May River Dermatology

BLUFFTON
350 FORDING ISLAND RD, STE 100 | BLUFFTON, SC 29910

HILTON HEAD ISLAND
25 HOSPITAL CENTER COMMONS, STE 200 | HILTON HEAD, SC 29926

JOHNS CREEK
10680 MEDLOCK BRIDGE RD, STE 204 | JOHNS CREEK, GA 30097

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, & vitamins)

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	
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 Skin Cancer (Type: Basal Cell, Squamous Cell, Melanoma, etc): _____

_____

_____

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,____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:_____

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 Signature **(If patient is a Minor, must have Responsible Party Signature)** **Date**

INSURANCE

Insurance Company # 1:_____ PRIMARY INSURED'S NAME:_____

Date of Birth:_____Policy #:_____Group #:_____Relationship:_____

Tricare: Active Duty (Yes / No) Sponsor's Name, Date of Birth, ID # _____

Insurance Company # 2 :_____ PRIMARY INSURED'S NAME:_____

Date of Birth:_____Policy #:_____Group #:_____Relationship:_____

Tricare: Active Duty (Yes / No) Sponsor's Name, Date of Birth, ID # _____

- 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**

HIPAA CONSENT

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:

_____	_____	_____
Patient Name (PRINT)	**Patient or Legal Guardian 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, 350 Fording Island Rd., Suite 100, 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 Name (PRINT)	**Patient or Legal Guardian Signature**	**Date**

_____
Relationship to Patient (if other than patient)

I,_____, have reviewed this authorization and elected not to complete at this time.

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.
- I understand that I will be charged a $50.00 no show fee for each missed appointment that is not cancelled with a minimum 24 hour notice.
- 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.

Please provide your credit card to our front desk staff at check-in so they can save the card information using a secure and encrypted method.

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 **Date**

(If patient is a Minor, must have Responsible Party Signature)