DERMATOLOGY
CENTER OF COLUMBIA

Demographics and HIPAA Privacy Notice

Name:_____ **Date:**_____

Street Address:_____

City/State:_____ **Zip Code:**_____

Date of Birth:_____ **SSN:**_____ **Gender:**_____

Phone Number:_____ **Phone Number (night):**_____

Email Address:_____ **Marital Status:**_____

Emergency Contact:_____ **Emergency Contact Phone:**_____

Preferred Language:_____ **Race:**_____ **Ethnic Group:**_____

***By providing your email address you will be sent an email to register for our patient portal. This allows you instant access to your visit notes, lab and biopsy results, and allows you to securely communicate with our office staff. Registering for the patient portal is highly recommended, however if you would prefer to OPT OUT of the patient portal please initial here:_____.

Preferred Pharmacy

Pharmacy Name:_____

Phone Number:_____

City/Zip Code:_____

Referring Provider

Primary Care Provider:_____

Practice Name:_____

Referring Provider:_____

If self-referral, how did you hear about us? Facebook Instagram Google Newspaper Family/Friends

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CENTER OF COLUMBIA

HIPAA Privacy Notice

I, _____(patient name) acknowledge that I have reviewed and understand the HIPAA privacy policies of Dermatology Center of Columbia, LLC and have been given the opportunity to receive a copy of these policies.

Patient Name:(print)_____

Patient Signature:_____

If under the age of 18
Parent or guardian name (print):_____

Parent or Guardian signature:_____

Do we have your permission to leave a detailed message regarding test results, appointment information, or billing/account information at the number you have provided? Yes____ No____

Is there anyone (spouse, parent, guardian, family member, ect.) with whom you authorize us to share any medical information in the event you are not available to take our call? Yes___ No___

If yes, please provide us with the following information for this person:

Name:_____

Phone Number:_____

Relationship:_____

Date:_____

DERMATOLOGY
CENTER OF COLUMBIA

Patient Financial Policy Acknowledgement

Dermatology Center of Columbia, LLC is committed to providing you with the best possible medical care. The following information regarding our financial policy is provided to avoid any misunderstandings or disagreements concerning payment for our professional services.

Our providers participate with a variety of insurance plans. It is your responsibility to:

1. Bring your current insurance card(s) to every visit.
    - If you do not bring your insurance card(s), you will need to pay the entirety of your visit-related charges at time of service. You may then file with your insurance company to receive reimbursement.
2. Be prepared to pay your copay, co-insurance, or any portion of the charges as specified by your plan at the time of registration. During your visit we will calculate the amount you owe based on your deductible and your insurance contracted rate; this amount is to be paid in full at the end of the visit. Any discrepancies in our calculation will be billed to you or refunded in a timely manner.
3. Should there be a lapse in your insurance coverage at time of service, you will be responsible for all visit-related charges.
4. Account balances. Payment for any balances for charges to self-pay patients are due in full at the time of service. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns. Outstanding balances must be paid in full prior before any additional medical services will be rendered. For medical care not covered by your insurance (e.g. cosmetic services), payment in full is due at time of service.
5. We accept cash, most major credit cards, and personal checks as payment for our services. Writing a cold check is against the law. If a check is unable to be deposited, any bank fees associated with the cold check and a $25 dollar fee will be charged to the patient. Payment for services rendered and any bank fees will be due within 10 days of verbal and/or written notification. If payment is not remitted, the balance will be turned over to a collection agency and local law enforcement will be notified.
6. If Pathology is necessary during your visit. Pathology has their own billing services and you will receive a separate bill in the mail from the Pathology Lab. You will need to call the number provided on that statement for any questions.
7. **Late Arrival.** We understand that delays can happen, however, we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment. Patients may elect to wait to be "worked into" an opening in the schedule that morning or afternoon, however, we can make no guarantees that an opening will arise.
8. **No Show.** We understand that you may need to reschedule or cancel your appointment, however, we must receive a phone call 24 hours prior to your scheduled appointment to reschedule or cancel these appointments. Failure to contact our office 24 hours prior will result in a No Show fee;
    New / Established Patient appointments $30, Cosmetic Appointments $50 and Surgery Appointments $200

With Regards to Referrals

1. It is your responsibility to ensure that any referrals for treatment as required by your insurance company ,receive "prior authorization" before your clinic visit is scheduled.
    - Visits not having prior authorization will be rescheduled or you will be financially responsible for the visits and associated services provided.
2. If the patient is a minor (18 years or younger). The parent or guardian must sign below.
    - The parent, guardian, or unaccompanied minor is responsible for any payment due at the time of services, the necessary referrals, and providing a current insurance card.
3. If you have questions about your insurance, we are happy to assist you.
    - Specific coverage issues, however, should be directed to your insurance company.

Dermatology Center of Columbia, LLC firmly believes that a good provider/patient relationship is based on understanding good communication.

Please sign below acknowledging that you have read and agree with this financial policy.

_____ _____

Signature of Patient or Responsible Party Date

DERMATOLOGY
CENTER OF COLUMBIA

Name:_____

Medical History Form

Past Medical Conditions:

- ☐ None
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign Prostatic Hyperplasia
- ☐ Cerebrovascular accident
- ☐ Chronic Obstructive Lung Disease
- ☐ Coronary Arteriosclerosis
- ☐ Depressive Disorder
- ☐ Diabetes Mellitus
- ☐ Disease caused by 2019-nCoV
- ☐ Elevated Blood Pressure
- ☐ End-stage Renal Disease
- ☐ Epilepsy
- ☐ Gastroesophageal Reflux Disease
- ☐ HIV / AIDS
- ☐ PCOS
- ☐ Hypertension
- ☐ Hearing Loss
- ☐ Human Immunodeficiency Virus Infection
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory Disease of Liver
- ☐ Leukemia
- ☐ Malignant Lymphoma
- ☐ Malignant Tumor of Breast
- ☐ Malignant Tumor of Colon
- ☐ Malignant Tumor of Lung
- ☐ Malignant Tumor of Prostate
- ☐ Radiation Therapy Treatment Management
- ☐ Transplantation of Bone Marrow
- ☐ Shingles
- ☐ Stroke

Other Past Medical Conditions: _____

Past Surgeries:

- ☐ None
- ☐ Abdominoperineal Resection
- ☐ Bilateral Replacement of Knee Joints
- ☐ Biopsy of Breast
- ☐ Biopsy of Prostate
- ☐ Coronary Artery Bypass Graft
- ☐ Entire Transplanted Kidney
- ☐ Excision of Basal Cell Carcinoma
- ☐ Excision of Melanoma
- ☐ Excision of Squamous Cell Carcinoma
- ☐ Colostomy
- ☐ Tubal Ligation
- ☐ History of Appendectomy
- ☐ History of Bilateral Mastectomy
- ☐ History of Cholecystectomy
- ☐ History of Colectomy
- ☐ History of Liver Excision
- ☐ History of Hysterectomy
- ☐ Lumpectomy of Breast
- ☐ Mastectomy of Breast
- ☐ Mechanical Heart Valve Replacement
- ☐ Prostatectomy
- ☐ Surgical Biopsy of the Skin
- ☐ Total Knee Replacement
- ☐ Total Hip Replacement
- ☐ Transplantation of Heart
- ☐ Transplantation of Liver
- ☐ Other:_____

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CENTER OF COLUMBIA

Skin Conditions

Have you had any of the following skin conditions:

- ☐ None
- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asteatosis Cutis
- ☐ Basal Cell Carcinoma of Skin
- ☐ Contact Dermatitis due to Poison Ivy
- ☐ Dysplastic Nevus of Skin
- ☐ Eczema
- ☐ Hay Fever
- ☐ Herpes Labialis
- ☐ Herpes Zoster
- ☐ Malignant Melanoma
- ☐ Pruritus of Scalp
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma
- ☐ Sunburn of Second Degree

Skin Protection

Do you wear sunscreen? ◯ Yes ◯ No

If Yes, what SPF? _____

Do you tan in a tanning salon? ◯ Yes ◯ No

Family History of Melanoma

Do you have a family history of Melanoma:

- ☐ None
- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter

DERMATOLOGY
CENTER OF COLUMBIA

Medications

List all medication names and dosages including prescription creams, over the counter, herbal supplements, and skin care products or attach a list.

_____
_____
_____

List all allergies and reactions, including medication, food and environment.

_____
_____
_____

☐ No Known Allergies

Social History

What is your smoking status? ◯ Current Smoker ◯ Non-Smoker ◯ Former Smoker

Do you consume alcohol? ◯ Yes ◯ No

If yes, how many alcoholic drinks do you consume in one week? _____

Illicit Drug Use? ◯ Yes ◯ No

What is your Occupation and workplace? _____

DERMATOLOGY
CENTER OF COLUMBIA

Quality Measures

(For patients 65 years of age and older)

Vaccination Status

Have you received a pneumonia vaccination? ◯ Yes ◯ No

Advanced Care

Do you have a health care proxy in the event you are unable to make your own medical decisions? ◯ Yes ◯ No

If you do have a health care proxy, Please provide:

Designee's Name:_____

Designee's Contact Number:_____

Do you have a living will? ◯ Yes ◯ No

Which statement(s) best reflects your wishes on advance care recommendations?

- ☐ Do not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
- ☐ Do not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life.
- ☐ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.