Patient Information

(Please Print)

Patient's Name: _____
Last First Middle

Birthdate: ___ /___ /___ SSN: _____ Gender: ☐Male ☐Female

Race: _____ Ethnicity: _____ Preferred Language: _____

Marital Status: ☐ Single ☐ Married ☐ Other: _____ Spouse's Name: _____

Home Address: _____
Street & Apt # City State Zip

Home Phone: ( ) _____ Work: ( ) _____ _

Cell: ( ) _____ **May we send communications by text?** ☐ YES ☐ NO

Where do you prefer to be contacted? _____ **May we leave a message?** ☐ YES ☐ NO

E-mail: _____ **May we send communications by e-mail?** ☐ YES ☐ NO

Employment Information

Occupation: _____ Employer: _____

Address: _____
Street City State Zip

Phone #: _____ Ext. _____ **May we leave a message?** ☐ YES ☐ NO

If Under the Age of 18

Name of Parent/Legal Guardian: _____

Relationship to Patient: _____

Who may authorize treatment for the minor? _____

Emergency Contact

Name: _____ Relationship: _____

Home Phone: ( ) _____ Work: ( ) _____ _ Cell: ( ) _____

Home Address: _____
Street & Apt # City State Zip

How did you hear about Dr. Coley?

☐ Family/Friend: _____ ☐ Physician: _____ ☐ Seminar/Event

☐ Billboard ☐ Internet (website, Google) ☐ Other: _____

Insurance Information

Primary Health Insurance: _____ Policy #:_____ Group #:_____

Insurance Referral Required? ☐ YES ☐ NO Copay? _____ Employer: _____

Insured Name: _____ Birthdate: ___ /___ /___ SSN: _____

Secondary Health Insurance: _____ Policy #:_____ Group #:_____

Insurance Referral Required? ☐ YES ☐ NO Copay? _____ Employer: _____

Insured Name: _____ Birthdate: ___ /___ /___ SSN: _____

I understand that office visit charges are payable on the day service is rendered. I authorize Coley Cosmetic and Hand Surgery Center to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Coley Cosmetic and Hand Surgery Center and myself.

Patient Signature: _____ Date: _____

MEDICAL HISTORY

Patient Name: _____DOB: _____ Height_____ Weight:_____
Reason for Visit: _____ Referred by: _____

MEDICAL HISTORY: (Circle all that apply. Please provide a brief explanation to any "YES" answers)

Ear/Eye (dryness)/Sinus problems/nose bleeds	YES	NO	Liver problems/Hepatitis	YES	NO
Heart Disease/Surgery	YES	NO	GI problems (ulcer/reflux/abdominal pain)	YES	NO
High or Low Blood Pressure	YES	NO	Genitourinary Problems (UTI/kidney or bladder issues)	YES	NO
CAD/chest pain/palpitations	YES	NO	Arthritis/Joint pain	YES	NO
Bleeding Disorders/Anemia/Bleeding Tendencies related to anticoagulant therapy/DVT or PE/bruises easily	YES	NO	Anxiety/Depression	YES	NO
Pulmonary Disease/Sleep Apnea/cough/ Asthma	YES	NO	Stroke/Seizures/paralysis/Migraines/dizziness	YES	NO
Thyroid problems	YES	NO	Cancer	YES	NO
Diabetes	YES	NO	Infections (including MRSA)/STD's	YES	NO

OTHER MEDICAL PROBLEMS:

_____

_____

MEDICATIONS: (include prescription, over the counter, vitamin and herbal remedies)

_____

_____

_____

ALLERGIES and REACTIONS: (include all medication, food, tape and latex allergies)

_____

HOSPITALIZATIONS/SURGICAL HISTORY: (include any reactions to anesthesia or experiences with post-operative nausea)

_____

_____

FAMILY ILLNESSES: (include any reactions with anesthesia)

_____

_____

SOCIAL HISTORY:

Do you smoke? ☐ YES ☐ NO If so, how much per day? _____ How many years? _____
Do you consume alcohol? ☐ YES ☐ NO If so, how much per week? _____
Do you use any recreational drugs? ☐ YES ☐ NO If so, how much? _____ How often? _____

WOMEN ONLY:

Are you or could you be pregnant? ☐ YES ☐ NO
Total number of pregnancies: _____ Total number of live births: _____ Did you breastfeed? ☐ YES ☐ NO
Do you have a family history of breast cancer? ☐ YES ☐ NO
Have you had a mammogram? ☐ YES ☐ NO If so, when? _____ What were the results? _____

PHARMACY INFORMATION:

Pharmacy Name and Location: _____ Phone # _____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Patient/Parent Signature_____ Date_____

Financial Policy

We are delighted that you have chosen our facility as a provider in your care. Our goal is to provide you with useful information about our financial policy to ensure that you have the best experience possible. If you have any questions regarding this policy, please contact our Clerical Office Specialist or our Office Manager at (336) 617-8645.

Initial Visit

On your initial visit, you will be asked to provide demographic and insurance information. Following that visit, periodic updates will be requested. If, during the time you are a patient at our practice, you change any of your personal information, including address, telephone number, and insurance carrier, please inform us. As a courtesy, we will submit claims to your medical insurance on your behalf. You are responsible for supplying us with correct information at all times. Failure to do so may result in you being liable for the entire balance of your bill.

Insurance Claims

While filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the dates services are rendered. Your insurance is a contract between you, your employer and your insurance company. We are not a party of this contract. Therefore, we strongly encourage patients to review their coverage and benefits and to familiarize themselves with their plan. Not all services are a covered benefit in all policies, therefore we cannot guarantee payment of all claims by your insurance company. Reduction or rejection of your claim does not relieve you of your financial responsibility. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to, those charges above the usual and customary allowance. **NOTE:** Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnoses are made based on medical information, not based on coverage by insurance companies. Therefore, a diagnosis change will not be made for the sole purpose of insurance reimbursement.

Medicaid

Patients are required to provide a copy of their current Medicaid card and must pay a copay in the amount of $3.00 at each visit, if applicable. As a courtesy, we will submit claims to Medicaid on your behalf. Therefore, you are responsible for supplying us with a current Medicaid Card and information regarding your current Primary Care Physician (PCP). Failure to provide your current PCP's information may result in rejection of your claim. Rejection of your claim does not relieve you of your financial responsibility. To ensure we have your current PCP's information and that claims are processed in an accurate and timely manner, all Medicaid patients will require a referral from their PCP, regardless of being seen in the Emergency Room.

Self-Pay Accounts

Self-pay accounts are patients who are having procedures that have been deemed "cosmetic" (considered "not medically necessary"), patients without insurance coverage, patients covered by insurance plans in which the office does not participate, patients who present without a current insurance card in which to process claims, Liability cases or auto accidents. Self-pay patients are required to pay $50.00(Cosmetic) or $230 (Hand) at their initial visit or consultation and at each subsequent visit, thereafter. Patients meeting the above mentioned criteria will be considered as a Self-pay Account until they can prove otherwise.

Worker's Compensation

Prior to their appointment, patients are required to provide our office with the claim number, date of injury, employer's information (name, address, phone number and the name of their Human Resource Representative) and if available, the Insurance carrier's information (Claims adjuster's name, name of insurance company, address, phone number and fax number). If this information is not provided, we will not be able to process your claim. You may be asked to either reschedule your appointment or pay for your visit at the time of service. Some insurance companies require an authorization PRIOR to seeing a specialist, procedures, treatments and surgery. It is the patient's responsibility to follow up with their case manager to determine if an authorization is needed.

Copays, Fees, Outstanding Balances and Payments

Copays are requirements placed on you by your insurance company. All copays are due at the time of service and cannot be waived. If you are unable to pay your copayment, your appointment may need to be rescheduled.
In addition to copays, any past due balances will also due at the time of service, unless previous arrangements have been made with our Office Manager.
Fees (testing, radiology, pathology, supplies and other services provided or recommended by Dr. Coley) are standard and based on the complexity of your visit. Payment in full is required at the time of your visit.
It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress. Extended payment arrangements are available, if needed. To take advantage of Extended Payment Arrangements, please talk to our Office Manager. We accept cash, certified or cashier's checks, Visa, MasterCard, American Express or Discover. Financing is also available through Care Credit. For more information regarding this program, please speak to a member of our staff. Personal checks may be accepted for those services deemed "medically necessary". Checks returned for insufficient funds will be charged a service fee of $35.00, in addition to the original amount of the check and will be placed on a "cash only" basis.

Disability Forms, FMLA and Other Forms

These forms take a considerable amount of time for our staff to complete. We ask that you allow 7-10 business days for completion of these forms. There will be a charge of $25.00 due at the time the forms are received. There will be an additional fee for requests to expedite completion of these forms. Under no circumstances, can forms be completed in less than five (5) business days.

Medical Records

Patients are required to complete and sign a written consent prior to release of their medical records. According to North Carolina's Statute 90-411, patients will be charged a handling fee of $10.00 and copying charges of 75 cents/page for pages 1-25, 50 cents/page for pages 26-100 and 25 cents/page for pages in excess of 100. Payment is due in advance and we ask that you allow 7-10 business days for processing. Collaborating physicians and specialists assisting in the care of a patient will not be charged for copies of medical records.

Refunds

Refunds are not permitted on purchases made toward skincare products. If you are not completely satisfied, you may return your skincare with 7 days of the original purchase date. Our aesthetician will be happy to discuss replacement products OR issue you a credit on your account that may be used on future purchases.

My signature below indicates that I understand and agree to the above policy.

Patient Signature: _____ Date: _____

HIPAA AUTHORIZATION CONSENT FORM

Patient's Name: _____ Birthdate: ___ /___ /___

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you for treatment, payment or healthcare operations. **We take our patients' privacy very seriously and will not disclose any information without your consent.**

I understand that as part of my care, Coley Cosmetic & Hand Surgery Center originates and maintains paper and/or electronic medical records containing my health information. I understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify services billed were provided, and
- A tool for routine healthcare such as assessing quality and reviewing the competence of healthcare professionals

Communication by Email and Text Message – I understand, that during the course of my care, it may become useful to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. I am aware that these methods, in their typical form, are not considered a confidential means of communication. Should I choose to use an electronic form of communication to communicate with Coley Cosmetic & Hand Surgery Center, I understand there is a chance that a third party may be able to intercept those messages. Third parties may include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages.
- Your employer, if you use your work email to communicate
- Third parties on the Internet, such as server administrators, and others who monitor Internet traffic

Do you give permission to allow Coley Cosmetic & Hand Surgery Center to use unsecured email and mobile phone text messaging to transmit your protected health information regarding your appointment reminders, health related information and marketing offers?

( ) YES ( ) NO

I am aware of the risks involved for transmission of my protected health information by an unsecure means and that message and data rates may apply as result from these transmissions. At any time during my care, I understand that I reserve the right to terminate my consent for communications by electronic methods, and that my care will not be affected for refusing to agree to communications by an electronic method.

( ) YES ( ) NO

Do you give permission for our office to discuss your health history or any medical concerns with anyone other than yourself?

( ) YES ( ) NO

If yes, please list the individual(s) and their relationship to you.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Should it become necessary to disclose my protected information to another entity for the above purposes, I consent to such disclosure for these permitted uses, including disclosures via fax and transcription. My signature acknowledges that I was presented a copy of Patient's Rights and Responsibilities and Privacy Practices from Coley Cosmetic & Hand Surgery Center, PA. I am aware that a copy of this signed consent will remain on file and that it is my responsibility to inform Coley Cosmetic & Hand Surgery Center, PA of any needed changes to this consent.

Patient Signature: _____ Date: _____