Welcome and thank you for choosing May River Dermatology, LLC

Effective treatment requires good communication. It is critical that the New Patient Packet is completed thoroughly so we can meet your needs.

Pages 2 & 3 (**Social and Medical History)** -Please provide us with your social, medical, family history and list of current medications. If you already have a list of your medications please attach it to the new patient packet and we will enter that information into your chart.

Page 4 (Demographic Information) – Please document your personal information, emergency contact, pharmacy of preference and medical insurance information. We will scan your insurance cards and photo ID so please bring them in with you to your appointment.

Page 5 (HIPAA Consent & LUX, LLC Disclosure)- The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule gives individuals a right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their individual rights with respect to their protected health information (PHI). By signing this section of the form you consent to our use and disclosure of PHI, payment and health care operations within medical offices and organizations involved with your care.
This section of the form provides disclosure of Carmen Traywick, M.D.'s ownership of Lux, LLC

Page 6 (Third Party PHI authorization) – *This is an optional form*. Please let us know the name of anyone (spouse, children, relatives, or friends) you would like to give permission to access and request your health record. If there is no one you would like to authorize please write "none" or put a line across the page and sign.

Page 7 (Billing Policy) – This document outlines our standard billing practices. As a courtesy to our patients we will bill their health insurance carrier(s) for medically necessary visits and procedures. In order to do this properly and in a timely manner, we will need accurate insurance information. We also ask that you pay close attention to our policies regarding 1) coinsurance, co-pays, account balances and insufficient funds, 2) biopsies, and 3) the option to leave a credit card on file.

Page 8 & 9 (Directions) – Maps and contact information for our Bluffton and Hilton Head offices. Please make sure to confirm desired office with our staff and use the map to make it easier for you to find the correct office.

We look forward to seeing you soon.

May River Dermatology

BLUFFTON
350 FORDING ISLAND RD, STE 100 | BLUFFTON, SC 29910
PH 843.837.4400 | FAX 843.837.4440

HILTON HEAD ISLAND
25 HOSPITAL CENTER COMMONS, STE 200 | HILTON HEAD, SC 29926
PH 843.689.5002 | FAX 843.837.4440

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	
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):

Disclosure of Financial Interest in LUX, LLC

You are receiving this notice because Carmen Traywick, M.D. may recommend to you products, procedures, or treatment at LUX, LLC located at 350 Fording Island Road, Suite 101. A list of estimated costs for those products and procedures can be obtained at the front desk at any time.

We are required to notify you that Dr. Traywick owns a portion of LUX, LLC. Your ongoing medical care at May River Dermatology is not dependent upon accepting the recommendation for treatment, procedures, or products offered at LUX, LLC. You have the right to obtain the products or services offered at LUX, LLC from any other entity of your choice. Other providers we recommend are:

Dr. Joel Cook MUSC 135 Rutledge Ave. Charleston, SC 29425	Dr. Luis Vega Aqua Medspa and Salon 2206 Mossy Oaks Rd Beaufort, SC 29902

Please acknowledge that you have read and understand the terms of this disclosure here:

_____	_____	_____
Patient Name (PRINT)	**Patient or Legal Guardian Signature**	**Date**

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

BLUFFTON OFFICE MAP

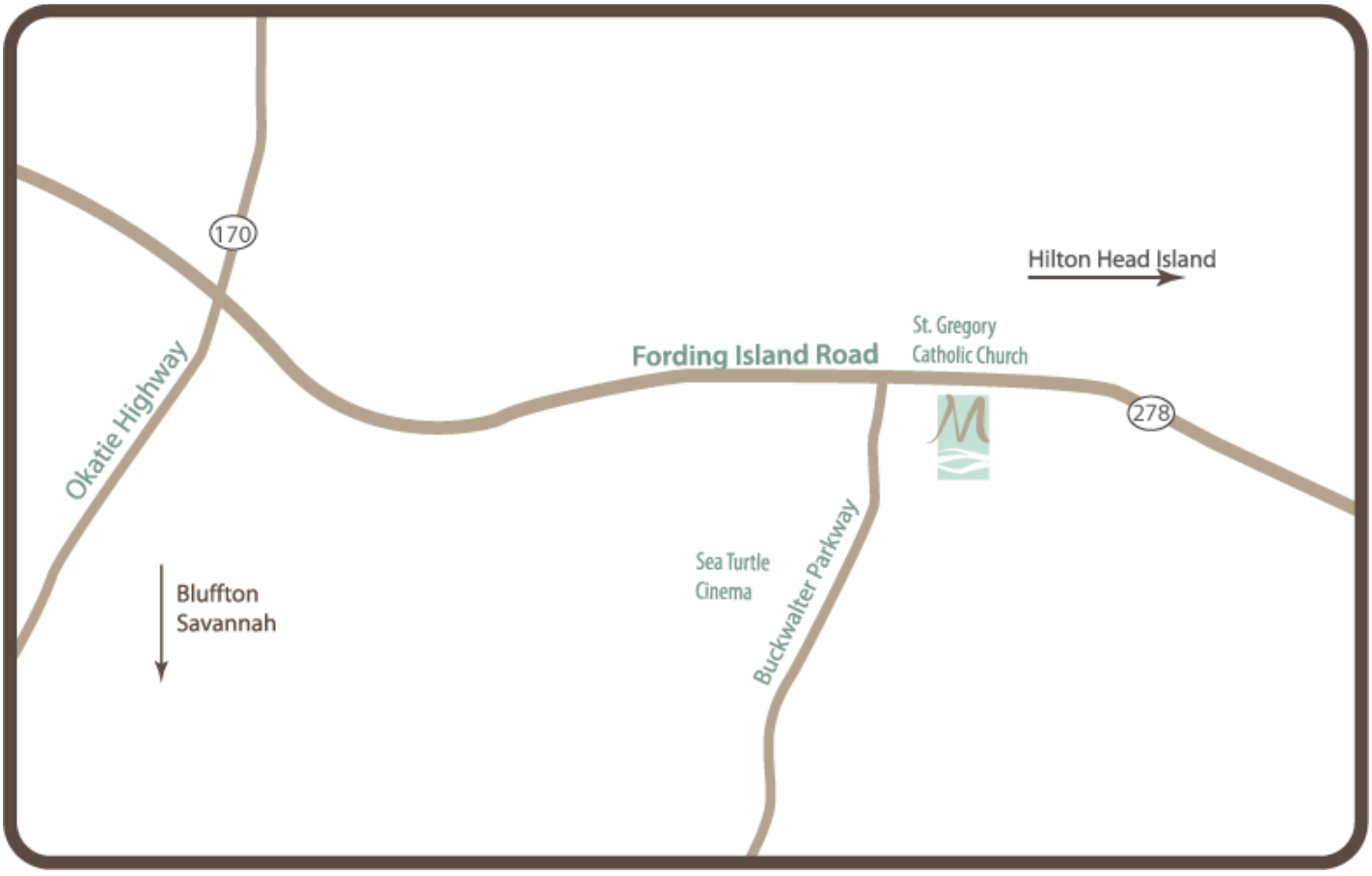
843.837.4400
350 Fording Island Rd, Suite 100
Bluffton, SC 29910

From Beaufort:
Take SC 170 S
Merge onto US 278 E toward Bluffton/ Hilton Head Island
The office is about 2 miles east of the intersection of SC 170 and US 278. It is on the right after Buckwalter Prkwy. and across from St. Gregory the Great.

From Downtown Savannah:
Take U.S 17 N into SC
Turn right onto SC-315 N/S Okatie Hwy | Continue to follow S Okatie Hwy | Continue onto May River Rd
At the traffic circle, take the 3rd exit onto SC-170 E/Okatie Hwy
Merge onto US-278 E/Fording Island Rd via the ramp to Hilton Head Island
The office is about 2 miles on the right (after Buckwalter Parkway and across from St. Gregory the Great)

From Southside Savannah:
Take I-95 N toward Florence
Take exit 8 to merge onto US-278 E/Independence Blvd toward Beaufort
The office is about 10 miles on the right (after Buckwalter Parkway and across from St. Gregory the Great)

From Hilton Head Island to Bluffton Office:
Take US 278 W
The office is about 8 miles (from the bridge) on the left (before Buckwalter Parkway and across from St. Gregory the Great). You will have to pass May River Dermatology on your left, make a U-turn at Buckwalter Parkway, and then we will be on your right



HILTON HEAD OFFICE MAP

843.689.5002
25 Hospital Center Commons, Suite 200
Hilton Head Island, SC 29926

From Beaufort to Hilton Head Office:
Take SC 170 S
Merge onto US 278 E toward Bluffton/ Hilton Head Island (go about 13 miles)
Once over the bridge, veer to the right toward William Hilton Pkwy/ US 278 BR E
Turn left onto Beach City Rd (go 0.2 miles)
Take left onto Hospital Center Blvd (go 0.3 miles)
Take right onto Hospital Center Commons (Look for Building 25, Suite 200)