**

What You Should Bring

- Plan to arrive 15 minutes prior to your scheduled appointment time.
- **A valid copy of your Insurance ID Card is required at the time of your office visit.** If we are unable to verify your insurance information before you see the doctor, payment in full will be expected at the time of service.
- If your insurance requires an authorization for the visit, you must obtain this prior to arriving for your appointment.
- Completed Patient Registration and Medical History forms.
- A photo ID.
- A major credit card.
- Medical records related to your visit.

Office Hours

The office is open Monday-Friday 8:00 AM-5:00 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 or serious situation 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.

FINANCIAL POLICIES

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. It is your responsibility to understand your insurance plan coverage. You may wish to contact the number on the back of your card to review and verify your benefits. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services or diagnosis codes which they will not cover. **Our office never guarantees that your insurance will pay for all services.** If, for any reason your claim is denied, or the payment from them is less than anticipated, you are responsible for the balance due on your account.

Initial

Co-payments, Deductibles and Coinsurance

A **copayment** is a dollar amount set by your insurance company which you are responsible for at each visit. A **deductible** is the amount you are obligated to pay before your insurance company starts paying for your healthcare costs. Some insurance plans may also have a **coinsurance**, in which you may be responsible for a percentage of healthcare costs in addition to your copay or deductible. Payment will be due at time of service if your deductible has not been met or if your plan requires a coinsurance payment. Should your insurance company notify us that additional payment over and above copayments, deductibles, or coinsurance is due from you, you will be billed for this amount.

- We may require a deposit to schedule certain procedures with the balance due in full at the time the procedure is performed. You will be notified of this prior to scheduling your procedure.
- All past due balances are required to be paid in full before new services are rendered. Prior balances and copayments may be collected at check-in.

Initial

Credit Card of File

We offer a Credit Card on File program as a convenient method of paying for the portion of your services that your insurance policy requires you to pay such as copay, deductible, and co-insurance. We must have a signed authorization on file to charge your credit card. This program expedites the checkout process and enables us to process refunds on your account efficiently.

Refunds

Please allow 10-14 business days for refunds to be processed once an overpayment has been determined.

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.

Self-pay

Patients who do not have insurance coverage are considered self-pay. Payment in full for services provided are due at the time of service for self-pay patients.

Laboratory and Pathology Fees

It may be necessary to obtain a tissue sample (biopsy) or perform lab tests to confirm a diagnosis or determine a course of treatment. Advanced Dermatology & Skin Surgery has an on-site lab and pathologist who perform the slide preparation and interpretation of our patients' biopsy specimens. Fees associated with this service are separate from the procedure performed by your treating provider. You may receive an additional bill for lab services that are not paid by your insurance. Depending on specific factors, your provider may send the specimen to an outside lab for slide processing and interpretation. In those instances, patients or their insurance will receive a bill from the outside lab.

Initial

Cosmetic Services (services that are not medically necessary)

Patients are responsible for all cosmetic procedure fees at the time of service. We do not bill insurance companies for cosmetic procedures. The cost of any procedure will be a separate fee from an office visit or consultation fee.

Missed Appointments, Late Cancellations, & Non-Compliance

Please keep in mind that appointments are time-slots reserved specifically for you. We require a 24-hour advance notice if you are unable to keep your scheduled appointment. As a courtesy, we offer appointment reminder calls which will allow you to cancel or reschedule at that time. However, it is ultimately your responsibility to keep track of your appointments whether you receive a reminder call or not.

- 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 within 24 hours of your appointment, there will be a \$50 charge.
- Patients with repeat cancellations or missed appointments may be discharged from our practice.
- Please note that noncompliance with treatment plans (including medications and/or lab work) and abusive/inappropriate behavior towards staff and/or other patients will result in dismissal of your care from our practice.

Initial

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.

Methods of Payment

For your convenience, we accept cash, personal checks, MasterCard, Discover, American Express, Visa and CareCredit. There is a \$25 fee for all returned checks.

Medical Records

A signed authorization is required. Please allow us 72 hours to process your request.

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 _____

Home Phone _____ Cell Phone _____ City _____ State _____ Zip Code _____

(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 _____

Home Phone _____ Cell Phone _____ City _____ State _____ Zip Code _____

(Area Code)

(Area Code)

(Area Code)

Date of Birth ____/____/____ Sex _____

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

Primary Insurance Name _____ **Secondary** Insurance Name _____

Ins. Address _____ Ins. Address _____

Name of Insured _____ Name of Insured _____

Insured's ID# _____ Insured's ID# _____

Insured's SSN _____ Insured's SSN _____

Group # _____ Group _____

Insured's Date of Birth _____ Insured's Date of Birth _____

Employer Name _____ Employer Name _____

Employer Address _____ Employer Address _____

Employer Phone (____) _____ Employer Phone (____) _____

Relationship of patient to the Insured _____ 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

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)



Credit Card on File Authorization

Advanced Dermatology & Skin Surgery offers a Credit Card on File program as a convenient method of paying for the portion of your services that are patient responsibility such as copay, deductible, and co-insurance. Your credit card information will be kept confidential and secure.

I (we), the undersigned, authorize and request that Advanced Dermatology & Skin Surgery charge my credit card for the balance due that my health plan has identified as my financial responsibility. This authorization relates to all charges not covered by my insurance company for services provided to me by Advanced Dermatology & Skin Surgery. My card will remain securely stored for future use by Open Edge, a secure credit card processor affiliated with Global Payments Merchant's Services that partners with Advanced Dermatology & Skin Surgery to collect payments. This authorization will remain in effect until revoked by me in writing.

Patient's chart # _____ Patient's name: _____ DOB: _____

☐ Please keep my credit card on file and charge my account to pay for charges not paid by my insurance plan.

Charge limits: Balances exceeding \$ _____ require verbal authorization from me. Charges under this amount require no further authorization.

Patient/Guardian signature: _____ Date: _____

Credit card information:

Card type: Amex Visa Mastercard Discover

Is this card a Flexible Spending/Health Savings card? Yes No

Card number ending in(last 4 digits) : _____ Expires: _____

Cardholder name: _____

Card's bill to address: _____

City _____ State _____ Zip _____ Contact phone: _____

Transaction type: AUTHORIZATION

Email receipt to _____ @ _____ or ☐ mail receipt

Authorization received by: _____ Office location: _____



Credit Card on File Policy

Advanced Dermatology & Skin Surgery offers a Credit Card on File program as a convenient method of paying for the portion of your services that your insurance policy requires you to pay such as copay, deductible, and co-insurance. Your credit card information will be kept confidential and secure. This policy has been implemented to simplify and enhance your patient experience, and to simplify our business operations.

Q & A about Credit Card on File

How does this work? At patient registration we will ask you to sign a credit card on file agreement. As part of the agreement you will be able to set a maximum to be charged to your card. Charges that exceed this maximum require verbal authorization from the card holder prior to processing payments. At checkout, fees due at the time of service will be paid using the card on file unless you elect to pay by an alternative method.

What are the benefits to me? You can use your credit card on file to pay for copays, coinsurance, and deductibles at future visits. It will make checkout easier, faster, and more efficient.

What if I don't have a credit card? It is our policy that payment is due at the time of service. You may also keep your Health Savings Account (HSA) or Flex Spending Account (FSA) credit cards on file. If you do not have either of these types of cards, then you can use a debit or credit card. We accept Visa, Mastercard, American Express, and Discover.

How can I be assured that my credit card information will remain safe? We are under the strict rules and guidelines of Payment Card Industry (PCI) Compliance, and HIPAA Compliance to protect patient privacy and credit card information is considered protected health information. Open Edge, our credit card processing vendor, will store your information on a secure and encrypted site, which will enable us to run bank card transactions on our computer system. Our employees will not have access to your bank card.

Effective 1/2018