Carolina Dermatology
& SKIN CANCER SURGERY, P.A.
BILLIE F. COSGROVE, M.D. **MICHAEL D. SULLIVAN, M.D.**
1814 Glen Meade Road Wilmington, NC 28403
910.254.3544 Fax 910.254.3543

PATIENT INFORMATION

NAME_____
LAST FIRST MIDDLE

HOME ADDRESS_____
CITY STATE ZIP

MAILING ADDRESS_____
CITY STATE ZIP

HOME PHONE_____ WORK PHONE_____ SS#_____

BIRTHDATE_____/_____/_____ AGE_____ GENDER_____ MARITAL STATUS_____

SPOUSE NAME (if minor, PARENT'S)_____
LAST FIRST MIDDLE

RESPONSIBLE PARTY (if different than patient)

NAME_____
LAST FIRST MIDDLE

ADDRESS_____
CITY STATE ZIP

HOME PHONE_____ WORK PHONE_____ SS#_____

BIRTHDATE_____/_____/_____ EMPLOYER_____

INSURANCE INFORMATION (please present current insurance ID cards at time of check in)

PRIMARY INSURANCE NAME_____

INSURANCE ADDRESS_____

NAME OF INSURED_____

INSURED'S ID #_____ GROUP #_____

INSURANCE PHONE_____

EMPLOYER NAME_____ EMPLOYER PHONE_____

EMPLOYER ADDRESS_____

RELATIONSHIP OF PATIENT TO INSURED _____

SECONDARY INSURANCE NAME_____

INSURANCE ADDRESS_____

NAME OF INSURED_____

INSURED'S ID #_____ GROUP #_____

INSURANCE PHONE_____

EMPLOYER NAME_____ EMPLOYER PHONE_____

EMPLOYER ADDRESS_____

RELATIONSHIP OF PATIENT TO INSURED _____

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CAROLINA DERMATOLOGY AND SKIN CANCER SURGERY

NEW PATIENT HEALTH INFORMATION

Age _____

Name _____ Today's Date _____

Have you ever been diagnosed with:

☐ Yes ☐ No CANCER

If YES, please describe type and treatment and date.

_____

_____

☐ Yes ☐ No HEPATITIS Type _____ When Diagnosed _____

☐ Yes ☐ No POSITIVE HIV

☐ Yes ☐ No BLEEDING PROBLEMS

☐ Yes ☐ No FAMILY HISTORY OF MELANOMA

*☐ Yes ☐ No PERSONAL HISTORY OF SKIN CANCER—BASAL CELL CARCINOMA, SQUAMOUS CELL CARCINOMA, MELANOMA

If YES, please describe the type of skin cancer, location, treatment and date.

_____

_____

PLEASE LIST ANY OTHER SIGNIFICANT MEDICAL PROBLEMS:

_____

_____

☐ Yes ☐ No Do you smoke? _____ pp day

☐ Yes ☐ No Do you use alcohol? _____ how much?

Do you have or have you had:

☐ Yes ☐ No HEART MURMER

☐ Yes ☐ No PROSTHETIC HEARTH VALVE

☐ Yes ☐ No ARTIFICIAL JOINT

☐ Yes ☐ No HAYFEVER/ASTHMA

☐ Yes ☐ No ARE YOU PREGNANT/ BREASTFEEDING?

☐ Yes ☐ No KELOIDS/THICK SCARS

☐ Yes ☐ No PACEMAKER

☐ Yes ☐ No STROKE

☐ Yes ☐ No GASTROINTESTINAL DISORDER

☐ Yes ☐ No SEIZURES

☐ Yes ☐ No ARE YOU ON BIRTH CONTROL PILLS?

☐ Yes ☐ No UNEXPLAINED WEIGHT LOSS?

☐ Yes ☐ No ALLERGIC TO ANY MEDICATIONS?

Please List _____

PLEASE LIST MEDICATIONS (dosages not necessary) Dates updated by nurse/Dr.

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____
7. _____ _____
8. _____ _____

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TERTIARY INSURANCE NAME_____

INSURANCE ADDRESS_____

INSURANCE PHONE_____

IN CASE OF EMERGENCY, NOTIFY_____ PHONE_____

REFERRING PHYSICIAN_____

PRIMARY CARE PHYSICIAN_____

DO WE HAVE PERMISSION TO:

LEAVE A MESSAGE ON YOUR HOME ANSWERING MACHINE? [ ] YES [ ] NO

LEAVE A MESSAGE AT YOUR PLACE OF EMPLOYMENT? [ ] YES [ ] NO

DISCUSS YOUR MEDICAL CONDITION WITH ANY MEMBER OF YOUR HOUSEHOLD? [ ] YES [ ] NO

MY SIGNATURE AUTHORIZES THE DOCTOR(S) OF THIS PRACTICE TO RELEASE ANY AND ALL OF MY MEDICAL RECORDS, WHICH MAY INCLUDE INFORMATION REGARDING CHEMICAL DEPENDENCY, HIV, AND/OR MENTAL HEALTH ISSUES, BY MAIL OR FAX, TO MY PRIMARY CARE OR REFERRING PHYSICIAN, TO CONSULTANTS IF NEEDED AND AS NECESSARY TO PROCESS INSURANCE CLAIMS, INSURANCE APPLICATIONS AND PRESCRIPTIONS. I PERMIT A COPY OF THESE AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE.

_____ **DATE**_____/_____/_____

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR POWER OF ATTORNEY*

I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN. I UNDERSTAND THAT INSURANCE IS A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR AND IS NOT A SUBSTITUTE FOR PAYMENT. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ALL COPAYS, COINSURANCE, DEDUCTIBLES AND NON-COVERED SERVICES AT THE TIME OF SERVICE.

_____ **DATE**_____/_____/_____

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR POWER OF ATTORNEY*

*IF POWER OF ATTORNEY, COPY OF SUCH IS REQUIRED.

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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.

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 staff members.

PAYMENT. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

HEALTHCARE OPERATIONS. Your health information may be used as necessary to support the day-to-day activities and management of Carolina Dermatology and Skin Cancer Surgery, P.A. 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 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.

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 to revoke your authorization.

INDIVIIDUAL 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
- 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
- The right to receive a printed copy of this notice

CAROLINA DERMATOLOGY AND SKIN CANCER SURGERY, P.A. 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 are also 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. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION. You may generally inspect or copy the protected health information that we maintain. 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 Dr. Billie F. Cosgrove or our office receptionist. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

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:

Billie F. Cosgrove, M.D.
Carolina Dermatology and Skin Cancer Surgery, P.A.
1814 Glen Meade Road
Wilmington, NC 28403

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 will not be penalized or otherwise retaliated against for filing a complaint.

CONTACT PERSON. The name and address of the person you may contact for further information concerning our privacy practices is:

Billie F. Cosgrove, M.D.
Carolina Dermatology and Skin Cancer Surgery, P.A.
1814 Glen Meade Road
Wilmington, NC 28403
(910) 254-3544

EFFECTIVE DATE. This notice is effective on or after January 1, 2003.

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the NOTICE OF PRIVACY PRACTICES of Carolina Dermatology and Skin Cancer Surgery, P.A. Our NOTICE OF PRIVACY PRACTICES provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our NOTICE OF PRIVACY PRACTICES is subject to change. Upon request, we will provide you with the most recently revised notice on any office visit.

If you have any questions about out NOTICE OF PRIVACY PRACTICES, please contact:

Billie F. Cosgrove, M.D.
Carolina Dermatology and Skin Cancer Surgery, P.A.
1814 Glen Meade Road
Wilmington, NC 28403
(910) 254-3544

I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES of Carolina Dermatology and Skin Cancer Surgery, P.A.

Signature_____ Date___/___/___
(patient / parent / guardian / responsible party)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the patient's acknowledgement, describe the good faith efforts made to obtain the patient's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of provider representative_____ Date___/___/___

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