Pinehurst Medical Clinic

Pinehurst Medical Clinic Dermatology
200 Pavilion Way, Second Floor, Southern Pines NC 28387
1818 Doctors Drive, Sanford, NC 27330

Dear New Patient of Pinehurst Medical Clinic Dermatology,

We are pleased to welcome you as a new patient of Pinehurst Medical Clinic Dermatology. To ensure the best possible experience during your upcoming visit, please take note of the following:

1. Plan on arriving at least 30 minutes prior to the scheduled time of your appointment to avoid delays.

2. Bring your medical insurance card(s) and medications with you on the day of your appointment. To find a list of PMC's contracted payers or to review additional insurance information, please visit pinehurstmedical.com/resources-category/insurance

3. Complete your new patient paperwork before coming to your appointment. If you need a paper copy mailed to you, please call (910) 695-2161 to make this request. Please allow at least 2 business days for your request to be processed, and an additional 5-7 business days to receive a paper copy in the mail.

4. If previous medical records are needed our office may contact you to make arrangements to obtain records.

5. Please note: Full body skin exams (skin cancer screenings) are a very important part of your health maintenance. If you have other skin problems, such as hair loss, rashes, or acne, it can be difficult for a dermatologist to address everything in one visit. A thorough skin check should take up most of the visit, leaving little time for additional skin concerns. Please schedule a separate appointment for any other skin health problems, where the provider can focus thoroughly on just that problem.

We look forward to seeing you soon. In the event you need to cancel your appointment, we ask that you give us at least 24 hours' notice.

Sincerely,
PMC Dermatology
Southern Pines: (910) 235-3330
Sanford: (919) 708-1555

Pinehurst Medical Clinic

REGISTRATION FORM

PATIENT INFORMATION

Patient's Name:		
Address:		
City:	**State:**	**Zip Code:**
Home Phone:		
Mobile Phone:	**Other Phone:**	
Patient e-mail:		
Date of Birth:	**Sex:** □ Male □ Female	
Marital Status: □ Married □ Single □ Divorced □ Widowed □ Unknown		
Race: □ Black/African American □ Asian □ White □ American Indian/Alaskan Native □ Native Hawaiian/Other Pacific Islander □ Unknown		
Ethnicity: □ Hispanic □ Non-Hispanic		
Primary Language: □ English □ Spanish □ Other: _____		
Social Security Number:		
Primary Care Doctor:		

EMPLOYER INFORMATION

Employment Status: □ Employed □ Self-employed □ Retired □ Disabled □ Student □ Unemployed
Employer Name:
Employer Telephone:

EMERGENCY CONTACT

Emergency Contact Name:
Relationship to Patient:
Emergency Contact Phone:

RESPONSIBLE PARTY INFORMATION

Parent/Guardian Name:		
Address:		
City:	**State:**	**Zip Code:**
Telephone:		

INSURANCE INFORMATION

Insurance Company:	
Policy / Group Number:	**Effective Date – From:**
Subscriber Name:	**Patient's Relationship to Insured:**
Subscriber SSN:	**Subscriber's DOB:**
Subscriber Employer:	**Subscriber's Sex:** □ Male □ Female

Pinehurst Medical Clinic
DERMATOLOGY

MRN: _____

Medical History Form

Patient Name: _____DOB: _____Date: _____

Primary Care Provider: _____

Pharmacy (Name/City/Phone#): _____

Alerts: (please circle all that apply)

Allergy to adhesive	Breastfeeding	MRSA
Allergy to latex	Defibrillator	Pacemaker
Allergy to lidocaine	Immunosuppression	Rapid heartbeat w/epinephrine
Allergy to topical antibiotic oint.	Keloid scarring	Pregnancy
Blood-thinners		Planning pregnancy

Drug Allergies:

_____ _____

_____ _____

☐ NO KNOWN DRUG ALLERIGES

Medications: (please list all current medications

_____ _____

_____ _____

_____ _____

_____ _____

☐ NO MEDICATIONS

Social History

Smoking status: current smoker ☐ former smoker ☐ never smoked ☐

Alcohol use: none ☐ <1 drink/day ☐ 1-2 drinks/day ☐ 3 or more drinks/day ☐

Occupation: _____

Do you wear sunscreen? Yes ☐ No ☐

If yes, what SPF? _____

Do you, or have you ever used a tanning bed?

Yes ☐ No ☐

Family history of skin cancer? Yes ☐ No ☐

If yes, Basal Cell, Squamous cell, Melanoma and who?

_____

Past Medical History: (please circle all that apply)

Acne
Actinic Keratosis (pre-cancers)
Asthma
Basal Cell Carcinoma
Blistering Sunburns
Dry Skin
Eczema
Flaking/Itching Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy Reactions
Precancerous Moles
Psoriasis
Squamous Cell Carcinoma
HS

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplant
Benign Prostatic Hyperplasia (BPH)
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease (CAD)
Decreased Immunity
Depression
Diabetes
End Stage Renal Disease
Gastroesophageal Reflux (GERD)
Head Trauma
Hearing Loss
Hepatitis
Hypertension (high blood pressure)
HIV/AIDS
Hypocholesteremia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lupus
Lyme Disease
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Other: _____

Past Surgical History: (please circle all that apply)

Biological Valve Replacement
Heart Transplant
Hip Replacement (right, left, or bilateral)
Kidney Transplant
Knee Replacement (right, left, or bilateral)
Liver Transplant
Lumpectomy (right, left, or bilateral)
Mastectomy (right, left, or bilateral)
Mechanical Valve Replacement

List any cancer surgeries below:

****Please note:**
Full body skin exams are a very important part of your health maintenance. If you have other skin problems, such as hair loss, rashes or acne, it can be difficult for a dermatologist to address everything in one visit. A thorough skin check should take up most of the visit, leaving little time for additional skin concerns. Please schedule a separate appointment for any other skin health problems, where the provider can focus thoroughly on just that problem.

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Account #_____

Patient Acknowledgment and Authorization

Please initial each section and sign to indicate acknowledgment and authorization.

_____ **Patient Payment Policy**
I have read and understand the Pinehurst Medical Clinic, Inc. Patient Payment Policy and I agree to pay for treatment rendered to me/the patient.

_____ **Notice of Privacy Practices**
I understand that Pinehurst Medical Clinic, Inc. will use and disclose my/the patient's health information for the purposes of treatment, payment, and healthcare operations, as permitted by law. Further information can be found in the Notice of Privacy Practices, which has been offered to me.

_____ **Assignment of Insurance Benefits**
I authorize the payment of medical benefits to Pinehurst Medical Clinic, Inc., and hereby assign to Pinehurst Medical Clinic, Inc. and the professionals involved in my/the patients care, all rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs that I identify for which benefits may be available to pay for the services provided to me/the patient.

_____ **Consent to Treat**
I, the Patient/the Patient's Legal Representative, hereby grant permission to Pinehurst Medical Clinic, Inc., and its authorized representatives to perform examinations/treatment deemed necessary or advisable for diagnosis and treatment.

_____ **Patient Rights and Responsibilities**
I understand that I have the right, and the responsibility, to participate in my/the patient's care and treatment. I understand that I have the right to be informed about the treatment being recommended, and the responsibility to ask questions if I do not understand it. I agree to provide accurate and complete information about my/the patient's health history and presenting complaint, to agree upon a treatment plan, and follow that plan. I understand that the Pinehurst Medical Clinic health care providers will treat me with respect,
and I agree to do the same for them.

Patient Name (printed): _____

Patient/Legal Guardian Signature: _____ Date: _____

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Pinehurst Medical Clinic Consent for Release of Protected Health Information to Family

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment of my care:

1. _____ Phone: _____ Relationship: _____

2. _____ Phone: _____ Relationship: _____

3. _____ Phone: _____ Relationship: _____

Check all that apply:

- ☐ All of my medical information
- ☐ Information necessary to schedule appointments for me
- ☐ Lab or test results
- ☐ Information necessary to provide, call in or pick up prescriptions for me
- ☐ Information necessary to help my family member(s) to pick up or arrange for medical equipment to be provided to me
- ☐ Information necessary to bill for or submit claims for care provided to me to government or private insurance payers

My consent will remain in effect as long as I am a patient at Pinehurst Medical Clinic, unless and until I notify Pinehurst Medical Clinic in writing of any changes.

Patient Name (printed): _____

Patient/Legal Guardian Signature: _____ Date: _____

Relationship to patient: _____

Pinehurst Medical Clinic

Pinehurst Medical Clinic Patient Payment Policy

1. Payment is due at the time of service. This may include deductibles, co-payments, co-insurance, and services not covered by an insurance company.
2. Payments may be made by cash, check, money order, MasterCard, Visa, Discover, or American Express.
3. You may receive a separate bill for services provided by a FirstHealth Cardiology & Specialty Clinic provider at PMC.
4. Patients without insurance may be eligible to receive a discount for payment in full on the day services are provided. You will need to speak to a Patient Account Representative.
5. A No-Show Charge will apply should you fail to keep your scheduled appointment without giving us a 24-hour or greater advanced notice of your cancellation. Three (3) consecutive appointment cancellations and/or no-shows may result in dismissal from Pinehurst Medical Clinic. The No-Show fees are $75 for a new patient office visit, $25 for an established patient office visit, and $25-$250 for procedure/testing appointments.
6. Patients may be charged a fee for the completion of forms.
7. Patients who feel their level of income is not sufficient to enable them to pay the amount they owe may apply for financial assistance by completing an application. This application may be obtained from one of our financial representatives or by calling Financial Services at 910-295-9392. Please note in general, financial assistance is extended only to patients whose family income is at or below 150% of the federal poverty limits.
8. Balances due after your insurance has paid will be reflected on billing statements sent to the patient's, or responsible party's, address. The amount due on the statement is due in full upon receipt. If you are unable to pay the amount in full it is your responsibility to call Financial Services to discuss making other payment arrangements.
9. Unpaid charges billed to your insurance will appear on your statement indicating they are pending a response from the insurance company. If a charge has been filed with your insurance for over 60 days without a response, please contact your insurance company. If the charge remains unpaid it may become your financial responsibility.
10. It is important to remember that health insurance coverage and plans vary, and not all charges will be covered or paid in full. If your insurance denies a service or does not pay in full, you are responsible for paying the remaining balance.
11. Services received as a result of an accident are to be paid promptly. We do not allow additional time for payment where the accident results in a lawsuit or insurance case.
12. If your health insurance plan requires a preauthorization or referral, it is your responsibility to ensure it is obtained before services are received.
13. New patient visits are coded per industry standards based on whether the patient is new to the specialty or subspecialty. Reference the following link for additional information: https://www.aapc.com/blog/41276-new-vs-established-patients-whos-new-to-you/
14. Failure to pay a balance due promptly may result in one or more of the following:
    a. Your account may be referred to a collection agency,
    b. Your past due status may be reported to the applicable credit bureaus,
    c. Your ability to receive services from Pinehurst Medical Clinic may be jeopardized.

We encourage those who have questions regarding this policy document or any aspect of their bill to contact us at (910) 295-9391 or toll-free at (866) 327.3159.

Increase Communication with your *Skin Care Experts*, Activate your EMA patient portal account at your visit!

EMA®

Pinehurst Medical Clinic
DERMATOLOGY

Ask a PMC Dermatology staff member to help you activate your EMA Patient Portal to allow:

- 24/7 access to medical information
- Faster notification of test results
- Increased ability to communicate with your Dermatology Care Team
- Receive important updates, and more.

Practice URL:
Pinehurstderm.ema.md