GREENVILLE DERMATOLOGY

PATIENT INFORMATION (please print)

Full Name: _____ Preferred Name:_____
(first) (middle) (last)

Social Security Number_____

Birthdate: _____ Age _____ Male _____ Female _____

Street _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ E-mail _____

Occupation _____ Employer _____

Referring Physician _____ Primary Physician_____

Marital Status: _____ Married _____Divorced _____Single _____Widowed _____Separated

Race: ___Caucasian (White) ___American Indian ___African American (black) ____Hispanic
___Biracial ____Asian/Oriental ___Other ____Unknown ____Refuse/Decline

Ethnicity: ___Hispanic/ Latino ____Non-Hispanic/ Latino ____Refuse/Decline

Spouse Information: Name _____DOB _____

Phone Number _____ SSN _____ Spouse's Employer_____

Parent Information (Complete **Only** if Minor, Student, or covered under parent's insurance)

Father's Name _____ Employer _____ Phone_____

Social Security Number _____ DOB _____

Mother's Name _____ Employer _____ Phone_____

Social Security Number _____ DOB _____

Person Responsible for Medical Bills

Name _____ DOB _____

Primary Insurance _____ Secondary Insurance _____

Patient/Legal Guardian _____ **Date** _____

GREENVILLE DERMATOLOGY

Reason for today's visit

Chief Complaint and History of Present Skin Problem

Name: _____ DOB: _____ Date: _____

Are you here for a follow-up of a previous visit? Yes_____ No _____

Do you have any new skin problems? Yes _____ No _____

What is your primary skin concern/reason for your visit today?

_____

Where on the body is this problem?

_____

Describe any symptoms (itching, pain, tenderness, irritation, burning, bleeding, etc)

_____

How severe is this problem? Mild _____ Moderate _____ Severe _____

How long have you had this problem? Days_____ Weeks _____ Months _____Year(s) _____

Describe any past and/or current treatments for this problem (OTC/Rx/Surgery)

_____

Are there any other skin concerns you would like to have evaluated at this time? Yes_____ No _____

If yes, please describe: _____

GREENVILLE DERMATOLOGY

HEALTH AND MEDICATION INFORMATION

Patient Name_____

Preferred Pharmacy (location) _____

Alerts:

- ☐ Allergy to adhesive
- ☐ Allergy to lidocaine/Xylocaine/Adrenalin
- ☐ Allergy to topical antibiotics
- ☐ Allergy to Rubber or Latex
- ☐ Artificial heart valve
- ☐ Artificial joint placement
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ MRSA
- ☐ Pacemaker
- ☐ Require antibiotics prior to surgical procedure
- ☐ Rapid heartbeat with epinephrine
- ☐ Are you pregnant or currently trying to get pregnant

Past and Present Health Conditions:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End-Stage Renal Disease
- ☐ GERD (Acid Reflux)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension (High Blood Pressure)
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia (Cholesterol)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ None

Circle any Other Conditions: Acid Reflux; ADD/ADHD; Bleeding/Blood Disorder; Blood Transfusion; Epilepsy/Nerve Disease; Heart Disease; Kidney Disease; Lung Disease; STD's; Stomach/Intestinal Disease;

_____

Past Surgical History

- ☐ Appendix Removed (Appendectomy)
- ☐ Bladder Removed (Cystectomy)
- ☐ Breast Biopsy __ Right __ Left
- ☐ Lumpectomy __ Right __ Left
- ☐ Mastectomy __ Right __ Left

Colon Removed (Colectomy)

- __ Colon Cancer Resection
- __ Diverticulitis
- __ Colostomy

- ☐ Gallbladder Removed

Heart

- __ Biological Heart Valve Replacement
- __ Coronary Artery Bypass Surgery
- __ Heart Transplant
- __ Mechanical Valve Replacement

Joint Replacement

Hip __Right __ Left

Knee __ Right __ Left

Kidney

__ Biopsy __ Stone Removal

__ Transplant __ Nephrectomy

Liver

__ Hepatectomy (removed) __ Shunt

__ Transplant

Ovaries

__ Endometriosis __Ovarian Cancer

__ Ovarian Cyst __ Tubal Ligation

- ☐ Pancreas Removed (Pancreatectomy)

Prostate Removed (Prostatectomy)

__Biopsy__Cancer__TURP__Removed

- ☐ Rectum: Low Anterior Resection

Skin

__ Basal Cell __ Melanoma

__ Skin Biopsy __ Squamous Cell

- ☐ Spleen Removed (Splenectomy)
- ☐ Testicals Removed __ Left __Right

Uterus Removed (Hysterectomy)

__ Fibroids __Uterine Cancer

__ Cervical Cancer

- ☐ None
- ☐ Other

List other surgeries: _____

Skin Disease History:

- ☐ Acne
- ☐ Actinic keratosis
- ☐ Asthma
- ☐ Basal cell skin cancer
- ☐ Blistering sunburns
- ☐ Dry skin
- ☐ Eczema
- ☐ Flaking or itchy scalp
- ☐ Hay fever/allergies
- ☐ Melanoma
- ☐ Poison ivy
- ☐ Precancerous moles
- ☐ Psoriasis
- ☐ Squamous cell skin cancer
- ☐ None

Other skin conditions: atypical moles; fever blisters; large scars; keloids; scalp condition;
_____

Do you use sunscreen? ___Yes ___No SPF ___
Do you currently use tanning beds __Yes __No

List all prescription and non-prescription medicines you are now taking:

_____
_____
_____
_____
_____
_____

Do you have any drug allergies? ___Yes ___No
(If yes, please list allergy & reaction)

_____
_____

Social History:

Do you currently smoke? ___Yes ___No

Were you a former smoker? ___Yes ___No

When did you quit smoking? _____

Do you drink alcohol? ___Yes ___No

Family History (Only first degree relatives only: mother, father, sister, brother, grandparents)

☐ Cancer	Who: _____	Type: _____
☐ Cholesterol	Who: _____	Type:_____
☐ Diabetes	Who: _____	Type: _____
☐ Heart Disease	Who: _____	Type: _____
☐ High Blood Pressure	Who: _____	Type: _____
☐ Kidney Disease	Who: _____	Type: _____

Patient Initials: _____

Have you had a flu shot/pneumonia vaccine? ___ Yes ___ No if so, when? _____

Authorization to Release Medical Information

Patient Name: _____ DOB: _____

The privacy of your medical care is very important to us. We will only discuss and/or release information to the person(s) and in the manner in which you have designated.

Confidential Communication: Please provide phone number(s) where we can reach you

Home: _____ Work: _____ Cell: _____

Medical Information: I authorize medical information to be left on the following voicemail

___ Home ___ Work ___Cell ___ I do not authorize

Designated Person(s) in which we may leave a message with if we cannot reach you.

By authorizing others to view or have access to my PHI, your PHI may no longer be protected by federal privacy law.

___Only me personally (this allows for **NO ONE** to receive any information includes spouses and/or family members)

___ Name: _____ Relationship: _____ Phone: _____

___ Name: _____ Relationship: _____ Phone: _____

___ Name: _____ Relationship: _____ Phone: _____

Signing this form authorizes Greenville Dermatology to release and receive relevant medical information acquired during the course of treatment without further authorization from you. I authorize the above designated person or persons to obtain my protected health (PHI) as required. You may revoke this authorization in writing and send to Greenville Dermatology, 369 Woodruff Road, Greenville, SC 29607

Biopsy Consent

If you have a biopsy done and it requires further consultation, signing this waiver gives Greenville Dermatology permission to send the specimen to and from ***DermPath Diagnostics, Pathology Consultants, or D-Path*** to the necessary physician. Without your signature Greenville Dermatology will not be able to send the specimen to any other provider, such as an oncologist, MOHs surgeon, etc.

****Greenville Dermatology will leave results for benign lesions or lesions that require no further treatment on your voicemail***

_____ Patient or Guardian Initials

Patient or Guardian Signature: _____ Date: _____

GREENVILLE DERMATOLOGY, LLC

369 WOODRUFF RD. GREENVILLE, SC 29607
864-242-5872/ FAX 864-242-5640

FINANCIAL POLICY

Thank you for choosing our practice. Our goal is to provide the best possible care. This information is to avoid any confusion regarding payment for the services we render. Your signature on the patient registration form indicates you have read and agree with the Patient Responsibility Payment Policy. Please present current insurance cards and government photo ID at the time of your visit.

Payment Policy:

- We accept cash, personal check, debit cards, Visa, MasterCard, Discover and American Express.
- If you do not have insurance, or it cannot be verified, total payment for your visit is due at the time services are rendered.
- **Co-pays, deductibles and any non-covered services and outstanding balances are due upon check-out. Your insurance company requires us to collect your co-pays and deductibles at time of service. Once insurance has processed your claim, bills are sent out with any outstanding patient balance; these are due 30 days of statement date.**
- If you do not have in-network benefits or are self-pay we expect payment at check-out.
- Additional Forms: copies of Medical Records, disability or other forms are at additional charge and are payable at time of pickup.($25-$45)
- **For returned checks,** a $35 collection fee will be applied toward your account.
- **Missed appointments** not cancelled or rescheduled within 24 hours have a fee of $50.
- **Missed procedure or surgery appointments** not cancelled or rescheduled with 48 hours have a fee of $150.
- **Prescription refills called-in/written –** if not obtained during normal working office hours or patient missed appointment have a fee of $20

Insurance:

- We file your insurance as a courtesy. **It is your responsibility to be knowledgeable about your policy benefits and to know the physician you are seeing participates in your plan PRIOR to services being rendered. We can never guarantee insurance coverage for any service provided. (Skin tags are often denied for not medically necessary).** You are to notify our office of any changes to your insurance coverage and to pay any amount that is determined to be your responsibility. We cannot submit claims with preventative codes. Insurance claims have to be paid within a timely manner, therefore if the insurance balance is unpaid within 30 days you can be held responsible. You may need to seek reimbursement directly from your carrier.
- If your plan requires a referral or prior authorization, it's your responsibility to notify your carrier of this prior to your visit, we may assist you in doing this.

Medicare:

- A current copy of your Medicare or Medicare Advantage card is required. Co-pays, deductibles and non-covered services will be your responsibility. Some Medicare Advantage plans require you to go to participating providers. It is your responsibility to know what doctors are in network. Otherwise you will be responsible for payment at time of service.

Medicaid:

- Greenville Dermatology does **NOT** contract with every Medicaid plan. If your plan requires an authorization through a family physician, you must have established a relationship with them first. Due to the changing nature of Medicaid plans, it is your responsibility to inform our office of any changes prior to your scheduled appointment. A current copy of your Medicaid card is required for every visit.

Labs:

- Any Biopsies performed will be sent to **Dermpath Diagnostics, Pathology Consultants, or D-Path** for slide preparation. You may receive a separate bill from one of these companies for their services depending on your insurance coverage. We will provide them with your insurance information.
- If your insurance requires that tests be sent to a specific lab, it is your responsibility to tell the assistant which lab is required. We will not pay for any lab charges.

Cosmetic and Elective Services:

- Full payment is required at time of service. Cosmetic and elective procedures may require a deposit or payment in full to hold the appointment. Please be aware that a missed appointment can result in loss of some or all of your deposit.

Patients Under 18 Years Old:

- The patient registration form must be signed and guaranteed by the parent or legal guardian accompanying the minor at the initial visit. The guarantor is legally responsible for payment.
- We are unable to know the financial responsibilities of divorced parents. The adult accompanying the minor is responsible for payment of the patient portion due at the time of service.
- When a minor become 18, s/he will sign this form and may designate parental rights for information and payments.

Greenville Dermatology, LLC

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.

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

If you have any questions about this notice, please contact the Practice Manager by phone at 864-242-5872 or in writing at 369 Woodruff Rd. Greenville SC 29607

WHO WILL FOLLOW THIS NOTICE

This notice describes the information of privacy practices followed by our employees, staff, vendors, business associates and other office personnel. The practices describes in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide coverage for your healthcare provider.

UNDERSTANDING YOUR HEALTH INFORMATION

This notice applies to the protected health information that we have about you at this office. Protected Health Information ("PHI") is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health condition and related health services.

We are required by law to give you this notice. It will tell you about the way in which we may use and disclose your protected health information and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU FOR TREATMENT

We may use your PHI in rendering treatment to you. We may disclose health information about you to doctors, nurses, technicians, pharmacy, office staff or other personnel who are involved in taking care of you and your health. For example, we are permitted to use your PHI in providing you medical care when you visit our office. This includes coordination or management of your healthcare. Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in a prescription to a pharmacy, scheduling lab work and ordering x-rays.

PAYMENT

We may disclose your PHI for payment purposes. For example- we may need to give your health plan information about services you receive here so your health plan will pay us or reimburse you for the services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

HEALTHCARE OPERATIONS

We may use and disclose healthcare information about you in order to support business activities of this office. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical professionals, students of affiliated healthcare programs, volunteers or other staff who care for you, licensing and conducting or arranging other business activities. These disclosures may be made verbally, written or in an electronic format. We may disclose your PHI to use or release your information for interpreters when there are language barriers. For instance we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician, we may ask your name, address, insurance and other demographics a the registration desk or we may call you by name from the lobby or other areas within the building. For example, medical records storage and shredding vendor may provide some related services for business operations and will have a written contract that requires them to protect your PHI.

In addition, the practice may use or disclose your PHI in accordance with the specific requirements of HIPPA regulations without us needing to obtain an authorization or giving you an opportunity to agree or object if any of the following instances occur:

- Required by law. For example, we must provide your PHI to the Secretary of the Department of Health and Human Services if the Secretary or federal, state and local law so requests.
- Required for public health purposes. For example, we may disclose PHI for the maintenance of vital records such as the number of births and deaths, to prevent or control disease, injury or disability, to report adverse events products defects or problems or reactions, to note product recalls, to notify a person who may have been exposed to a disease or may be at risk for getting or spreading one.
- Required for disaster relief organizations. For example, we may disclose PHI to a disaster relief organization to coordinate your care and/or locate family members in the event of a disaster.
- Required disclosures about victims of abuse, neglect, or domestic violence. For example, we may disclose PHI for the reporting of spousal, adult or child abuse, such as, The Department of Social Services.
- Required by a health oversight agency for oversight activities authorized by law. For example, we may disclose PHI to government health oversight agencies for such purposes as investigation, inspections, audits, surveys and licensure.
- Required in the course of any judicial or administrative proceeding. For example, we may disclose PHI in response to a court or administration order if you are involved in a lawsuit or similar proceeding.
- Required for law enforcement purposes. For example, we may disclose PHI for the purpose of identifying a fugitive from justice, missing persons, witness, suspect, in response to criminal conduct while in the office, and in an emergency to report a crime, location of the crime or victims or the identity, description or location of the person who committed the crime.
- Required by a coroner or medical examiner. For example, we may disclose, we may disclose PHI to a medical examiner to identify a deceased individual or to identify the cause of death.
- Required for organ or tissue donation purposes. For example we may disclose PHI to an organ donation bank or facility to facilitate donation.
- Required for research purposes. For example we may disclose PHI to a medical university to aid research activities.
- Required to prevent or lessen a serious and imminent threat to the health or safety to the person or the public. For example, we may disclose PHI to prevent the spread of a communicable disease.
- Required for military and veteran purposes. For example, we may disclose the PHI of individuals who are in the armed forces for activities deemed necessary by appropriate military command authorities to ensure the proper execution of the military mission.
- Required for penal purposes. For example, we may disclose a patient's PHI to a correctional facility if the patient is an inmate in the facility or person.
- Required for workers' compensation programs. For example, we may disclose a patient's PHI for workers compensation and other similar programs.

ELECTRONIC COMMUNICATIONS

You have a right to your PHI as applicable by law in an electronic version. For example we may disclose your PHI to a patient portal, encrypted email if available through the office, or portable media, such as, a CD according to office policies. To safeguard your password, we will provide a written password at the time of your initial visit for the patient portal. If you request a replacement password, your must do must do so in writing and provide a photo ID in person before this information will be release. We cannot be responsible for any lost passwords. For security reasons, patients will not be allowed to use their devices for electronic downloads. There will be a charge for all electronic media and paper copies of PHI. If we do not have a format to release electronic PHI to meet your needs, you may request a paper copy. Requests for electronic or paper PHI will be available within 30 days to the patient.

REQUESTING RESTRICTIONS

You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or healthcare operations. In addition, you have the right to request that we restrict disclosure of your PHI to certain individuals involved in your care or the payment of your care, such as family members or friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, emergencies, or when the information is necessary to treat you. We may terminate the restriction by informing you of the termination, except that such termination is only effective with respect to PHI crated or received after we have informed you of the restriction termination. To request restrictions, submit a Request for Limitation and Restrictions of Protected Health Information form to the registration desk. **Patients may request in writing for claims or information not be submitted to an insurance plan, if services are paid in full at the time of services rendered. The patient will be responsible to notify the office for each visit affected by this restriction. This restriction cannot be applied to prior claims already submitted to an insurance company. This will be honored unless required by law to disclose the information. It is the patient's obligation to notify other medical providers or facilities referred that insurance should not be filed.**

INSPECTIONS AND COPIES

You have the right to inspect and request a copy of your health information we use to make decisions about your care. This included medical and billing records, but does not include psychotherapy notes, information complied in reasonable anticipation of, or use in, a civil criminal or administrative action and your health information that is subject to a law that prohibits access to such information. You must submit a written request to the Practice Manager in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If law requires such a review, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

RIGHT TO AMEND

If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as this office keeps the information.

To request an amendment, you must submit your request in writing to the Practice Manager. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.

b) Is not part of the health information that we keep?

c) You would not be permitted to inspect and copy.

d) Is accurate and complete.

RIGHT TO AN ACCOUNTING OF DISCLOSURE

You have the right to request an "accounting of disclosures". This is a list of disclosures we made of health information about you made by us in the six years prior to the date on which the accounting is requested. This list does not include disclosures made:

- To carry treatment, payment and healthcare operations
- to you
- For our directory
- For national security or intelligence purposes;
- To correction institutions or law enforcement officials.

To obtain this list, you must submit your request in writing to the Practice Manager. It must state a time period. Your request should indicate in what form you want the list, for example on paper or electronic. The first accounting request within a 12 month period is FREE. For additional accounts, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any fees are incurred.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified than those identified in the previous sections without your specific written authorization. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing at any time to our office. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission

FILING A COMPLAINT

If your privacy right have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact the office designated at the bottom of this notice. All complaints must be in writing an we will not penalize you for filing a complaint.

The effective date for this notice is January 1, 2017

Contact information regarding this notice or the privacy policies describe above:

Attn: Privacy Officier

Greenville Dermatology

369 Woodruff Rd.

Greenville SC 29607

www.greenvilledermatology.com

Greenville Dermatology, LLC is committed to maintaining the privacy of your protected health information.

If you feel that we are upholding the privacy regulations as established by HIPPA, you do not need to do anything further with this notice.

GREENVILLE DERMATOLOGY, LLC

Acknowledgement of Receipt of Notice of Privacy Practices

Greenville Dermatology's Notice of Privacy Practices describes how Protected Health Information about you may be used or released. It also explains you rights regarding your medical information. Greenville Dermatology is required by federal law to obtain acknowledgement that you have received this Notice.

I acknowledge that I have received Greenville Dermatology's Notice of Privacy Practices.

_____ _____

Patient Name Witness

_____ _____

Patient/Legal Representative Signature Date