2406 Blue Ridge Road # 180
Raleigh, NC 27607
Phone 919-322-0049 Fax 919-322-0056

Patient Registration Information

Name:_____
First: Last Name: M.I.

What would you like to be called? _____ Date of Birth: _____Age: ____ Sex: M F

Home Address: _____City: _____ State: _____ Zip:_____

Home Phone:_(___)_____Work Phone:_(___)_____Other:_(___) _____

Occupation: _____ Social Security: _____

Employer's Name & Address: _____

EMAIL Address: _____

Martial Status: minor_____single_____married_____widowed_____divorced_____separated_____

Name of Spouse (or Parent if Minor):_____

Patients Doctor (Internist, Family, Practitioner, Pediatrician):_____

Address: _____Phone: (____) _____

Pharmacy Name & Phone Number: _____

How did you hear about us/Referred by? _____

Spouse, Parent or Guardian Information

Name:_____Date of Birth:_____SSN: _____

Employer:_____Phone: _(_____) _____

Employer's Address: _____

Payment Information

Office Policy: Payment is expected at any time your visit for any deductible, co-payments, unpaid Medicare or insurance balance and any cosmetic procedures or skin care products. We appreciate your cooperation in settling your account at each office visit. If your insurance plan is responsible for payment, please present your insurance card to our reception desk.

Please note that a $50 "No Show" fee will apply for each missed appointment or when rescheduling does not happen within 24 hours prior to any visit.

Primary Insurance:
Name of the Insurance Co.:_____
Policy Holder's Name:_____SSN:_____
Date of Birth:_____Relationship to Patient:_____

Secondary Insurance:
Name of the Insurance Co.:_____
Policy Holder's Name:_____SSN:_____
Date of Birth:_____Relationship to Patient:_____

Skin Center OF THE TRIANGLE

2406 Blue Ridge Road # 180
Raleigh, NC 27607
Phone 919-322-0049 Fax 919-322-0056

Medical Information

I. Medical/Surgical History:

Do you have now or have you ever had:

	Yes	No
High Blood Pressure		
Diabetes/High Blood Sugar		
Asthma		
Tuberculosis		
Hay Fever/Seasonal Allergies		
Seizures		
Stroke Or Mini-Stroke		
Heart Attack/Angina		
Pacemaker		
Heart Murmur/Palpitations		
Kidney/Bladder Problems		
Prostate Problems		
Glaucoma		
Hepatitis/Liver Disease		
Recurrent Yeast Infections		
Bowel Disease/Colitis/Crohn's		
Frequent/Sever Headaches		
Cancer Other Then Skin		
Radiation		
Artificial Joint Heart Valve		
Past Surgery		
Other		

If 'Yes' to any above, please explain:

II. Current Health:

	Yes	No
Do you smoke?		
How much?		
Do you drink alcohol?		
How much?		
Do you use drugs?		
How much?		

III. Medications

List all medications you are taking, including any over-the-counter herbals or vitamins:

IV. Dermatologic History:

Do you have now or have you ever had

	Yes	No
Keloids/Abnormal Scaring		
Poor Wound Healing		
Skin Pigmentation Problems		
Reaction To Local Anesthetics		
Cold Sores/Herpes Infections		
Eczema		
Psoriasis		
Abnormal ("Dysplastic") Moles		
Precancerous Spots		
Skin Cancer – Melanoma		
Skin Cancer – Basal Cell		
Skin Cancer – Squamous Cell		
Abnormal Cold Sensitivity		
Abnormal Sun Sensitivity		
Cosmetic Surgery		

If 'Yes' to any above, please explain:

V. Allergies:

Are you sensitive / allergic to any oral medications? Please List:

VI. Family History

Do you have a family history of:

	Yes	No
Allergies/Asthma		
Skin Cancer – Melanoma		
Abnormal ("Dysplastic") Moles		
Skin Cancer – Basal/Squamous Cell		
Other Skin Disorder		

VII. Females

	Yes	No
Excess Facial/Body Hair		
Regular Menstrual Periods		
How many pregnancies?		
How many miscarriages/abortions?		
Are you pregnant or nursing?		
Names/ages of your children:		

2406 Blue Ridge Road # 180
Raleigh, NC 27607
Phone 919-322-0049 Fax 919-322-0056

Assignment of Rights & Benefits (1)

_____
Patient's Name (or responsible party for a minor)

I hereby assign all rights and benefits under my contract with my insurance company to THE SKIN CENTER OF THE TRIANGLE and/or Providers for the purposes of determining the details of the benefits of my policy and obtaining payment for services given.

The assignment further permits THE SKIN CENTER OF THE TRIANGLE and/or Providers to obtain from my insurance all information necessary, for the determination of benefits allowed under the contract and permits the direct disclosure to THE SKIN CENTER OF THE TRIANGLE of all information including benefits provided, limits and exclusions of benefits and reasons for denial of benefits or reduction in charges for services rendered.

The assignment shall allow THE SKIN CENTER OF THE TRIANGLE and/or Providers to take actions necessary to obtain the benefits I have, in good faith, been promised by my insurance. All benefits are to be paid directly to THE SKIN CENTER OF THE TRIANGLE and/or Providers.

A photocopy of this assignment shall be considered as effective and valid as the original.

I further authorize THE SKIN CENTER OF THE TRIANGLE and/or Providers to initiate a complaint to Insurance Commissioner's office for any reason on my behalf.

I understand that my insurance carrier may disallow certain diagnoses or services as medically uncovered, medically unnecessary or cosmetic. I agree to be responsible for payment of all such services rendered to my dependents or me.

I also understand that my insurance policy is a contract between my insurance company and me. If my insurance company does not claim within 30 days after it is received, I agree to remit payment to THE SKIN CENTER OF THE TRIANGLE and/or Providers within 2 weeks of receiving the bill, and contact my insurance company regarding this settlement. THE SKIN CENTER OF THE TRIANGLE and staff will assist me in processing my claim; however, I am ultimately responsible for paying of my account.

I agree that if my insurance carrier issues a check in my name for reimbursement for services rendered by either the physician and/or facility, I will within five days of receipt of this check make payment in the amount of said check to the physician or facility.

A $20.00 fee will be charged for each insufficient funds check returned.

This is a direct assignment of my rights and benefits under this policy.

_____
Policy Holder / Insured Name

_____
Patient Name Date Patient Signature

(1) Assignment means "to give". This form means you are giving this office full authority to act on your behalf in obtaining information and collecting money for your health care at this office. You are still responsible for the full payment of your care including the annual deductible, co-payments and amounts the insurance will not pay.

2406 Blue Ridge Road # 180
Raleigh, NC 27607
Phone 919-322-0049 Fax 919-322-0056

Authorization to Contact Patient and Record of Disclosures

>>The HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. (PHI) The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.<<

I wish to be contacted in the following manner (check all that apply):

___Home telephone.
___Okay to leave a message with detailed information.
___Okay to mail to my home address.
___Okay to mail to my work/office address.
___Written communication.
___Leave a message with call back number only.
___Okay to fax to: _____.

___Work Telephone
___Okay to leave a message with detailed information. __Leave a message with call back number only.

___Other:_____
_____

_____
Patient Signature Date

_____
Print Name

Office Use Only

****

Healthcare entries must keep records of PHI disclosures. The information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and disclosure for TPO may be permitted without prior consent in an emergency.

Date_____Disclosed to whom_____
Description of disclosure_____
By whom Disclosed_____Address or fax number_____
Purpose of Disclosure_____

___1. Check box if disclosure is authorized.
___2. Enter how disclosure was made: F-fax, E-e-mail, M-mail, O-other

Comments:_____
_____
_____
_____

2406 Blue Ridge Road # 180
Raleigh, NC 27607
Phone 919-322-0049 Fax 919-322-0056

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. If you have any questions about this Notice please contact: the office manager. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information Based upon Your Written Consent

You will be asked by your physician to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

Following are examples of the types of uses and disclosures of your protected health care information that physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information, for example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information form time-to-time to another physician of health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: As your services will be completely paid on the date of service or agreements for credit issuing agencies signed, we do not release any billing information to anyone but yourself and then only with written consent from you to do so.

Healthcare Operations: We may use of disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of employees, licensing, marketing, and fundraising activities, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to employees that see patients at our office. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use of disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use of disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about or practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact and request that these fundraising materials not by sent to you.
We may use of disclose your demographic information and the dates that you received treatment form your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive there materials, please contact our Privacy Contact and request that these fundraising materials not be sent to you.

Skin Center OF THE TRIANGLE

2406 Blue Ridge Road # 180
Raleigh, NC 27607
Phone 919-322-0049 Fax 919-322-0056

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May be made with Your Consent, Authorization or Opportunity to Object

You have the opportunity to agree or object to the use of disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this care, only the protected health information that is relevant to your health care will be disclosed.

You have the right to inspect and copy your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care of for the notification purpose as described in this notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment of healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care of for the notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use of disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction in writing to our Privacy Contact.

You have the right to request confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable request. We may also condition this accommodation by asking you for information as to how payment will be handled of specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosure we may have made to you, for a facility director, to family members or friends involved in your care, or for notification purposes. You have the right to receive this information is subject to certain exceptions, restrictions, and limitations.
You have the right to obtain a paper copy of this notice from us. Upon request, even if you have agreed to accept this notice electronically.

3. Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact (office manager) of your complaint. We will not retaliate against you for filing a complaint. You may contact our office for further information about the complaint process.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name	Signature	Date

2406 Blue Ridge Road # 180
Raleigh, NC 27607
Phone 919-322-0049 Fax 919-322-0056

Physician-Patient Arbitration Agreement

HIPAA

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have viewed and been offered a copy of the Notice of Privacy Practices from The Skin Center of the Triangle, Office of Deborah Kessler Hudak, MD.

Reference for complete Notice of Privacy Practices and
Updates to this policy, effective January 2013 may be found at:
http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf

_____
Patient Name (Print)

_____
Signature & Relationship to Patient

_____
Date

For Office Use Only:

We have made a good faith effort in attempting to obtain written acknowledgement of receipt of the Notice of Privacy Practices. Acknowledgement could not be obtained for the following reason(s):

- o Patient/Individual refused to sign (Date of refusal)_____
- o Communications barriers prohibited obtaining an acknowledgement
- o An emergency situation prevented us from obtaining an acknowledgement
- o Other

_____

Attempt was made by: _____ date: _____

Skin Center OF THE TRIANGLE

2406 Blue Ridge Road # 180
Raleigh, NC 27607
Phone 919-322-0049 Fax 919-322-0056

Article 1 - **Agreement to Arbitration:** It is understood that any dispute as to medical malpractice, that is as to whether any medical service rendered will be determined by submission to arbitration as provided by North Carolina law, and not by a lawsuit or resort to court process except as North Carolina law provides for judicial review of arbitration processing. Both parties to this contract by entering into it are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and are instead are accepting the use of arbitration.

Article 2 - **All Claims must be Arbitration:** It is the intention of the parties that this agreement binds all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn at that time of the occurrence given rise to any claim. In the case of any pregnant mother the term "patient" herein shall mean both the mother and the mothers expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of small claims court against the physician and physician's partners, associates, association or partnership and employees, agents and estates of any of them must be arbitrated including without limitations, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any actions in any court by physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute shall be resolved by arbitration, whether or not the subject of any existing court action.

Article 3 - **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have absolute right to arbitrate separately the issue of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of North Carolina law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to Code of Civil Procedures and summon adjudication person in accordance with Code of Civil Procedure.

Article 4 - **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one processing. A claim shall be waved and forever barred if (1) on the date notice thereof is received the claim, if asserted in a civil action, would be barred by the applicable North Carolina statute of limitation, or (2) the claimant fails to pursue arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for the arbitration shall be governed by the North Carolina Code of Civil Procedures provisions relating arbitration.

Article 5 - **General Provisions:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature and if revoked will govern all medical services received by the patient.

Article 6 - **Retroactive Effect:** If patient intents this agreement to cover services rendered before the date it is signed (including, but limited to emergency treatment) patient should initial below:

Effective as of the date of first received medical service.

_____
Patient or Parent Representative's initial

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain full forced and shall not be affected by invalidity of any other provision. I understand that I have the right to receive a copy of the arbitration agreement. By my signature below I acknowledge that I have received a copy.

Notice: By signing this contract you are agreeing to have any issue of medical malpractice decided by natural arbitration and you are giving up your right to a jury or court trial (see Article 1 of contract).

_____ _____
Physician or Authorized Representative's Signature Date

_____ _____
Signature of Translator (If applicable) Date

_____
Print Name of Translator

_____ _____
Patient's Signature Date

_____
Print Patient's Name

_____
Patient's Representative Signature Date

_____
Print Name and Relationship to Patient

A signed copy of this document is to be given to the patient. The Original is to be filed in the Patient's medical records.

2406 Blue Ridge Road # 180
Raleigh, NC 27607
Phone 919-322-0049 Fax 919-322-0056

Important Notification

The Skin Center's Insurance and Payment Policies:

As a courtesy to our patients, The Skin Center of the Triangle will file your insurance for you. Should your insurance company apply our services to your deductible, you will receive a bill.

All copayments are due at the time of service, as well as any applicable coinsurance.

It is the patient's responsibility to notify The Skin Center of the Triangle of any changes in insurance coverage.

We at the Skin Center of the Triangle will make every effort to assist you and our Practice Manager will be happy to answer any questions regarding your account.

Thank you.

Patient's Signature Date