18 Oak Forest Road, Ste A
Bluffton, SC 29910
Ph: 843.837.4400
Fax: 843.837.4440
MayRiverDerm.com

Patient name: ____

Date of Birth: ______/______/_______ **Today's Date:** ______/______/_______

Reason for today's visit:____

Are you allergic to any medications? ☐YES ☐NO If yes, list below:

1. ______________________________ 2.______________________________

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):

1. ____________________ 3. ____________________ 5. ____________________

2. ____________________ 4. ____________________ 6. ____________________

Current weight (pounds):____________________ **Height (feet/inches):** ____________________

Occupation: ______________________________

Please completely fill circle next to answer choice

Social History

Alcohol Consumption: O Never O Occasionally O Frequently (every day)

Smoking Status: O Current Every Day O Current Some Days O Former Smoker O Never

Sunscreen use: O Yes O No

At least 1 blistering sunburn: O Yes O No

Healthcare worker: O Yes O No

Past Medical History – Do you have any history of:

Hypertension: O Yes O No

Heart Disease: O Yes O No

Diabetes: O Yes O No

Asthma: O Yes O No

Arthritis: O Yes O No

Cancer: O Yes O No

Pacemaker: O Yes O No

Artificial valves: O Yes O No

MEDICAL HISTORY (continued)

Are you pregnant or breast feeding?:	O Yes	O No	O N/A
Keloid scarring:	O Yes	O No	
Problems with healing:	O Yes	O No	
Skin disease (eczema, psoriasis, etc.):	O Yes	O No	
Skin cancer:	O Yes	O No	
Melanoma:	O Yes	O No	
Atypical moles:	O Yes	O No	
HIV positive:	O Yes	O No	
Hepatitis C positive:	O Yes	O No	
Problems with anesthesia:	O Yes	O No	

Surgical History

Artificial hip joint:	O Yes	O No
Artificial knee:	O Yes	O No

Family History

Family history of skin cancer:	O Yes	O No	O Unknown
Family history of melanoma:	O Yes	O No	O Unknown
Family history of other skin diseases:	O Yes	O No	O Unknown

Any Surgery (Last 6 months):______________________________

Any Hospitalization (Last 6 months):______________________________

Any other information you would like us to know:

____

____

____

____

____

____

PATIENT DEMOGRAPHICS

Patient's Name:____

First Name MI Last Name

Date of Birth__________________ ____Male ____ Female Social Security #: ______________________________

Street Address:____

City /State/ Zip Code:____________________________________ ______________________________________

Home Phone w/Area Code:_________________________ Cell Phone w/Area Code:___________________________

Preferred Language:____________ Race (Black, Hispanic, White, etc): _____________ Ethnicity : ________________

Spouse's Name:____________________________________ Spouse's Date of Birth: __________________

Responsible Party:______________________________Relationship: ___Self ___Spouse ___Parent ___Other:________

If patient is a Minor, are parents __Married __Divorced Custodial Parent:____

Custodial Parent's Home Phone w/Area Code:___________________ Work Phone w/Area Code:_________________

Custodial Parent's SS #:______________________________ Date of Birth:________________________

In case of emergency, contact:____

Phone Number w/Area Code:____________________Relationship to Patient:____________________________

(Circle One) Primary Care or Referring Physician: ____

Pharmacy Name and Street:____

How did you hear about our practice? ___Yellow Pages, ___Pink Magazine, ___Hilton Head Monthly, ___Celebrate Hilton Head, __City Sun,

___Website, Other ____

Would you like to have access to your medical records, receive appointment reminders and other notifications via a secured patient portal and email? ______Yes _______No

Email address:____ __________

Insurance Information

Insurance Company # 1:__________________________________ Phone Number:_______________________

>>Primary Insured's Name:______________________________ >>Date of Birth:_________________________

Policy #:__________________ Group #:_____________ Relationship:____________________

Insurance Company # 2:________________________________ Phone Number:_______________________

>>Primary Insured's Name:_______________________________ >>Date of Birth:________________________

Policy #:__________________ Group #:_______________ Relationship:________________________

- I hereby authorize the payment of medical benefits to May River Dermatology, LLC for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.
- I further agree to pay all collection costs, attorney fees, and other expenses that may be incurred to enforce the collection of any amounts outstanding.
- I hereby authorize May River Dermatology, LLC to release any medical information necessary to complete and process my insurance claims.

____ ________________

Patient's OR Insured's Signature (If patient is a Minor, must have Responsible Party Signature) Date

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Self Pay

I currently do not have health insurance coverage. Therefore, I understand that all charges must be paid on the date of service. My payment today will be made by:

_____Cash _____Check _____MasterCard/Visa

____ ________________

Patient's OR Insured's Signature (If patient is a Minor, must have Responsible Party Signature) Date

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HIPAA CONSENT FORM

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 Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: ____
Printed Name – Patient or Representative

____ ____________________
Signature Date

Relationship to Patient
(if other than patient): ____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THIRD PARTY

(Complete this form if you would like for May River Dermatology, LLC to disclose certain protected health information to family members)

I, ________________________________, authorize May River Dermatology, LLC to use and/or disclose certain protected health information (PHI) as described herein. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I authorize the following person (s) and/or organization(s) to receive my PHI, as disclosed by the person(s) and/or organizations(s) above.

Name(s) & Relationship(s):____

____

Organization(s) & Address: ____

____

Specific description of PHI that I authorize for disclosure (complete medical records, progress notes, labs, photos, etc):

____

____

____

Specific description of the purpose for each use or disclosure (or write "At the request of the individual "in this space):

____

This authorization will expire on (date, event, or indefinite): ______________________________

I have the right to revoke this authorization in writing except to the extent that May River Dermatology, LLC has acted in reliance upon this authorization. My written revocation must be submitted to May River Dermatology, LLC Compliance Officer, 18 Oak Forest Rd, Suite A, Bluffton, SC 29910. I further understand that my eligibility for health benefits, my enrollment in a health plan, and my treatment will not be affected by whether or not I sign this authorization.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

______________________ Patient's Name	______________ Date of Birth
______________________ Signature of Patient or Legal Guardian	______________ Date
______________________ Relationship to Patient (If other than patient)	

BILLING POLICY

The following sets forth the general billing policy of May River Dermatology, LLC ("the clinic"). Please review this information and sign where indicated.

- I understand that it is my responsibility to provide the clinic with current, accurate billing information at the time of check in and to notify the clinic of any changes in this information.
- A late fee of 1.5% per month (18% APR) may be assessed to any balance which remains unpaid 30 days after the statement date on which the balance first appears.
- I understand that I am responsible for payment of my account at the time of service for deductibles, non-covered services, medically unnecessary services, copayments and insurance balances. It is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment). I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and the clinic is required to report to the carrier any enrollees failing to pay the co-pay.
- I understand that the clinic will attempt to obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.
- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $30 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check, or credit card.
- I understand that there may be a small fee to copy and mail medical records.
- I understand it is the policy to collect the deductible and/or coinsurance prior to scheduling my elective surgery. I further understand that THE FEE I AM QUOTED IS AN ESTIMATE based on 1) anticipated surgery to be performed and 2) current information provided to clinic by my insurance carrier.

Initials

______ Please be aware that if a biopsy is required at your visit, you will receive a separate bill for this service. The specimen is sent to a pathology lab, where a physician (pathologist) interprets the tissue. This physician will bill you directly for this service. If your insurance requires us to use a specific lab, you must notify us in advance of your visit and we will do our best to accommodate your needs. If you have any problems with your bill from the pathologist, please call our office and we will be happy to help you resolve the matter.

______ I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/ deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment after the second statement is mailed, the account may be sent to an outside collection service. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.

______ I authorize the clinic to generate charges to my credit card for any unpaid balance without further permission or notice should my account fall into a 60 day or later (after the date of service) category. A receipt with detail explanation for any charges will be mailed to your home address. All personal information is protected by HIPAA and can only be used for purposes of treatment, payment, or healthcare operations.

☐ VISA ☐ MC ☐ Amex Credit Card #: ____

Name as it appears on the credit card: ____

Expiration Date (MM/YY): _____/_____ Security Code (3 or 4 digit number printed on front or back of card): ________

My signature below confirms that I have read these billing policies and my financial obligation as pertains to May River Dermatology, LLC.

____ ____________________

Patient's OR Insured's Signature (If patient is a Minor, must have Responsible Party Signature) **Date**