



You are scheduled at our Rock Hill office on _____ Please arrive at the office at _____.
Thank you

KINDLY GIVE 48 BUSINESS HOURS NOTICE IF YOU MUST CANCEL OR RESCHEDULE (704) 919-1105

Welcome to Dermatologic Surgery of the Carolinas!

Enclosed you will find several information forms to fill out prior to your arrival at our office for your appointment. **Please bring completed forms with you on your appointment day.** The enclosed forms include:

- Patient information form
- Medical history form
- Signature form for Privacy Policy (HIPAA), Financial Policy, and Release of Medical Information
- Directions to our office

If you should have any questions regarding your appointment, insurance coverage or the Mohs procedure, please do not hesitate to contact our office at (704) 919-1105. Here at Dermatologic Surgery of the Carolinas we strive to provide top-quality, cutting-edge treatment of skin cancer and other dermatological conditions so please do not hesitate to contact us if you have any questions or concerns.

Along with the enclosed forms, please bring the following to your upcoming appointment:

- **Insurance card** (We cannot see you without verifying your insurance with your insurance card)
- **Co-pay or Deductible** (We will verify this with you prior to your appointment time)

Completing these forms with their required signatures and having your insurance card and co-pay/deductible can dramatically decrease the time required for check-in, so we appreciate your assistance and we look forward to your visit.



Release of Medical Information

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications and prescriptions.

Signature: _____ Date: _____/_____/_____

Privacy Practices (HIPAA)

By signing below, I acknowledge that I have read and understand Dermatology Surgery of the Carolinas “Notice of Privacy Practices”. This document is posted on our website (www.dsc-charlotte.com) and made available at our check-in desk. We would also be happy to provide you with a copy of this policy for you to take home with you.

Signature: _____ Date: _____/_____/_____



Financial Policy

Payment is required for all services at the time they are rendered. **An estimate of ALL co-payments, deductibles, co-insurances not covered by your insurance carrier will be collected up front and due on the date of service.** Failure on our part to collect these from patients may be considered insurance fraud.

When calling to confirm your appointment, we will notify you of the amount due at the time of service – this is only an ESTIMATE. Due to the possible extensive nature of some dermatologic procedures, there may be instances where additional procedures may be necessary in order to fully remove or treat your condition and/or lesion. This would result in additional fees.

To provide the best care possible, Dermatologic Surgery of the Carolinas may, on occasion, send specimens to an outside source for processing. Examples of these services are pathology and laboratory testing. Should we send a specimen to other providers, you will receive a separate billing statement from the outside pathologist and/or laboratory; these charges will be in addition to those services rendered by Dermatologic Surgery of the Carolinas.

We accept payment in the form of **cash, check, Visa, MasterCard, Amex and Care Credit.** In the event that your account must be turned over to collections, a \$25.00 collection fee will be added to your account. There is a \$30 fee for any returned check. Your signature below signifies your understanding and willingness to comply with this policy.

I have read and understand this financial policy statement. I agree to make in-full prompt payment to Dermatologic Surgery of the Carolinas when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered.

In addition to the above, if I am a Medicare patient, I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature: _____ Date: _____/_____/_____

FOR PATIENTS WHO ARE MINORS: If the patient is younger than eighteen, then the financial policy must be signed by a parent or legal guardian. A parent or legal guardian must be present for any patient younger than sixteen.

MEDICAL HISTORY

Patient Name: _____ **DOB:** _____



Please list any medications, herbal supplements and/or vitamins you are currently taking and dosage (mg): · None

Do you have or have you had any of the following? (if yes, please check) · None

- | | | |
|--|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Cold sores/herpes | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Seasonal allergies/asthma |
| <input type="checkbox"/> Artificial heart valve
(Year_____) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin Cancer (melanoma) |
| <input type="checkbox"/> Artificial joints or metal implant
(Year_____) | <input type="checkbox"/> Heartburn/Reflux | <input type="checkbox"/> Skin Cancer (basal/squamous cell carcinoma) |
| <input type="checkbox"/> Atopic Dermatitis/Eczema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Pre-Cancers (actinic keratoses) |
| <input type="checkbox"/> Atypical moles | <input type="checkbox"/> HIV | <input type="checkbox"/> Skin disorders (other) |
| <input type="checkbox"/> Autoimmune disease (lupus,
rheumatoid arthritis) | <input type="checkbox"/> Keloids or scarring problems | <input type="checkbox"/> Systemic problems (fever/chill/etc.) |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid trouble |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Liver disease or hepatitis | <input type="checkbox"/> Ulcers (stomach) |
| | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Transplant (lung, heart, kidney, liver etc) |
| | <input type="checkbox"/> Muscle aches | <input type="checkbox"/> Other conditions |
| | <input type="checkbox"/> Pacemaker/Defibrillator | Please list: _____ |
| | <input type="checkbox"/> Plastic/cosmetic surgery | |

Female patients (check all that apply): I am: pregnant nursing planning to become pregnant soon

Are you allergic to any medications/anesthetics? Yes No

(if yes, please list) _____

Personal history of previous skin cancer? Yes No **Location/When treated?** _____

Please list other major illnesses: _____

Please list major surgeries/hospitalizations:

_____ Date: _____ Date: _____

_____ Date: _____ Date: _____

Please list IMMEDIATE FAMILY that have had any of the following (mother, father, maternal or paternal grandmother or grandfather, brother, sister):

- | | |
|---|---|
| <input type="checkbox"/> Skin Cancer-Melanoma: _____ | <input type="checkbox"/> Psoriasis: _____ |
| <input type="checkbox"/> Skin Cancer (Basal/Squamous cell): _____ | <input type="checkbox"/> Eczema: _____ |
| <input type="checkbox"/> Other Cancers: _____ | <input type="checkbox"/> Other: _____ |

- | | | | |
|---|--|--|--|
| Do you smoke? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you use sunscreen on a daily basis? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you use smokeless tobacco? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you had at least one blistering sunburn? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drink alcoholic beverages? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever used a tanning bed? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| How many drinks on a typical day? _____ | | Do you currently use a tanning bed? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you use recreational drugs? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Did you have a flu vaccine within the past year? | <input type="checkbox"/> Yes <input type="checkbox"/> No Approx Date _____ |
| | | Did you have a pneumonia vaccine in the past year? | <input type="checkbox"/> Yes <input type="checkbox"/> No Approx Date _____ |



Last Name: _____ First Name: _____ MI: _____ Previous Name: _____ (Maiden name, former married name, etc.) Mailing Address: _____ (if PO Box, complete Home Address below) City: _____ State: _____ Zip Code: _____ Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____ Extension: _____	Primary Care Physician: _____ Referring provider: _____ Patient Date of Birth: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> White Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Do not wish to report Preferred Language: _____ Email: _____
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Responsible Party (if different from patient above): Statements will be mailed here. This does not change legal responsibility. Name: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Phone: (____) _____ Email: _____ Relationship to patient: _____	Adult Emergency Contact: Name: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Phone: (____) _____ Alt. Phone: (____) _____ Relationship to patient: _____
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HOME ADDRESS (REQUIRED if PO Box given as mailing address): Address: _____ City: _____ State: _____ Zip Code: _____	PHARMACY INFORMATION: Name: _____ Address: _____ Phone: (____) _____
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By signing below, I authorize Dermatologic Surgery of the Carolinas, LLC to leave messages in reference to any items that assist in carrying out healthcare operations.

Do we have your permission to leave a detailed message/appointment reminder on your:
 Home phone: Yes No Cell: Yes No Work phone: Yes No Email: Yes No

Please list any persons to whom your protected health information can be disclosed (e.g., spouse, parent, etc):

Name: _____ Phone Number(s): _____ Relationship: _____
 Name: _____ Phone Number(s): _____ Relationship: _____

Patient or Responsible Party Signature _____ **Date** _____



DIRECTIONS TO OUR ROCK HILL OFFICE

Directions from I-77 North (Charlotte/Fort Mill) or I-77 South (Columbia)

- Take the 82C exit (Highway 161) toward York.
- Go west on Celanese Rd/Highway 161 and proceed approximately 2.3 miles to India Hook Rd.
- Make a left on India Hook road. India Hook Rd. becomes Herlong Avenue and proceed straight on Herlong Avenue.
- Pass Piedmont Medical Center (Hospital) on your right and in approximately 0.5miles- turn into Herlong Professional Park (2nd medical park past the hospital on the right).
- Enter this medical park and proceed to the middle building, Building 420. Our office is on the far right of this building, Suite 103.

Directions from West (York)

- Take Highway 5 East toward Rock Hill. Proceed approximately 8 miles.
- Take a left on South Herlong Avenue.
- Proceed 0.9 miles until you see Herlong Professional Park on your left.
- Enter this medical park and proceed to the middle building, Building 420. Our office is on the far right of this building, Suite 103.

Directions from Gastonia

- Take Union Rd. South out of Gastonia. Continue as Union Rd. turns into SC-274 as you enter South Carolina.
- Stay on SC-274/Hands Mill Hwy until encountering Old York Rd/SC-161.
- Take a left on Old York Rd/SC-161 and continue on this road as it turns into Heckle Blvd.
- Take Heckle Blvd to South Herlong Avenue and take a left.
- Proceed on S. Herlong Avenue 0.9 miles until you get to Herlong Professional Park on your left.
- Enter this medical park and proceed to the middle building, Building 420. Our office is on the far right of this building, Suite 103.

**Dermatologic Surgery of the Carolinas
420 S. Herlong Ave, Ste 103
Rock Hill, SC 29732
Phone: 704-919-1105**