dermatology
& laser center
of chapel hill

58 Chapelton Court, Suite 120
Chapel Hill, NC 27516
Phone (919) 942-2922 Fax (919) 903-9183
contact@dlcofchapelhill.com

Patient Information

Patient Name: _____

If under 18, Parent/Legal Guardian Name: _____

Address: _____ City _____ST_____ Zip_____

Phone 1: _____(home/cell/work) Phone 2: _____(home/cell/work)

Date of Birth: _____Age: _____Gender: _____

Employer: _____ Occupation: _____

Email: _____ I do **NOT** want to receive exclusive offers via email. _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone#(s): _____

How did you learn about our practice?

- ☐ Referring Physician_____
- ☐ Patient/Friend
- ☐ Internet
- ☐ Community Event_____
- ☐ Other_____

PrimaryCarePhysician(PCP): _____ Phone#_____

Referring Physician: _____ Phone#_____

Pharmacy: _____ Address/Phone#: _____

INSURANCE: Please provide a copy of your insurance card. DLC accepts BCBS, Cigna, Medicare, United Healthcare. *We are out of network with Blue Local, Blue Value and Medicare Advantage Plans.* Patients are responsible for paying Out-of-Network service, knowing their own insurance benefits and securing referral obligations.

Does your insurance require a referral from your PCP? Please indicate: _____

Primary Insurance: _____ Secondary Insurance: _____

Policy #: _____ Policy #: _____

Primary Insured Person: _____ Secondary Insured Person: _____

Co-Payment: $_____ Co-Payment: $_____

RESPONSIBLE PARTY: (Person who should receive the bill.)

Patient's relationship to Responsible Party: Self Spouse Child Other _____

Name: _____ Date of Birth: _____ Age_____

Address: _____City _____ST _____ Zip _____

Phone 1:_____(home/cell/work) Phone 2:_____(home/cell/work)

FORM UPDATE REQUIRED EVERY 2 YEARS

Patient Name: _____ Date: _____
Reason for today's visit: _____

Current Medications and Supplements

Medication	Dosage	Frequency	Route

Do you have any ***allergies to medications***? If yes, please list:

_____ ☐ No Allergies to Medications

Skin Disease History:

- ☐ Acne
- ☐ Actinic keratosis
- ☐ Atypical/dysplastic moles
- ☐ Basal cell skin cancer
- ☐ Cold sores
- ☐ Dry skin
- ☐ Eczema
- ☐ Melanoma
- ☐ Peeling/blistering sunburn
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Seasonal allergies
- ☐ Squamous cell carcinoma
- ☐ Tanning bed use
- ☐ Warts
- ☐ Other: _____

Sunscreen use:
- ☐ Yes, SPF _____
- ☐ No

Medical History:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Defibrillator
- ☐ Depression
- ☐ Diabetes
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Kidney disease
- ☐ Liver disease
- ☐ MRSA
- ☐ Osteoarthritis
- ☐ Pacemaker
- ☐ Radiation treatment
- ☐ Rheumatoid arthritis
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Tuberculosis

Surgical History:

Year	Body Location	Type of Procedure

Tobacco use:

- ☐ Never Smoked
- ☐ Quit/Former Smoker
- ☐ Current Daily Smoker (Packs per day): _____

Please indicate:

- ☐ Allergy to bandages, tape or adhesive
- ☐ Allergy to lidocaine
- ☐ Pregnant or nursing
- ☐ Currently taking a blood thinner

Family Skin Disease History:

__Melanoma. Family Member (s): _____
__Basal Cell Carcinoma. Family Member(s): _____
__Squamous Cell Carcinoma. Family Member (s): _____
__Autoimmune Disease. Family Member (s): _____

Do you currently have any of the following symptoms?

- ☐ Chills
- ☐ Fever
- ☐ Problems with scarring
- ☐ Problems with healing
- ☐ Rash
- ☐ Problems with bleeding
- ☐ Easy bruising

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Financial Policy and Office Protocols

Insurance Participation: Medicare, Cigna, United Healthcare and Blue Cross Blue Shield*: At the time of service, we collect copay, co-insurance and/or deductible amounts. We also collect payment in full for non-covered services. You are responsible for charges your insurance company does not pay. **We do not accept Blue Local, Blue Value or Medicare Advantage Plans.*

Third Party Charges: Your care may require our providers to send a specimen or blood work to an outside laboratory for testing. The outside lab will bill your insurance company directly. You will receive a separate bill from the labs: TriPoint Diagnostics, DermPath and/or Labcorp.

Out-of-Network and Self-Pay Patients: Payment is due in full at the time of service. We accept cash, check, Visa, MasterCard, Discover, and American Express. There is a $30.00 Returned Check fee. Please keep your receipt and obtain instructions from our office for how to file an out of network claim. Your insurance company will send the explanation of benefits and any payment directly to you. It is your responsibility to follow up with your insurance carrier.

Appointments: You will receive a text reminder 3 days prior to your appointment. We require a 48-hour cancellation notice. Our standard $105.00 fee will be charged for cancelled appointments with less than a 48-hour notice unless for an emergency.

- For the first office visit, please arrive 15-20 minutes early. New patient forms must be completed prior to seeing the medical provider and receiving any medical care. New Patient Forms are also available on our website, www.dlcofchapelhill.com, under "Patient Resources."

- Each time a patient misses an appointment without providing 48-hours notification ("no shows"), another patient is prevented from receiving care. After two no-show appointments, we will collect $105.00 in advance to schedule future appointments. If an individual has three (3) no shows within a three (3) year period, we may discharge the individual from our practice.

- Please be aware that Monday appointments must be cancelled by noon on the previous Friday. If you are scheduled for Accutane follow-up, and you cancel or "no show," we may not be able to reschedule your appointment in a timely manner.

- Anytime you will be late for an appointment, please call to inform us. If running more than 15 minutes late, you may be required to reschedule. We will try to accommodate, as we all run late sometimes.

- Appointment length is determined by the health issues provided to the front office at the time the appointment is scheduled (i.e. is the visit for acne, a mole check, a surgical procedure, or a consultation regarding specific skin and/or cosmetic concerns?). Lengthy delays result in patients asking for additional time to address issues other than those originally scheduled. Please be considerate of those waiting.

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MEDICATION REFILLS

Please allow up to 48 hours for prescription requests. Whenever possible, we try to accommodate requests the same day you call. Please submit your request via the patient portal, as this can result in a quicker response time. You may also leave a voicemail on the office **NURSE** line to request a refill. Please leave your **full name, DOB, name of medication and pharmacy contact information.** Please note: Patients not seen at our office in at least one year will be required to schedule an appointment before we will refill the prescription.

LAB AND TEST RESULTS

Some test and lab results can take up to 10-14 days. We will call you if your results require further treatment or evaluation. Your normal results will be available on the patient portal. You may request a copy of your records.

MEDICAL RECORDS

Medical records require a 72-hour notice and are subject to a fee. A **medical records release form** must be on file before records are released. Records may be released to another provider free of charge. Your records may be released to you free of charge.

REFERRALS

You are responsible for insurance prior authorizations. You will need to know if a referral is needed from your insurance company for your visit. If your DLC provider wants to refer you for a test, or to another specialist, please allow 5 days for the medical staff to process your referral.

NO RECORDING POLICY

DLC prohibits the use of any recording devices in the waiting area or in the exam rooms. Any unauthorized recording or photography may result in dismissal from our practice.

Responsibilities: As our patient, it is your responsibility to: truthfully complete all required chart forms; arrive for your appointment on time and prepared; follow the prescribed treatment plan; have dependable transportation to and from our office; have adult supervision post-procedure when required by our providers; accept financial responsibility for any charges not covered by your insurance and pay for services at the time rendered; treat our staff and other patients respectfully.

I agree that I have completed all information truthfully and have read and understand my patient responsibilities.

Patient Signature: _____ Date:_____
Relationship to patient (if not self):_____

Privacy Notice Agreement

I understand that the Dermatology & Laser Center of Chapel Hill, PLLC, may use my health information for treatment, payment, and health care operations. I have been shown a copy of the practice's Notice of Privacy Practices (NPP) that describes how my information may be used and disclosed. I understand that the Practice has the right to change this notice at any time. I may obtain a current copy of the NPP by contacting the practice at (919) 942-2922.

Patient Signature: _____ Date:_____
Relationship to patient (if not self): _____
FORM UPDATE REQUIRED EVERY 2 YEARS