CAROLINA DERMATOLOGY
OF GREENVILLE

Patient Name: _____

Date of Birth: _____

HISTORY FORM

PLEASE FULLY COMPLETE THE REASON(S) FOR YOUR VISIT TODAY:

1. Reason for today's visit? _____

2. How long have you had this problem? _____

3. What location of your body is affected? _____

4. What are your symptoms (i.e. itching, burning, pain)? _____

5. Does anything make your problem worse? _____

6. Does anything make your problem better? _____

7. Does this problem affect your sleep? _____

8. How does this affect your life? _____

9. Have you been evaluated for this problem before? _____

   If so, by whom? _____

10. What was the diagnosis given?_____

11. Did you receive any treatment? _____

12. What was the treatment and how often did you receive it? _____

13. Is there anyone in your family with similar symptoms? _____

_____ INITIALS

_____ DATE

Carolina Dermatology, PA
920 Woodruff Road
Greenville, SC 29607
Phone: 864-233-6338
www.carolinaderm.com

CAROLINA DERMATOLOGY
OF GREENVILLE

Patient Name: _____

Date of Birth: _____

Primary Care Provider: _____ Phone #: _____

Past Medical History: (Please circle all that apply)

Anxiety
Arthritis
Asthma
Arterial Fibrillation (irregular heartbeat)
Bone Marrow Transplant
Benign Prostate Hyperplasia/BPH
Breast Cancer
Colon Cancer
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD/IBS
Hearing Loss
Hepatitis
Hypertension/BP
HIV/Aids
High Cholesterol
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Strokes

Other:

_____

_____

_____

Past Surgical History**:**

SURGERY	**YEAR OF PROCEDURE**	**SURGEON**

Height: _____ Weight: _____

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Skin Disease History: (Please check all that apply)

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Other:
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Squamous Cell Skin Cancer

_____

_____

_____

Do you wear sunscreen? ☐ YES ☐ NO

If yes, what SPF? _____

Do you tan in a tanning salon? ☐ YES ☐ NO

Do you have a family history of Melanoma? ☐ YES ☐ NO

If yes, which relatives? _____

_____

Medications: (Please list all medications)

_____

_____

_____

Allergies: (Please list all allergies)

_____

_____

_____

_____

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Patient Name: _____

Date of Birth: _____

Social History: (Please check all that apply)

- ☐ Currently Smokes
- ☐ Has Smoked in the Past
- ☐ Drug Use
- ☐ None
- ☐ Other:

_____

Cautions: (Please check all that apply)

- ☐ Artificial Joints Within Past 2 Years
- ☐ Pacemaker
- ☐ Coronary Artery Pressure
- ☐ Artificial Heart Valve
- ☐ HIV/AIDS
- ☐ Blood Thinners
- ☐ Pre-medication Prior to Procedures
- ☐ Allergy to Latex
- ☐ Pregnant or Planning Pregnancy
- ☐ History of Low Blood or Platelet Count
- ☐ Use of Oxygen
- ☐ Prior Chemotherapy

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Patient Name: _____

Date of Birth: _____

CONSENT TO OBTAIN PRESCRIPTION HISTORY

This consent form authorizes Carolina Dermatology, PA to obtain and review my prescriptions history. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names or dosages.

By signing this consent form, you agree that Carolina Dermatology, PA can request and use your prescription medication history from other healthcare providers, pharmacies, and benefit payors (such as your insurance company) for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Carolina Dermatology, PA to request, view, and use my external prescription history for treatment purposes. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

PATIENT NAME (Printed): _____

PATIENT DATE OF BIRTH: _____

PATIENT SIGNATURE: _____

DATE OF SIGNING CONSENT FORM: _____

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CAROLINA DERMATOLOGY
OF GREENVILLE

Consent to Treatment and Other Acknowledgments

By reading and signing this document, I, 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 lab and radiographic studies) as ordered or approved by my attending physician(s), or any healthcare professional assigned to my care by my attending physician(s), and I acknowledge and consent to the following: While routinely performed without incident, there may be material risks associated with any procedure. If I have any questions concerning these procedures, I will ask my physician(s) to provide me with additional information. I also understand my physician may ask me to sign additional Informed Consent documents relating to specific procedures.

I hereby expressly authorize and all healthcare professionals providing care to release all necessary information to any insurance company, health plan or other entity (third party payor) which may be responsible for paying for my care. I authorize and direct all payors to pay all benefits due for such care directly to Carolina Dermatology, PA and all professionals (including independent contractors) providing for such care and I hereby assign such sums to them. I understand this authorization and assignment shall remain valid unless I provide written notice of revocation to Carolina Dermatology, PA and the third party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.

By signing this document, I certify that I have read and understand its contents and that information provided by me is accurate and complete (including insurance information and current eligibility for benefits).

A copy of this document may be utilized the same as the original.

Name:_____ **DOB:**_____/_____/_____

Today's Date:_____/_____/20_____

Revised 9/2024

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Consent to Medical Treatment:

Carolina Dermatology, PA maintains personnel and facilities in order to assist my physicians in providing me with medical care, and I authorize Carolina Dermatology, PA (Clinic) providers and personnel to perform on me the care ordered by my physicians. I consent to receive services by telemedicine (using Interactive audio, video, or data communications to carry out consultations, evaluations, screenings, diagnosis, treatment, monitoring or other communications benefiting a patient) if appropriate for my condition, and I understand the risks, benefits and alternatives of doing so, I choose to receive services even if my insurance plan may not cover or continue to cover specific service, including the specific services rendered during the admission. I understand that I have the right to be informed by my providers of the nature and purpose of any proposed operation or procedure and any available alternative methods of treatment together with an explanation of the risks associated with each of them. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to the recognized standards of medical practice, and I acknowledge that Clinic and its personnel are not responsible for providing me this information. I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of examinations and or treatments provided by Clinic.

Consent to Recording or Filming.

I authorize Clinic, the attending physician, or other Clinic authorized persons to record, photograph or film me for treatment, quality improvement or education purposes. Such recording, filming or photographs will be released only as permitted by law or authorized by me.

Assignment of Insurance Benefits. Patient Financial Responsibility and Credit Report Authorizations:

I guarantee payment of all charges made for or on account of the patient. I assign my right and my insurance benefits payments or other payment sources directly to Clinic and/or the physicians providing services in conjunction with Clinic. This assignment includes, but is not limited to, radiology reading, pathology services, emergency room visits or EKG readings. I understand I will receive separate bills for certain Clinic and physician services. I understand I am financially responsible to Clinic and physicians for charges not covered by this insurance assignment, I further understand Clinic can obtain my credit report for collection purposes and I am responsible for any collections, attorney fees and costs. I have provided all Medicare information and insurance cards to Clinic. I agree that in the event benefits paid under this assignment or any other amounts paid by me/us or my/our behalf exceeds the amount due the Clinic, my physicians, or those entitles for services in connection with this treatment, and such excess amount may be applied to any other indebtedness that l, my spouse, or any child for whom I am financially responsible, may have with the Clinic or any other facility entity related to Clinic.

Authorization to Disclose Information and Privacy Act:

I authorize Clinic, and its affiliates to use or disclose my protected health information for the purposes of treatment, payment or healthcare operations. This consent shall cover any of my protected health information that Clinic may maintain or receive. I authorize the release of medical and related information about my treatment to the Professional Standards Review Organization responsible for reviewing the medical care furnished to me. This authorization will expire six years from the date shown below; however, I reserve the right to revoke this authorization at any time by contacting the Corporate Privacy Officer at (770) 285-7910. I understand I have the right to review the Notice of Privacy Practices before signing this consent. I further

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understand that the Notice of Privacy Practices provides a more complete explanation of the uses and disclosures of my protected health Information.

Authorization to Release Medical Information:

I authorize the Clinic and my physicians to disclose any medical information related to my services or treatment to my insurance company, governmental or charitable agencies and their agents, my employer and professional review organizations with whom I may have insurance coverage or who may be assisting in the payment of my bill and my medical care. I also authorize the Clinic and my physicians to release any medical information to any licensed physician or medical facility to which I may be referred or transferred for further medical care. In addition, I authorize the Clinic and my physicians to release any. medical information necessary to prove the Clinic's damages in any legal proceeding brought about to enforce any unpaid balance on any of my accounts. This authorization will expire two (2) years from the date shown below, and I understand that I or my legal representative may revoke this authorization at any time, unless legal action has already been taken, or in In the event of my death, the release of medical information is necessary to verify any charges incurred by me.

Authorization to Release Medicare and Medicaid Information:

I certify that the information provided by me in applying for payment under Titles V, Will and/or XIX 01 the Social Security Act is correct. I understand that health care services paid for under Medicare, Medicaid and Maternal and Child Health programs are subject to review by professional organizations, which may recommend dental of payment if my medical condition does not warrant continued Clinic care. I authorize the Financial Counseling Wellness staff of the Clinic to assist me in the processing of any benefits application, including Medical Assistance, Aid to Families with Dependent Children, or Special Assistance, initiated for the patient within six months of the date of this authorization. The Financial Counselor may have access to and copy any records or information to which I would be entitled. I authorize and direct the County Department 01 Social Services to provide such information to the Financial Counselor orally via telephone. I authorize and consent to referral to the County for benefits by use of any appropriate referral form. The doctrine of informed consent has been explained to me, I acknowledge that this consent is voluntary and that it may be revoked by me at any time except to the extent that action has already been taken in reliance on it. Unless otherwise revoked, this consent shall be valid for one year from the date of authorization, or until final determination of any benefits application as described above, whichever is later.

For Underinsured Patients or Uninsured Patients:

I authorize Clinic and its affiliates, to use or disclose my protected healthcare information for the purpose of helping me find to find a healthcare provider and/or locate a payment source for my visit.

Release of Responsibility/Liability For Valuables:

I understand that Clinic has a policy for safekeeping of patient valuables requiring all money, credit cards and/or items of value including jewelry to be given to a family member to hold or leave at home. If I choose not to deposit such items of value with my family member, I absolve Clinic from responsibility for their loss, damage of disappearance.

Payment Guaranty: (Patient and/or responsible party/parties) agree to pay all charges for services rendered by Clinic and my physicians or other providers during treatment related to services provided by Clinic. This guaranty includes charges not covered by my insurance regardless of the reason insurance coverage is denied.

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OF GREENVILLE

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I agree to pay the reasonable cost of the attorney services in addition to the unpaid charges. I consent and authorize Clinic and its agents or subcontractors to contact outside sources including for the purpose related to my account, including evaluating and assessing my credit worthiness, my charity eligibility and the viability of collecting any amounts due for treatments I receive, whether at this time or on subsequent visits. I understand and agree that Clinic may assign my accounts as it deems necessary for the purposes of collecting any amounts I owe, including to collection agencies and attorneys. I consent and authorize Clinic and third-party agents of Clinic to contact me at any telephone associated with me, including a wireless number, and to use pre-recorded and/or an automatic dialing service in connection with any communication made to me or related to my account.

I affirm that my signature on this form indicates that I have disclosed any and all current Insurance coverage/s that may pay for this visit. Further, any failure on my part to Identify my insurance/s may result in additional charges for which I win be responsible. My signature also indicates that if I have no insurance coverage J will cooperate and participate in any efforts to help me qualify for any applicable coverage. Failure to do so may render me ineligible for any financial assistance discounts.

I have read the request and authorization in Its entirety and agree to be bound by all the terms and conditions herein. Witness my (our) hand(s) and seal(s) below,

_____. _____

Patient Responsible Party(ies)

_____ _____

Witness Relationship to Patient

Spouse____Parent____Other(specify)_____

I have been provided access to Clinic Notice of Privacy Practices

_____

Patient (or authorized representative) Date Time

Patient unable/unwilling to sign_____ Reason _____

Clinic Representative_____

Date/Time _____

CAROLINA DERMATOLOGY
OF GREENVILLE

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 <u>not</u> 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)

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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

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

_____ _____
Initials Date

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.

_____ _____
PATIENT 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:_____

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CAROLINA DERMATOLOGY
OF GREENVILLE

Patient Name: _____

Date of Birth: _____

PATIENT ACKNOWLEDGEMENT Health Insurance Portability and Accountability Act (HIPAA)

Our ***Notice of Privacy Practices*** provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this acknowledgement. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

The Summary of our Notice of Privacy Practices is posted in our main lobby. The complete Notice of Privacy Practices in also available in our main lobby for your review. If you would like to receive a copy of the Summary and complete Notice, we have one available for you at the front desk.

If you wish for persons other than those released under normal operations as indicated in the Notice to receive confidential information that is now protected under this law, you must release them in writing. Please indicate on your patient registration form spouse, or any family or friends whom you wish to be able to receive information about you. You may of course choose not to release anyone. You may also be more specific in your restrictions for the persons you have released, just provide that request in writing. Parents or Guardians of minor children do not need to be released.

We have found that the easiest way to identify persons who are inquiring about your information is for you to assign a security password to your account. Persons who call will be asked this password instead of your social security information. Please be aware that our staff has to follow federal law on information that we release by phone and we may at any time choose not to release information of any kind by phone if we feel that the person requesting information is not authorized or we feel the information may be too sensitive to release by phone.

By signing this form, you are acknowledging that the Carolina Dermatology, PA has made our Notice of Privacy Practices available to you for review and that we have offered you a personal copy

Signature: _____

This acknowledgement was signed by: _____

Printed Name – Patient or Representative: _____

Relationship to Patient (if other than patient): _____

Date: _____

In front of: _____
(Practice representative)

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Patient Name: _____

Date of Birth: _____

HIPAA AUTHORIZATION FORM

I authorize Carolina Dermatology, PA to use and disclose my protected health information (PHI) listed below upon my request. This includes faxing this information to designated entities or persons.

_____ Appointments _____ Restrictions _____ Medications _____Diagnosis

_____ Date of Visit _____Reason for visit _____Released from care

Entity or person(s) authorized to receive this information:

_____Camp _____Social Worker _____ School/Daycare/Preschool

_____Employer _____Family/Friends _____Parole Officer

_____Personal Representative's Employer

This PHI is being used or disclosed for the following purposes:

_____Verify return to work/school _____Work/School Excuse

_____To verify restrictions

This authorization shall be in force and effect until the time or event specified below, at which time this authorization to use and disclose PHI expires.

_____No longer in school _____Employment terminated

_____Released from Care _____ Child is no longer a minor

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at (office address or e-mail address). I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of Patient or Personal Representative Date

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