



To Our Valued Patients,

In order to best serve your health care needs more efficiently, Wake Health Medical Group (WHMG) and Creekside Women's Center (CWC) have partnered together to aid in your treatment plan. Both are primary care facilities and both have an emphasis on skincare.

Due to supervisory roles of the medical team, including the Family Nurse Practitioner/Physician Assistant, Wake Health Medical Group (WHMG) and Creekside Women's Center (CWC) have implemented a plan in which one or the other facilities will be your provider throughout your healthcare experience for each date of service. In no way, will your ongoing care be affected as each entity has an expert medical director that carefully monitors your care for each visit.

You will see the same providers and receive the same excellent care. We are providing this letter solely to advise you that your insurance company, and/or yourself, will be billed from either one of these entities for the medical services rendered to you.

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I have read and understand the criteria by which my care is being managed.

\_\_\_\_\_  
**Printed Name of Patient**

\_\_\_\_\_  
**Printed name: (if other than patient)**

\_\_\_\_\_  
**Patient/Guardian Signature**

\_\_\_\_\_  
**Date**





## Medical Information

### I. Medical/Surgical History:

Do you have now or have you ever had:

	Yes	No
Thyroid Disease		
High Blood Pressure		
Diabetes/High Blood Sugar		
Asthma		
Tuberculosis		
Hayfever/Seasonal Allergies		
Seizures		
Stroke/Mini-Stroke		
Heart Attack/Angina		
Pacemaker		
Heart Murmur/Palpitations		
Kidney/Bladder Problems		
Prostate Problems		
Glaucoma		
Hepatitis/Liver Disease		
Recurrent Yeast Infections		
Bowel Disease/Colitis/Crohn's		
Frequent/Severe Headaches/Migraines		
Cancer (other than skin)		
Radiation		
Artificial Joint Heart Valve		
Past Surgery		
Other		

**If YES to any above, please explain:**

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### II. Current Health:

	Yes	No
Do you smoke?		
How much per day? _____		
Do you drink alcohol?		
How much? _____		
Do you use drugs?		
How much? _____		

### III. Medications

List all medications you are taking, including any over-the-counter herbals or vitamins:

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### IV. Dermatologic History:

Do you have now or have you ever had

	Yes	No
Keloids/Abnormal Scarring		
Poor Wound Healing		
Skin Pigmentation Problems		
Reaction To Local Anesthetics		
Cold Sores/Herpes Infections		
Eczema		
Psoriasis		
Abnormal ("Dysplastic") Moles		
Precancerous Spots		
Skin Cancer – Melanoma		
Skin Cancer – Basal Cell		
Skin Cancer – Squamous Cell		
Abnormal Cold Sensitivity		
Abnormal Sun Sensitivity		
Cosmetic Surgery		

**If 'Yes' to any above, please explain:**

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### V. Allergies:

Are you sensitive / allergic to any oral medications? Please List:

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### VI. Family History

Do you have a family history of:

	Yes	No
Allergies/Asthma		
Skin Cancer – Melanoma		
Abnormal ("Dysplastic") Moles		
Skin Cancer – Basal/Squamous Cell		
Other Skin Disorder		

### VII. Females

	Yes	No
Excess Facial/Body Hair		
Irregular Menstrual Periods		
How many pregnancies?		
How many miscarriages/abortions?		
Are you pregnant or nursing?		
Names/ages of your children:		

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## Assignment of Rights & Benefits (1)

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Patient's Name (or responsible party for a minor)

I hereby assign all rights and benefits under my contract with my insurance company to WAKE HEALTH MEDICAL GROUP and/or Providers for the purposes of determining the details of the benefits of my policy and obtaining payment for services given.

The assignment further permits WAKE HEALTH MEDICAL GROUP and/or Providers to obtain from my insurance all information necessary, for the determination of benefits allowed under the contract and permits the direct disclosure to WAKE HEALTH MEDICAL GROUP of all information including benefits provided, limits and exclusions of benefits and reasons for denial of benefits or reduction in charges for services rendered.

The assignment shall allow WAKE HEALTH MEDICAL GROUP and/or Providers to take actions necessary to obtain the benefits I have, in good faith, been promised by my insurance. All benefits are to be paid directly to WAKE HEALTH MEDICAL GROUP and/or Providers.

A photocopy of this assignment shall be considered as effective and valid as the original.

I further authorize WAKE HEALTH MEDICAL GROUP and/or Providers to initiate a complaint to Insurance Commissioner's office for any reason on my behalf.

I understand that my insurance carrier may disallow certain diagnoses or services as medically uncovered, medically unnecessary or cosmetic. I agree to be responsible for payment of all such services rendered to my dependents or me.

I also understand that my insurance policy is a contract between my insurance company and I. If my insurance company does not pay a claim within 30 days after it is received, I agree to remit payment to WAKE HEALTH MEDICAL GROUP and/or Providers within 2 weeks of receiving the bill, and contact my insurance company regarding this settlement. WAKE HEALTH MEDICAL GROUP and staff will assist me in processing my claim; however, I am ultimately responsible for payment of services rendered.

I agree that if my insurance carrier issues a check in my name for reimbursement for services rendered by either the physician and/or facility, I will, within five days of receipt of this check, make payment in the amount of said check to the physician or facility.

A \$37.50 fee will be charged for each insufficient funds check returned. \*see office policies page

This is a direct assignment of my rights and benefits under this policy.

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Policy Holder / Insured Name

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Patient Name

Date

Patient Signature

(1) Assignment means "to give". This form means you are giving this office full authority to act on your behalf in obtaining information and collecting money for your health care at this office. You are still responsible for the full payment of your care including the annual deductible, co-payments and amounts the insurance will not pay.



## Authorization to Contact Patient and Record of Disclosures

>>The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. (PHI) The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home<<

I wish to be contacted in the following manner (check all that applies):

- Home Phone w/ detailed message  
 Work Phone w/ detailed message  
 Email  
 Text (standard rates may apply from your cell phone carrier)  
 Leave a message with office call back number only via Voicemail, Email or Text  
 Other \_\_\_\_\_

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Patient Signature

Date

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Print Name

Date

**I authorize the release of protected health information to the individuals listed below:**

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_



**WAKE HEALTH**  
MEDICAL GROUP

## **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. If you have any questions about this Notice, please contact the office manager. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

### **1. Uses and Disclosures of Protected Health Information Based upon Your Written Consent**

You will be asked by your physician to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

Following are examples of the types of uses and disclosures of your protected health care information that physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

**2.Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

**3.Payment:** As your services will be completely paid on the date of service or agreements for credit issuing agencies signed, we do not release any billing information to anyone but yourself without written consent from you to do so.

**4.Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of employees, licensing, marketing, and fundraising activities, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to employees that see patients at our office. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the disclosure *or* use of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact and request that these fundraising materials not be sent to you.

We may use *or* disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact and request that these fundraising materials not be sent to you.

### **Uses and Disclosures of Protected Health Information Based upon Your Written Authorization**

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.



**Other Permitted and Required Uses and Disclosures That May be made with Your Consent, Authorization or Opportunity to Object**

You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this care, only the protected health information that is relevant to your health care will be disclosed.

**You have the right to inspect and copy your protected health information. You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for the notification purpose as described in this notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical records.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use *or* disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction in writing to our Privacy Contact.

**You have the right to request confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosure we may have made to you, to another facility director, to family members or friends involved in your care, or for notification purposes. You have the right to receive this information, although it is subject to certain exceptions, restrictions, and limitations.

**You have the right to obtain a paper copy of this notice from us** - upon request, even if you have agreed to accept this notice electronically.

**4. Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact (office manager) of your complaint. We will not retaliate against you for filing a complaint. You may contact our office for further information about the complaint process.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



# Physician-Patient Arbitration Agreement

**Article 1 - Agreement to Arbitration:** It is understood that any dispute as to medical malpractice, that is as to whether any medical service rendered will be determined by submission to arbitration as provided by North Carolina law, and not by a lawsuit or resort to court process except as North Carolina law provides for judicial review of arbitration processing. Both parties to this contract by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2 - All Claims must be Arbitrated:** It is the intention of the parties that this agreement binds all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn at that time of the occurrence given rise to any claim. In the case of any pregnant mother the term "patient" herein shall mean both the mother and the mothers expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of small claims court against the physician and physician's partners, associates, association or partnership and employees, agents and estates of any of them must be arbitrated including without limitations, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any actions in any court by physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute shall be resolved by arbitration, whether or not it is the subject of any existing court action.

**Article 3 - Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within 30 days thereafter. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have absolute right to arbitrate separately the issue of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of North Carolina law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedures and summon adjudicated persons in accordance with the Code of Civil Procedure.

**Article 4 - General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one processing. A claim shall be waived and forever barred if (1) on the date notice thereof is received the claim, if asserted in a civil action, would be barred by the applicable North Carolina statute of limitation, or (2) the claimant fails to pursue arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for the arbitration shall be governed by the North Carolina Code of Civil Procedures provisions relating arbitration.

**Article 5 - General Provisions:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature and if revoked will govern all medical services received by the patient.

**Article 6 - Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but limited to emergency treatment) patient should initial below:

Effective as of the date of first received medical service.

\_\_\_\_\_ Patient Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain fully enforced and shall not be affected by invalidity of any other provision. I understand that I have the right to receive a copy of the arbitration agreement. By my signature below I acknowledge that I have received a copy.

**Notice:** By signing this contract you are agreeing to have any issue of medical malpractice decided by natural arbitration and you are giving up your right to a jury or court trial (see Article 1 of contract).

\_\_\_\_\_  
Physician or Authorized  
Representative's Signature

Date

\_\_\_\_\_  
Patient's Signature

Date

\_\_\_\_\_  
Signature of Translator  
(if applicable)

Date

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Patient's Representative Signature Date

\_\_\_\_\_  
Print Name of Translator

\_\_\_\_\_  
Print Name and Relationship to Patient

A signed copy of this document is to be given to the patient. The Original is to be filed in the Patient's medical records.



WAKE HEALTH  
MEDICAL GROUP



# WAKE HEALTH MEDICAL GROUP / CREEKSIDE WOMEN'S CENTER

## OFFICE POLICIES

Wake Health Medical Group & Creekside Women's Center strive to render excellent care to our entire patient community. To help ensure quality care for everyone, please read our office policies below:

- **Payments (insurance visits):** When verifying insurance benefits, it is not a guarantee of payment per your insurance company's disclaimer. You are responsible for all co-pays, deductibles, co-insurance amounts and non-covered services. The Patient/Guardian is aware that their insurance company may not pay on a claim and that it will be the Patient's/Guardian responsibility to do so.
  - All copays and deductible payments are due at the time of appointment. Previous account balances must be paid in full at the time of current day appointment **prior to seeing the provider.**
  - Deductible, Co-insurance and any additional charges will be collected at the time of check in for those opting for Day Of Service pricing. If you chose to opt-out (separate signed form required), you will be billed the remaining balance stated on your insurance EOB. You/guardian are ultimately responsible for all payment of charges for services rendered.
  - It is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of each insurance visit. If your plan requires a referral, it is your responsibility to obtain this **prior to your appointment.**
  - Office personnel will assist when necessary with claims submitted to your insurance company; however, ultimately you/guardian will be responsible for the payment.
  - We do not submit claims to patient's insurance companies if at time of visit if: 1) the patient requests to be self pay, 2) at the time of visit the patient's insurance company states the service/product is non covered, or 3) we were provided inaccurate information by patient.
  - Returned check fee is \$37.50
  - The patient will be responsible for all attorney fees, legal fees, and court costs if the account is turned over to collections. If the patient is a **minor**, the patient's Legal Guardian will be responsible for all attorney fees, legal fees and court costs if the account is turned over to collections.
- **Payments (Cosmetic and Self-Pay):**
  - Full payment is expected at time of services rendered.
- **Packages/Series:** Packages/Series for both medical necessary and cosmetic services are offered to patients allowing for savings and benefits of the service provided. All packages have a deadline for full payment. Payment is expected prior to or at check in on day of appointment.
  - **PACKAGE PAYMENTS (with 2 or more Treatments):**
    - Package payments are due in full prior to or on day of treatment.
    - Payment plans may be arranged with our financial coordinator on a case-by-case basis.
- **Cancellations:**
  - When an appointment is scheduled, that time has been set aside for you. When it is missed, that time cannot be used to treat another patient.
  - Cancellations for appointments and procedures must be received **24 hrs prior** to the scheduled appointment. You may leave cancellation message on the voicemail if you are unable to speak with a member of our staff.
  - Missed/Cancelled Appointment for a Single scheduled procedure:
    - First Time (per calendar year): **Excused/Waived**
    - 2<sup>nd</sup> & 3<sup>rd</sup> Occurrence after first excused: **\$25**
    - Each Occurrence after 3<sup>rd</sup> instance: **\$50**
  - Missed/Cancelled Appointments for Multiple scheduled procedures on a single day (ie: Office visit with provider and acne treatment):
    - First Time (per calendar year): 1<sup>st</sup> appt of day **Excused/Waived**; each additional appt of day: **\$25 each**
    - Each Occurrence after first excused: **\$50 each**



**Office Policies: Continued**

- **Refunds:** (For Insurance Only)
  - All insurance companies have ninety (90) days to process your claim. Even after ninety (90) days the insurance company may still be processing your claim.
  - Once we have received confirmation and payment from your insurance company and the remaining balance on your account is paid in full, a refund check will be issued to you within 30 days.
- **Medical Records:**
  - Medical records must be received at least 48 hours prior to the date of your appointment.
  - Fees for copies of medical records are set in accordance with the State of North Carolina. Fees must be paid prior to mailing or pick up of medical records.
- **Returns/Refunds:** Products and Services
  - Products may be returned **within 14 days** of purchase for a full refund if you report any type of **adverse reaction**.
    - **14-30 days:** Store account credit only
    - **30+:** No returns for any reason
  - Services/treatments purchased in advance or a “package” will remain on your account until used. They do not expire.
    - Adverse reaction to or dissatisfaction with any service/treatment must be reported to management **within 14 days of service**.
    - If reported to management, the remaining package can be exchanged (equal value) or refunded.
    - If for some reason you are unable to continue services/treatments within one year of purchase, (ie: medical condition or moving outside of 35 miles from our practice) we will refund unused services/treatments, less a 20% administrative fee.
    - No refunds for any reason after 1 year.
- **Minors**
  - Minors under 18 must be accompanied by a parent or legal guardian for all appointments.
  - Parents may leave the room once they have met with the treatment provider; however, minors under 18 who arrive without an adult present may not be seen for their appointment. The provider may also request that you be present after the appointment to communicate any updates in the minor's condition or recommended changes to the treatment plan.

**Signature of Patient/Guardian confirms that all questions regarding policies are fully understood and accepted**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*\*\*IF YOU WOULD LIKE A COPY OF OUR OFFICE POLICIES, PLEASE ASK THE FRONT DESK RECEPTIONIST\*\*\***

