PATIENT INFORMATION

Thank you for choosing our office! In order to service you properly, we need the following information. ***Please Print.*** *All information will be kept confidential.* ***Please complete the entire form.*** ***Thank you for your cooperation.***

FULL LEGAL NAME:_____

SS# XXX-XX-____ DATE OF BIRTH: ___/___/____ email address:_____

HOME ADDRESS:_____CITY:_____STATE:_____ZIP:_____

MAILING ADDRESS IF DIFFERENT:_____CITY:_____STATE:_____ZIP:_____

PREFERRED PHONE:_____ALTERNATE PHONE:_____

EMPLOYER:_____ADDRESS:_____

SEX: M/F_____MINOR:_____MARITAL STATUS:_____

IF MINOR:

WHO IS FINANCIALLY RESPONSIBLE FOR MINOR:_____RELATIONSHIP:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

EMPLOYER:_____ADDRESS:_____

HOME PHONE#_____DATE OF BIRTH _____

EMERGENCY CONTACT:_____PHONE:_____

****

PRIMARY INSURANCE COMPANY:

_____ID#_____GROUP:_____

WHO IS THE POLICY HOLDER:_____RELATIONSHIP:_____

DATE OF BIRTH:_____SS#_____EMPLOYER:_____

SECONDARY INSURANCE:

INSURANCE COMPANY:_____ID#_____GROUP_____

WHO IS THE POLICY HOLDER:_____RELATIONSHIP:_____

DATE OF BIRTH:_____SS#_____EMPLOYER:_____

TO ENSURE THAT WE HAVE THE CORRECT INSURANCE ADDRESS AND NETWORK, PLEASE ALLOW US TO COPY YOUR INSURANCE CARDS.

I AUTHORIZE RELEASE OF ANY INFORMATION CONCERNING MY (MY CHILD'S) HEALTH CARE, ADVISE AND TREATMENT PROVIDED FOR THE PURPOSE OF EVALATING AND ADMINISTERING CLAIMS FOR INSURANCE BENEFITS. I HEREBY AUTHORIZE PAYMENT OF ALL INSURANCE BENEFITS (INCLUDING MEDIGAP) OTHERWISE PAYABLE TO ME DIRECTLY TO THE DOCTOR.

X_____DATE:_____

SIGNATURE OF PATIENT/PARENT/GUARDIAN

AIKEN DERMATOLOGY AND SKIN CANCER CLINIC

NAME:_____ DATE:_____
Who is your primary doctor:_____
Doctor's address:_____ City:_____ State:____ Zip:____
Whom may we thank for referring you?_____

History of Present Illness or Problem

Describe the skin problem that brought you to this office:_____
_____
How long have you had this problem?_____
What have you used to treat the current problem?_____
Have you seen a dermatologist in the past two years? Yes_____ No_____ Who:_____

Allergies:
Please list all allergies: Drugs_____
Foods:_____
Latex:_____
Local anesthetics (such as Novocaine)_____
Please describe the reaction that you had to the above allergies:_____
_____

Personal and Family History
Have you ever experienced a blistering sunburn or been treated with chemotherapy or radiation?_____
Have you used Prednisone, Cortisone, or any other steroids over an extended period of time:_____
Please list any other skin problems:_____

Please list any past and present medical problems, hospitalizations, and surgeries (i.e. heart disease, thyroid disease, high blood pressure, cancer):_____
_____
Please list any medications you take_____
_____
Have you or anyone in your family been diagnosed with any of the following: (Please list relationship)?
Basal or squamous cell skin cancer_____ Lupus_____
Psoriasis_____ Diabetes_____
Melanoma_____ Arthritis_____
Other skin disorders_____

Review of Systems

Do **you** have or have **you** ever had the following:

						Frequent headaches	Y	N
Tearing of eyes	Y	N	Pain in joints	Y	N	Ankle swelling	Y	N
Double vision	Y	N	Difficulty walking	Y	N	Angina	Y	N
Glasses	Y	N	Blood in urine	Y	N	History of heart attacks	Y	N
History of cataracts	Y	N	Frequent urination	Y	N	Pacemaker	Y	N
Glaucoma	Y	N	Dark tarry stool	Y	N	Pain on urination	Y	N
Shortness of breath	Y	N	Abdominal pain	Y	N	Unexplained weight loss	Y	N
Persistent cough	Y	N	Swelling of joints	Y	N	Lightheadedness	Y	N
Heart palpitations	Y	N	History of stroke	Y	N	Chest pain	Y	N

Name:_____

DOB:_____

VACCINATIONS:	DATE(S)
FLU VACCINE(S)	
PNEUMONIA VACCINE	
PPD TEST (tuberculosis) (biologics only)	

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Any medication and any nutritional supplements.

Medication Name (brand & generic)	**Dosage** (strength & frequency)	**Date Reviewed** (include your initials)

Aiken Dermatology and Skin Cancer Clinic

Assignment of Benefits Form

I authorize submission of insurance claims by Aiken Dermatology and Skin Cancer Clinic, and request that payment of authorized insurance benefits, including Medicare plan payments (if I am a Medicare beneficiary), be made on my behalf to Aiken Dermatology and Skin Cancer Clinic for any services rendered to me.

I authorize the release of any medical or other information necessary by Aiken Dermatology, my insurance carrier, CMS, or other entities, as applicable, for benefits determination and claims payment. A copy of this authorization will be sent to CMS, my insurance carrier, or other applicable entities in accordance with Federal or State law, if the requested. The original authorization will be kept on file by Aiken Dermatology and Skin Cancer Clinic.

I authorize the use of my signature on all insurance submissions.

I understand that I am financially responsible for any Member portion (copay, coinsurance, deductible, payment in full for non-covered services), if applicable.

Patient's Name:

_____

Signature of Beneficiary/Responsible Party:

_____

Date:

_____

OFFICE POLICIES

Follow-up appointments: Patients are encouraged and expected to keep follow-up appointments. Consistent skin care will result in better control of your skin condition (and aids in early detection of skin cancer). Our providers will determine the appropriate time for your follow-up visit. It is best to schedule your follow-up visit at check-out to ensure that an appointment can be obtained. The clinic usually books several weeks in advance. Patient education, prevention, and early treatment of skin cancer are the important goal of this dermatology clinic and require regular follow-ups.

Cancellation list: If an immediate appointment is not available, please take the first one available and then request to be placed on our cancellation list. An appointment may become available within 72 hours.

Missed appointments: The Clinic discourages missed appointments and being late for an appointment. If you realize you will be more than 15 minutes late, please call and reschedule your appointment. Emergencies and conflicts do occur, and we understand this. However, we ask the patient to give the Clinic 24 hours notification if an appointment cannot be kept. Some emergencies do not allow such notice, but a phone call would be appreciated. If a patient misses one appointment without notice, there will be a $50 charge. If a second appointment and or subsequent appointments are missed, there will be a $75 charge for each. At the discretion of the Office Manager, after a third appointment is missed, the patient may be asked to seek dermatologic care elsewhere.

*Appointments which require an extended amount of time (ex: surgeries, melanoma, extensive warts), and are missed, will accrue a No-Show charge commensurate with the amount of time reserved for that appointment.

Phone policy: Patients are encouraged to call the office for any problems; however, medical questions are best addressed by consultation at the time of r they are unable to help you immediately, arrangements will be made to return your call. The medical assistants return phone calls twice per day: at lunch break and at the end of the day. Please feel confident in leaving a message with the staff. All messages are recorded in duplicate form. Usually, charts must be retrieved and reviewed by our providers prior to the call being returned. This is efficient, and results in better patient care. Should you have an emergency, please notify the receptionist.

New patients: A new patient is one who has never been seen before or who has not been seen in the last three (3) years. These patients must present to the Clinic 20 minutes prior to their appointment time to fill out or update their information. However, if the forms are downloaded from this website and completed, the patient need only arrive 5 minutes prior to their appointment time. A valid insurance card and proof of identity (e.g., driver license) are required for all new patients. This is necessary for insurance filing. If these documents are missing, full payment from the patient will be requested.

Referred patients: If another physician has referred you, we must have the referral in writing. It is the patient's responsibility to make sure this has been done through communication with the referring physician. Our providers will notify the referring physician of their findings.

Evening and weekend calls: Our office does not have an answering service. During after-hours, the message on our office machine will direct you in how to reach our providers. Please use these number for only true emergencies.

Cellphone policy: We do not allow "on" cellphones in the building. They may be turned "off" when entering the clinic. If you feel you have an emergency reason for keeping it turned on, please notify the receptionist of the reason.

Food/eating policy: You must not bring food or drinks into the building.

People accompanying the patient: We are unable to consult or treat anyone who does not have a medical appointment in their name. Legally, we must have a chart if a medical opinion is rendered. If the person is currently a patient, it would be improper to render consultation time to someone without an appointment.

Copying of Medical Records: If the patient decides to transfer their skin care to another physician, there will be a charge for copying said records. The fees are in strict accordance with sections 44-115-80 of the South Carolina Code, which states that a physician, or other owner of a medical record, may charge a fee for the search and duplication of a medical record, but the fee may not exceed sixty-five cents per page for the first thirty pages and fifty cents per page for all other pages, and a clerical fee for handling, not to exceed fifteen dollars per request. There will be no charge for our referring the patient elsewhere or if the patient is relocating out of the Aiken area. Medical records are the property of Aiken Dermatology and Skin Cancer Clinic.

I HAVE READ THESE OFFICE POLICIES AND UNDERSTAND THESE POLICIES

_____ _____

Signature **Date**

_____

Printed Name

Financial Policies

Fees: Payment for office visits and procedures are expected at the time of service, excepting certain insurance (see below). It is impossible to quote what an "office visit" will cost. The fee is dependent on the number of problems an individual presents with and the complexity of the problems. Only our providers can determine the fee and this is based not only on the time involved but the level of decision making.

Insurance: PROCESSING INSURANCE CLAIMS IS AN INCREASING AND UNFUNDED BURDEN. PLEASE HELP US TO MAKE IT EASIER.

Insurance guidelines differ from physician to physician office. Each office sets its own guidelines based on specialty and the physician's personal preference. There are hundreds of different insurance policies and each policy has many different plans. Without physically seeing a patient's card, we are unable to guarantee that we are a participating provider. We ask that you fax the FRONT and BACK of your card to our office so we can predetermine if we participate (803-642-8495).

*Please provide us with information on all insurance plans under which you are covered. If it is later discovered that you have other coverage and additional insurance filings are required, you will be charged a $25 processing fee per each claim that must be filed again. In addition, if your insurance does not pay because of you not giving timely and correct insurance information, you will be responsible for payment in full. You will accept financial responsibility if we have filed a "clean claim" to your insurance carrier and we have received no payment in 90 days. Any balance due if your carrier deems a procedure is cosmetic will be the patient's responsibility.

*As a courtesy to you, we will file your insurance claims for you (if greater than $150) if you assign benefits to Aiken Dermatology. However, a co-payment, co-insurance, or deductible may be due at the time of your visit per your contract with your insurance company. These are calculated based on our best efforts. Any differences will be billed OR credited/refunded to you.

*Your insurance plan's benefits may change from time to time. It may not cover something that was covered on a previous visit.

*You are responsible for responding promptly to requests from you insurance company to provide any additional information they may require from you. If you do not provide the requested information and they do not pay us for this reason, your account will become due and payable, in full, immediately.

*Contrary to common understanding, all procedures (e.g. warts, injections) are considered "surgical procedures" by most insurance companies and the fees for these services may apply to a separate surgical deductible, co-payment, or co-insurance.

*In our office, your surgical charge includes a suture removal visit. If, at the time of suture removal you wish to discuss or treat unrelated conditions, then you will be charged for a regular office visit.

*Pathology and laboratory fees are separate and are billed by the lab performing the services. Please do not call our office if you have a question about their billing.

*We charge for no-shows and for appointments not cancelled with 24 hours notice. Surgical and cosmetic appointments require 48 hours notice for cancellation.

***Fraudulent checks (bounced).** Any check submitted to Aiken Dermatology which is not honored by the bank will be immediately assessed a $30 penalty. The patient will be notified and will have 5 days to make payment. This payment must be made in cash or money order.

***Collections.** Any account (not pending insurance) that is 90 days past due will be turned over to a collections agency. Any collection fees, legal fees, or attorney's fees associated with this will be added to the amount owed.

***Medication Refills.** To ensure patient safety, certain medications are not renewed over the phone, fax, or mail. There is a $15 administrative fee for calling in lost prescriptions. There is also a $10 administrative fee for performing "Prior Authorizations".

If your insurance company requires a specific lab for specimens or bloodwork,

List it here:_____

_____ _____

Signature Date

I have read and I understand the policies outlined above and I agree to be bound by their terms.

_____ _____

Signature Date

_____

Printed Name

Aiken Dermatology and Skin Cancer Clinic
Patient Consent fro Use and Disclosure
Of Protected Health Information

With my consent, Aiken Dermatology and Skin Cancer Clinic may use and disclose **Protected Health Information (PHI)** about me to carry out **Treatment, Payment, and Healthcare Operations (TPO)**. Please refer to Aiken Dermatology's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Aiken Dermatology and Skin Cancer Clinic reserves the right to revise its Notice of Privacy Practices at any time.

A revised Notice of Privacy Practices may be obtained by forwarding a written request to AikenDermatology at 1520 Two Notch Rd, Aiken, SC, 29803.

With my consent, Aiken Dermatology may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.
With my consent, Aiken Dermatology may mail to my home or other designated location any items that assist the practice in carrying out TPO , such as appointment reminders, cards and patient statements.
With my consent, Aiken Dermatology may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements,

I have the right to request that Aiken Dermatology restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Aiken Dermatology's use and disclosure of my PHI (Protected Health Information) to out TPO (Treatment, Payment, and Healthcare Operations). I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign consent, Aiken Dermatology and Skin Cancer Clinic may decline to provide treatment to me.

READ CAREFULLY BEFORE COMPLETING

I give permission to discuss my Financial Information with :_____
(Family Member/Friend)

I give permission to discuss my Medical Information with:_____
(Family Member/Friend)

Patient Name:_____ Date: _____

Signature of Patient or Legal Guardian: _____

Print Name of Patient or Legal Guardian: _____