Vieta
DERMATOLOGY

289 Olmsted Blvd, Suite 5, Pinehurst, NC 28374
Phone: (910) 420-1282 / Fax: (910) 420-1116

Welcome to Vieta Dermatology! Thank you for filling out our Patient Information Form.

ABOUT YOU

First Name: ______________ M.I.: ____ Last Name: ______________
Sex: ◯ Male ◯ Female DOB: ______________
Social Security #: ______________
Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced
Street Address: ______________ Apt#: ______
City: ______________ State: ______ Zip Code: ______
◯ Home Phone: ______________ ◯ Cell Phone ______________
◯ Work Phone: ______________ (please check preferred contact number)
Email Address: ______________
Name of Employer: ______________ Occupation: ______________

REFERRAL TO VIETA DERMATOLOGY

Whom may we thank for referring you to our practice?
◯ Physician
Physician name: ______________ Physician phone #: ______________
◯ Family or Friend: Name: ______________
◯ Website (which one?): ______________
◯ Insurance Company Listing: ______________
◯ Other: ______________

Primary Care Physician (if different from the referring physician listed above)
Physician name: ______________ Physician phone #: ______________

EMERGENCY CONTACT

Name: ______________ Phone Number: ______________
Relationship to Patient: ______________
Do you give our office permission to discuss information related to your medical care to the person listed above? ◯ Yes ◯ No

(continued)

INSURANCE INFORMATION/RESPONSIBLE PARTY

Primary Insurance

Insurance Carrier: ______________________ Group Name or Number: ______________________

Subscriber ID: ______________________

Relationship to the Insured Person: ◯ Self ◯ Husband ◯ Wife ◯ Other: ______________________

If the insured party is different from the patient, you must complete the below information:

Cardholder's First Name: ______________________ M.I.: _____ Last: ______________________

Sex: ◯ Male ◯ Female

Address: ______________________ City: ______________ State: ____ Zip:________

Phone #: ______________________ DOB: ______________

Insured's Social Security #: ______________________

Secondary Insurance:

Insurance Carrier: ______________________ Group Name or Number: ______________________

Subscriber ID: ______________________

Relationship to the Insured Person: ◯ Self ◯ Husband ◯ Wife ◯ Other: ______________________

If the insured party is different from the patient, you must complete the below information:

Cardholder's First Name: ______________________ M.I.: _____ Last: ______________________

Sex: ◯ Male ◯ Female

Address: ______________________ City: ______________ State: ____ Zip:________

Phone #: ______________________ DOB: ______________

Insured's Social Security #: ______________________

(continued)

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MEDICAL HISTORY FORM / page 3 of 12

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

DOB: ______________________ Height: ______________ Weight: ______________________

REASON FOR TODAY'S VISIT

	PROBLEM # 1	PROBLEM #2
Chief complaint		
Location of the problem		
Length of time present		
Prior treatment		
Previous biopsy or labs		

MEDICATIONS (Oral)

Please list all current medications taken by mouth, including aspirin, over-the-counter medications, herbal supplements, and vitamins/minerals.

MEDICATION	DOSAGE	FREQUENCY

MEDICATIONS (Topical)

Please list all current topical medications and products applied.

MEDICATION	DOSAGE	FREQUENCY OF APPLICATION

(continued)

MEDICATIONS (Topical) continued

MEDICATION	DOSAGE	FREQUENCY OF APPLICATION

MEDICATION ALLERGIES

◯ No known drug allergies

MEDICATION	REACTION

Do you require antibiotics before dental or surgical procedures? ◯ Yes ◯ No

PAST MEDICAL HISTORY

Do you have a pacemaker? ◯ Yes ◯ No
Do you have a defibrillator? ◯ Yes ◯ No
Do you have artificial heart valves? ◯ Yes ◯ No
Do you have a cochlear Implant? ◯ Yes ◯ No

GENERAL MEDICAL HISTORY (Circle any conditions you currently have or have had in the past)

Anemia
Anxiety
Arsenic Exposure (tobacco field worker)
Arthritis
Artificial Joints
Asthma
Atrial Fibrillation
Bleeding Disorder/Problems
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplant
Breast Cancer
Cognitive Impairment/Dementia
Colon Cancer
COPD

(continued)

GENERAL MEDICAL HISTORY (Continued)

Coronary Artery Disease
Cold Sores/Fever Blisters
Deep Venous Thrombosis
Depression
Diabetes, Type I
Diabetes, Type II
End Stage Renal Disease
GERD/Acid Reflux
Heart Attack
Hearing Loss
Hepatitis: A, B, C, or unknown
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Inflammatory Bowel Disease: Crohn's, Colitis
Leukemia
Lung Cancer
Lupus
Lymph Node/Spleen Removal
Lymphoma
Organ Transplant: ______________________
Prostate Cancer
Pulmonary Embolism
Radiation Treatment
Seizures
Stroke
Substance Abuse/Addiction
Tuberculosis
None

Please list any other past medical problems not listed above: ______________________________

PAST SURGICAL HISTORY

SURGERY	DATE	NOTES

◯ No past surgeries

SKIN HISTORY

Abnormal Mole/Dysplastic Nevus
Actinic Keratosis (precancer)
Acne
Basal Cell Carcinoma
Blistering Sunburns
Eczema
Hay Fever/Allergies
Melanoma
Merkel Cell Carcinoma
Mohs surgery
MRSA
Psoriasis
Rosacea
Squamous Cell Carcinoma
Vitiligo
Other: ______________________________
None

(continued)

Have you ever used a tanning bed? : ◯ Yes ◯ No Currently? ◯ Yes ◯ No
Have you had blistering sunburns? : ◯ Yes ◯ No
Do you use sunscreen daily? ◯ Yes ◯ No If yes, what SPF? ____________
Do you react to anesthesia? ◯ Yes ◯ No
Do you react to bandages/adhesives? ◯ Yes ◯ No
Do you heal with thick (keloid) scars? ◯ Yes ◯ No

Do you have a family history of melanoma? ◯ Yes ◯ No
If yes, which relative?____

Do you have a family history of non-melanoma skin cancer? ◯ Yes ◯ No
If yes, which relative?____
Do you have any other family history of cancer? ◯ Yes ◯ No
Do you have a family history of abnormal bleeding/clotting? ◯ Yes ◯ No
Mother: ◯ Alive ◯ Deceased Age: _______ Father: ◯ Alive ◯ Deceased Age: _______
Are you pregnant or trying to become pregnant? ◯ Yes ◯ No
Are you nursing? ◯ Yes ◯ No

Please check any that apply:
◯ Chemotherapy: Within the past 6 months ◯ Yes ◯ No
◯ Blood or platelet transfusion : Within the past 6 months ◯ Yes ◯ No
◯ Taking blood thinners
◯ Have you taken Isotretinoin: Within the past 6 months ◯ Yes ◯ No

SOCIAL HISTORY

◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Partner ◯ Adopted
Do you smoke? ◯ Yes ◯ No
If yes, circle the most accurate: 1 pack per day or less OR more than 1 pack per day
Do you drink? ◯ Yes ◯ No If yes, frequency: _______
Do you use drugs? ◯ Yes ◯ No If yes, frequency: _______
Occupation: ______________________________________

LOCAL PHARMACY INFORMATION

Name: ____
Address: ____
Phone Number: ____

(continued)

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FINANCIAL POLICIES /

Thank you for choosing Vieta Dermatology, PLLC. We are committed to compassionate, personalized care in a professional and confidential environment. We ask that you review and accept our financial policies prior to provision of services.

INSTRUCTIONS

Please review each part of our financial policies, initial each one, and sign at the bottom of the form. Complete the form and bring it with you at the time of your visit.

Payment Required at Time of Service: We require payment at the time of service. If you have health insurance and we are a participating network provider, we will ask for your co-insurance, co-payment, any unmet deductible and any balance not paid by your insurance, when applicable. If you do not have insurance, we are not a participating network provider for your insurance plan, or you are unable to present a valid member identification card from your insurance carrier at your visit, then we require full payment at the time of service. We accept cash, checks, VISA, MasterCard, Discover, and American Express.

(Initials)_________

Policy for Filing Insurance: We participate with most major insurance plans. If we are a participating network provider for your plan, we will be happy to file a claim on your behalf. Please remember that your health benefit plan is an arrangement between you and your insurance company. Your individual plan determines what benefits it covers, coverage limits and the need for prior authorizations and referrals. We will be happy to help, but we strongly encourage you to contact a representative of your insurance company for answers to questions regarding your insurance benefits.

Each time you come to our office, please bring with you a current insurance ID card and a valid government issued photo identification card (e.g. driver's license, passport). If we are able to validate your eligibility, we will file a claim on your behalf. Even when your insurance plan verifies your eligibility and benefits, it does not guarantee the accuracy of the confirmation of coverage of benefits. In some cases, your insurance plan may not cover the services we provide or may determine that some of the services are not medically necessary. Your insurance company's rejection of all or part of your medical insurance claim does not relieve you of your financial obligation to Vieta Dermatology, PLLC. If your insurance plan does not cover our charges in full, you are responsible for paying any remaining balance not covered by your insurance.

If we cannot verify your insurance or you are not eligible for insurance, we will consider you to be self-pay and financially responsible for the cost of your care at the time of the visit. By signing our Insurance Coverage Waiver Form, you will agree to accept full financial responsibility for the care that we provide.

(Initials)_________

(continued)

Medicare Insurance Benefits: I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Vieta Dermatology, PLLC /Sarah Vieta, M.D. on my behalf.

If Medicare covers you, we will submit your claims to Medicare on your behalf. Medicare requires that we provide only those services that the program deems as medically necessary. We may ask you to sign a notice that makes you financially responsible for any service provided that does not meet the medical necessity requirement. If Medicare does not cover the full amount of the service provided, we will bill your Medicare supplementary insurance carrier and/or you. If the secondary insurance carrier does not cover the balance owed, you will be responsible for paying the charges associated with the services provided.

(Initials)_________

Pathology Studies and Laboratory Tests: Our bills for service do not include pathology studies or laboratory tests. If you receive any of these services, you will receive a separate bill from the facility where the services were performed.

(Initials)_________

Referrals: Some insurance plans require a referral from the patient's primary care physician in order to be seen by a specialist. It is the patient's responsibility to: (1) know if his/ her plan requires a referral; and (2) to obtain a referral, if needed, prior to the visit to our office. If you are uncertain about your plan's requirements, please contact your insurance plan prior to your visit. Patients without a valid referral that meets insurance plan requirements will have the option to pay out-of-pocket for the entire cost of the visit on the day of service or to reschedule the appointment.

(Initials)_________

Co-Payments and Co-Insurance: Co-payments (a fixed dollar amount that is assigned to the patient) and co-insurance (a percentage of total charges that is the patient's responsibility) is due at the time of visit. Our contracts with insurance companies obligate us to collect these fees; we cannot waive them or bill them.

(Initials)_________

Self-Pay Patients: Payment is due in full at the time of service for self-pay patients. We will discuss the cost of any recommended procedures or services in excess of the basic office visit fee prior to the provision of service.

(Initials)_________

Returned Checks: There is a fee (currently $25.00) for any checks returned by the bank. This amount may change.

(Initials)_________

(continued)

Credits and Refunds: We will return any refunds owed to your insurance plan by check. If there are credits or refunds owed to a patient, we will first apply them to any outstanding balance. Remaining patient credits and refunds can be left on the account to be used towards future charges or can be returned to the patient (or to the responsible party who made payment) by check. Please allow 30-45 days for processing.

(Initials)_________

Outstanding Balances: Vieta Dermatology, PLLC mails billing statements to patients. Payment for any outstanding balance is due upon receipt. Outstanding balances may result from remaining patient balances after we have billed your insurance company. For example, we will bill insured patients for unmet deductibles, additional co-payments, non-covered services or any other charge that the insurance carrier assigns to the patient. We also bill patients penalty fees associated with our policy for cancellations, rescheduling, and no-shows.

I understand it is the policy of Vieta Dermatology, PLLC to collect any outstanding balance before additional services are rendered.

Failure to pay a balance due at the time of service could result in your appointment being rescheduled with the understanding that you will pay the balance due either prior to or the day of your rescheduled appointment. A past due account balance may be turned over to a collection agency, which would be reported as a collection on your credit file with the various credit bureaus.

In those instances when a patient has a follow-up visit before receiving a statement for prior amounts owed, we will inform the patient of the outstanding balance and request payment at the time of that follow-up visit.

(Initials)_________

Cosmetic Procedures and Services: We require payment in full at the time of service for cosmetic procedures and services provided by our physician. An initial consultation is required for all cosmetic patients prior to receiving treatments. There is a $150 fee for cosmetic consultations due at the time of check-in. The fee will be deducted from the total for any cosmetic treatment given on the day of consultation. The fee may also be deducted on the day of consultation for treatments scheduled for a later date and paid in full at the time of booking.

(Initials)_________

Cancellations, Rescheduled Appointments and No-Shows: We understand that plans change and emergencies arise. Please notify us as soon as possible if you need to cancel or reschedule your appointment. Vieta Dermatology, PLLC has a 24-hour cancellation policy. If you fail to notify us of a cancellation or rescheduled appointment within one (1) business day prior to your scheduled appointment or you miss an appointment, we charge a penalty fee of $50 for office visits, $100 for medical procedures, and 50% of the cost of the procedure (minimum $200) for cosmetic procedures. The penalties apply regardless of whether or not you receive a courtesy reminder call or text message reminder from our office. They also apply to appointments made just one day in advance.

(Initials)_________

(continued)

Responsible Party: When a patient is less than 18 years of age, the parent or guardian who signs the Vieta Dermatology, PLLC Patient Registration Form is responsible for all fees incurred by the minor. When a patient turns 18 or older, he/she becomes responsible for his/her account and financial obligations. If a parent prefers to assume complete financial responsibility for an adult offspring, Vieta Dermatology, PLLC must receive notification in writing.

(Initials)_________

Method of Payment: Vieta Dermatology, PLLC accepts cash, check, and all major credit cards. Payments may be made in person, by mail, or by phone.

(Initials)_________

Collections: If you have an outstanding balance that requires special arrangements, please contact our Practice Manager at (910) 420-1282 for assistance. It is our sincere desire to help you meet your financial obligations without being sent to collections. Outstanding balances that are not paid within 90 days will be sent to a collections agency. Once a patient's account is sent to collections he/she is responsible for the outstanding balance on the account in addition to any and all costs of collection, including all collection agency fees, service fees and/or legal fees (including court costs and attorney fees) that accrue while the account is in collections.

(Initials)_________

Benefits Assignment: I hereby authorize Vieta Dermatology, PLLC to bill my authorized health insurance company on my behalf for any/all services performed. I hereby authorize the assignment of benefits (payments) directly to Vieta Dermatology, PLLC/Sarah Vieta, M.D. for all my insurance claims related to services received. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible in full for any co-payments, co-insurance, deductible or balances due that are my responsibility for payment either at the time of service or after being notified that Vieta Dermatology, PLLC is unable to collect from my insurance carrier for whatever reason.

(Initials)_________

Release of Records: I authorize the release of any medical information necessary for the purpose of processing claims to insurance companies or their agencies. I permit a copy of this authorization to be used in place of the original.

(Initials)_________

(continued)

FEE INFORMATION

Copying Medical Records (in North Carolina)

Pages 1 - 25: $0.75 per page

Pages 26 - 100: $0.50 per page

Pages 100+: $0.25 per page

Minimum charge: $10.00

Electronic Copy of Designated Record Set within Medical Records Requested Under HIPAA:

$6.50

Failure to Cancel Appointment within 24 Hours:

Routine office visit: $50

Non-cosmetic office procedure: $100

Cosmetic procedure: 50% of cost of procedure, minimum $200

Patient Authorization: My initials above and my signature below signify that I have read and fully understand all of the above information. My initials above and my signature below also signify that I agree to the above policies.

Signature: ____ Date: ___________

Printed Name: ____

Relationship to Patient: _____________________________________

(continued)

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WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our Practice Manager.

I, ____ have received a copy of Vieta Dermatology, PLLC's Notice of Privacy Practices.

Signature of Patient/Legal Guardian: ____

Date: ___________________________