CAROLINA DERMATOLOGY
OF GREENVILLE

Patient Information: Date: _____

First, MI, Last Name: _____ Date of Birth: _____

SSN: _____ Gender at birth: ☐Male ☐Female Identify as: ☐Male ☐Female

Address: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Race: _____ Ethnicity: _____ Need Interpreter: ☐Yes ☐No Language: _____

NOTE: If patient is a minor, provide Parent or Guardian Name, DOB, and Relationship below:

_____ /_____/_____

Address (if different from above): _____

Primary Care Provider: _____ Referring Provider: _____

Preferred Pharmacy and Location: _____

Insurance Information: (Please bring insurance card(s) to appointment.)

Primary Insurance: _____ ID No: _____

Secondary Insurance: _____ ID No: _____

Medical History:

Briefly, what brings you in today: _____

_____

Personal History of Skin Cancer: ☐Yes ☐No If Yes, Type: ☐Basal Cell Carcinoma ☐Squamous Cell Carcinoma ☐Melanoma ☐Other: _____

Family History of Skin Cancer: ☐Yes ☐No Family Member(s): _____

History of skin disease: ☐Yes ☐No If yes, what type? _____

List any other diseases or conditions you have: _____

Pregnant: ☐Yes ☐No If yes, how many weeks: _____ Breastfeeding: ☐Yes ☐No

Pacemaker/Defibrillator: ☐Yes ☐No Artificial Heart Valve: ☐Yes ☐No Joint Replacement: ☐Yes ☐No

HIV: ☐Yes ☐No Hepatitis B or C: ☐Yes ☐No Diabetes: ☐Yes ☐No Blood Thinner: ☐Yes ☐No _____

Personal History of Cancer: ☐Yes ☐No If yes, what type? _____

List Current Medications (dose not necessary):

Medication Allergies: ☐Yes ☐No If yes, which one(s)? _____

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Acknowledgements

Consent to Treatment:

By reading and signing this document, you, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, anesthesia, medical services, and surgical or diagnostic procedures (including but not limited to the use of photography, lab and pathological studies) as ordered or approved by your attending physician(s), or healthcare professional assigned to your care. You acknowledge and consent to the following: While routinely performed without incident, there may be material risks associated with any procedure. If you have any questions concerning these procedures, you will ask your physician(s) or provider to provide you with additional information. You also understand your physician may ask you to sign additional Informed Consent documents relating to specific procedures.

Your Contact Information and Consent for Communication:

Please provide phone numbers and email address where we may contact you:

Cell: _____ Home: _____ Work: _____

email address: _____ *Note: An automated appointment reminder may call or text the numbers listed. You will have the option to opt out for future reminders.*

Please indicate which, if any, of the above we may leave a voice and/or text message (other than appointment reminders) related to your care: _____.

Release/Disclosure of Information:

Other than yourself, with whom may we discuss your medical information? *Note: You must notify us in writing if you wish to change this designation at any time.*

Name: _____ Relationship to you: _____ Contact #: _____

Emergency Contact Information:

Name: _____ Relationship to you: _____ Contact #: _____

Financial Responsibility:

It is your responsibility to provide accurate insurance information to our office, and we will file claims in a timely fashion. You agree to pay co-payments or self-pay amounts at the time of service, and understand that ultimately, you are responsible for payment of services based on the insurance explanation of benefits (EOB) and agree to pay any balances that are billed to you. Payment for cosmetic service will be made at the time of service.

You authorize the release of all necessary information to your insurance company, health plan or other entity (third party payor) which may be responsible for paying for your care, and direct all payors to pay benefits due for such care directly to Carolina Dermatology, PA, and assign such sums to them. You understand this authorization and assignment of benefits shall remain valid unless you provide written notice of revocation to Carolina Dermatology, PA and the third-party payor; however, such revocation shall not pertain to information released and/or charges incurred prior to such revocation.

Notice of Privacy Policy:

The Notice of Privacy Policy has been made available to me relative to how my Protected Health Information (PHI) may be used and my rights regarding my PHI.

By signing this document, you certify that you have read and understand its contents and that information provided by you is accurate and complete. A copy of this document may be utilized the same as the original.

Patient Signature: _____

Print Patient Name:_____

Patient DOB:_____/_____/_____ Today's Date:_____/_____/_____

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No-Show and Cancellation Policy

At Carolina Dermatology, we value your business, and we understand that sometimes plans change. If you need to cancel or reschedule your appointment, we respectfully request that you reach out to our office as soon as possible to allow us to accommodate your needs as well as the needs of our other patients.

Missing Appointments without Notice (No-Show):

If you no-show two appointments, our providers reserve the right to decline to reschedule your appointment.

Same Day Rescheduling and Cancellations:

Cancelling or rescheduling your appointment with less than 24-hour notice prevents us from being able to fill that appointment slot with a patient who may need a work-in appointment. If you repeatedly cancel or reschedule your appointment without a minimum of 24-hour notice, your provider may decline to reschedule with you going forward.

If our office decides not to reschedule your appointment, we will assist you in transferring your treatment records to another office of your choice. You will not be eligible to schedule with a different provider in the practice.

Self-Pay Policy

New Patient Appointments:

New patient office visits are $199. $100 is taken at the time of scheduling the appointment and $99 is taken when you arrive to be seen. If you decide to cancel your appointment with sufficient notice, as described above, you are eligible for a refund. No-showed appointments are not eligible for refunds.

Established Patient Appointments:

The office visit charge for existing patients is $153.

Any other treatment(s) that may happen during the appointment (biopsies, freezing, etc.) will be an additional charge. Payment plans may be available for any additional charges incurred above the office visit charge.

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Patient Name: _____

Date of Birth: _____

Practice Financial Policy

Please review and acknowledge below.

- Co-payments for office services are required at the time you check-in.
- As a courtesy, we will process and file your insurance claims for services at no cost to you.
- For services that are covered by insurance, the practice requires payment of approximately 20% of the total estimated charges or the co-payment specified by your insurance.
- For services that are not covered by insurance, the practice requires payment of 100% of total charges unless payment arrangements have been worked out.
- Returned checks are subject to a handling fee of $20.00. In the event your account must be turned over for collection, you will be billed and are responsible for all fees involved in that process.

You must realize that:

1. Your insurance is a contract between you and your employer and/or the insurance company. While we may be a provider of services, we are not a party to that contract. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.
2. Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. We will make every effort to ascertain your coverage for our services before treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. We will allow you 90 days to pay any balance remaining after insurance payment. After that time, your account will accrue interest at the rate of Prime plus 2%. Our staff will make arrangements for you to make monthly payments over an approved term. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, please do not hesitate to ask us. We are here to help you.

PLEASE READ THE ABOVE CAREFULLY <u>BEFORE</u> SIGNING. By signing below, I acknowledge that I have read and understand this policy.

Signature: _____ Date: _____
(Patient and/or Responsible Party)

Carolina Dermatology, PA
5 Stevens St Ste 300, Greenville, SC 29605 10 Enterprise Blvd Ste 202, Greenville, SC 29615
Phone: 864-233-6338 www.carolinaderm.com

CAROLINA DERMATOLOGY
OF GREENVILLE

Patient Name: _____

Date of Birth: _____

Insurance Information Release Consent Form

MEDICARE AUTHORIZATION

_____ _____
Initials Date

I authorize the holder of medical or other information to release to the Social Security Administration and Health Care Financing Administration, its intermediaries or carrier, any information needed to file a Medicare claim. I permit a copy of this authorization form to be used in place of the original and requested payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. DEDUCTIBLE AND CO-INSURANCE (20% IF NO SUPPLEMENT) IS DUE AND EXPECTED AT THE TIME OF SERVICE.

TRICARE INSURANCE

_____ _____
Initials Date

If you have Tricare or Tricare Prime, please READ CAREFULLY:

We are currently certified providers with Tricare and in Network with Tricare Prime; however, Tricare Prime (Active Duty members) does require a referral and/or prior authorization for which the patient is responsible for acquiring from their primary care physician.

I authorize the release of medical information for services rendered to my insurance company, and also authorize payment of medical benefits to the physician. I understand that I am responsible for any amount not covered by insurance. I also consent to the taking of photographs for medical, teaching purposes and office use.

Signature: _____ Date: _____

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Patient Name: _____

Date of Birth: _____

Authorization To Release Medical Information

If you are 18 years of age or older we must have your permission to discuss your treatment, medical, or financial information, etc., with anyone other than yourself. If a person's name is not listed on the consent form, we cannot discuss your information with them.

Please sign in ONLY ONE of the areas below

I hereby give my consent for Carolina Dermatology, PA and staff to review or discuss my medical treatment, lab results, pathology reports, and/or financial information with the following person(s), other than myself. I understand that I must submit a written request to amend this list.

1. _____ Relationship: _____
(First & Last Name) (Date of Birth)

2. _____ Relationship: _____
(First & Last Name) (Date of Birth)

3. _____ Relationship: _____
(First & Last Name) (Date of Birth)

Signature: _____ Date: _____

OR

If there is no one that you wish your information to be released to, other than yourself, please sign below:

DO NOT RELEASE ANY INFORMATION ABOUT MY MEDICAL RECORDS OR FINANCIAL INFORMATION TO ANYONE OTHER THAN MYSELF.

Signature: _____ Date: _____