seaside DERMATOLOGY

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NEW PATIENT PAPERWORK

Full Name :_____

Date of Birth:_____

Address:_____
_____
_____

Social Security Number: _____-_____-_____

Gender:_____

Primary Phone: (____) _____-_____

Work Phone: (____) _____-_____

Mobile Phone: (____) _____-_____

OK to leave detailed messages by phone? Yes___No___

Email Adress (**required**): _____

Emergency Contact Name: _____

Emergency Contact Phone: (____) _____-_____

Pharmacy Name and City:_____

Employment:_____

Providers:

Primary Care Physician: _____ Phone (**required**): (____) _____-_____

Referring Physician: _____ Phone (**required**): (____) _____-_____

Past Medical Conditions

☐ None	☐ Hypertension
☐ Anxiety disorder	☐ Hearing loss
☐ Arthritis	☐ Human immunodeficiency virus infection
☐ Asthma	☐ Hypercholesterolaemia
☐ Atrial fibrillation	☐ Hyperthyroidism
☐ Benign prostatic hyperplasia	☐ Hypothyroidism
☐ Cerebrovascular accident	☐ Inflammatory disease of liver
☐ Chronic obstructive lung disease	☐ Leukemia
☐ Coronary arteriosclerosis	☐ Malignant lymphoma
☐ Depressive disorder	☐ Malignant tumor of breast
☐ Diabetes mellitus	☐ Malignant tumor of colon
☐ Disease caused by COVID-19	☐ Malignant tumor of prostate
☐ Elevated blood pressure	☐ Malignant tumor of lung
☐ End-stage renal disease	☐ Radiation therapy treatment management
☐ Epilepsy	☐ Transplantation of bone marrow
☐ Gastroesophageal reflux disease	☐ Other

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 appendicectomy
- [ ] History of bilateral mastectomy
- [ ] History of cholecystectomy
- [ ] History of colectomy
- [ ] History of liver excision
- [ ] History of percutaneous transluminal coronary angioplasty
- [ ] History of tissue graft heart valve replacement
- [ ] History of total cystectomy
- [ ] History of transurethral prostatectomy
- [ ] Hysterectomy
- [ ] Kidney biopsy
- [ ] Low anterior resection of rectum
- [ ] Lumpectomy of breast
- [ ] Lumpectomy of left breast
- [ ] Lumpectomy of right breast
- [ ] Mastectomy of left breast
- [ ] Mastectomy of right breast
- [ ] Mechanical heart valve replacement
- [ ] Oophorectomy
- [ ] Pancreatectomy
- [ ] Percutaneous extraction of kidney stone with fragmentation procedure
- [ ] Portosystemic shunt operation
- [ ] Prostatectomy
- [ ] Prosthetic arthroplasty of bilateral hips
- [ ] Splenectomy
- [ ] Surgical biopsy of skin
- [ ] Total nephrectomy
- [ ] Total orchidectomy
- [ ] Total replacement of left hip joint
- [ ] Total replacement of left knee joint
- [ ] Total replacement of right hip joint
- [ ] Total replacement of right knee joint
- [ ] Transplantation of heart
- [ ] Transplantation of liver
- [ ] Other

Skin Conditions

- [ ] None
- [ ] Acne
- [ ] Actinic keratosis
- [ ] Asteatosis cutis
- [ ] Basal cell carcinoma of skin
- [ ] Contact dermatitis due to poison ivy
- [ ] Dysplastic naevus of skin
- [ ] Eczema
- [ ] Asthma
- [ ] Hay fever
- [ ] Malignant melanoma
- [ ] Pruritus of scalp
- [ ] Psoriasis
- [ ] Squamous cell carcinoma
- [ ] Sunburn of second degree
- [ ] Other

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? ◯ Yes ◯ No

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

Allergies & Medications

Medication Allergies	Reaction
Example:Penicillin	Rash

Medication	Dosage	Frequency
Example:Aspirin	81 mg	Daily

Social History

Are you currently or have you ever been a smoker? Y___ N___

Start smoking date: _____ Quit smoking date: _____

Number of packs per day: _____ Total number of years a smoker:_____

Are you up to date on your pneumonia vaccine? Y___ N___ If yes, date received?_____

Pregnant or actively trying to get pregnant? Y___N___ Weight : _____ Height:_____

seaside DERMATOLOGY

-Live your life, just do it with sunblock

Cancellation Policy No Show/Late Cancellation Policy

In an effort to ensure all patients receive care in a fair and timely manner, effective October 1, 2015, Seaside Dermatology, PA will charge a No Show/Late Cancellation fee of $100.00 for patients who do not show for their appointments or who cancel their appointment less than 24 hours notice. Providing advanced notice is not only a courtesy but provides an opportunity for another patient in need to be seen. The cancellation/missed appointment fees are the sole responsibility of the patient and are not covered by insurance. Seaside Dermatology understands that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.
Payment of any outstanding missed appointment/cancellation fees will be required for scheduling future appointments.

Cosmetic Appointment Policy

Effective December 1, 2018, Seaside Dermatology requests $50.00 deposit to create cosmetic appointments regarding Neurotoxin or Filler appointments and the deposit will be applied towards goods rendered at service date. If no goods are selected at service date, the deposit fee will be returned back via check. You agree to forfeit if you fail to show or notify Seaside Dermatology, PA that a reschedule is needed 24 hours prior to appointment.

Photo Consent

I give consent for medical photographs to be made of me or my child (or the person whom I am legal guardian). I understand that the photos will become a part of my medical record and will be used for medical record purposes only.

Patient Consent for Use and Disclosure of Protected Health Information

Our Notice of Privacy Practices provides information about how Seaside Dermatology may use and disclose protected health Information (PHI) about you to carry out treatment, payment, and healthcare operations. You have the right to review our Notice of Privacy Practices prior to signing this consent. Seaside Dermatology reserves the right to revise its Notice of Privacy Practices at any time. If we change our Notice, you may obtain a revised copy by contacting our office or by obtaining directly from our website at www.seaside-dermatology.com.

By signing this form, you consent to our use and disclosure of protected health information (PHI). 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. Seaside Dermatology provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

PATIENT/GUARDIAN SIGNATURE **DATE**

Patient Financial Agreement

PLEASE READ THOROUGHLY AND SIGN BELOW.

In consideration of receiving services from a Seaside Dermatology facility, you agree:

1. All services are provided to you with the understanding that you are responsible for the cost regardless of your insurance coverage. If you would like to know the cost of a service, please inquire prior to treatment. Please be aware that not all services are a covered benefit with different insurance companies. You are responsible for knowing what services are or are not covered. KNOW YOUR BENEFITS.
2. On the date of service, we will collect your deductible, co-pay, and payment for any uncovered services as well as the patient's portion as determined by insurance.
3. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. It is your responsibility to notify this office immediately if your insurance coverage or company changes. It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements, and to be sure all insurance information is current.
4. We will bill your insurance company as a courtesy but you are still ultimately responsible for payment of all services you receive. If your insurance company does not respond we will follow up with an inquiry on your behalf. If, however, your insurance does not respond again, a statement will be sent to you. You should call your insurance to question why the claim is not paid. Our office will be happy to assist after you have contacted your insurance.
5. If your medical claim has not processed and your insurance company has not resolved your dispute, you may register a complaint with the South Carolina Department of Insurance. Our office will do everything we can to assist you, however you must understand you cannot delay payment while you are awaiting the outcome of your complaint.
6. Any unpaid charges over 90 days old will be considered for an outside collection agency. You are responsible for any collection fees, legal fees, or court costs incurred in the collections process. This agency will report your failure to pay to the THREE (3) national credit reporting agencies.
7. Non-Insured: If you do not have medical insurance, you will be responsible for payment at the time of service for the service to be received that day, as well as any previous outstanding balance. If a procedure is necessary, payment may be required prior to the procedure.
8. Seaside Dermatology caps patient balances at $250. While we expect all accounts to be current, we do realize the financial hardships that medical bills can carry. Should you need to be seen at our facility, your will be required to pay your balance down to at least $250 before a visit takes place.
9. You will be assessed a $20 service fee on all returned checks due to insufficient funds in addition to the amount of the actual check. If your account becomes delinquent, the guarantor is responsible for any collection fees, interest, or attorney fees.
10. Non-Covered Services: Some services we provide may be deemed not medically necessary by your insurance carrier or not a covered benefit by your specific policy, therefore not paid by your insurance. Many cosmetic procedures we provide are not covered by insurance. The patient is responsible for payment at the time of service for all services not covered by insurance.
11. Collection Agency Policy: You are financially responsible for services in the office. Furthermore, any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, you will be financially responsible for any and all costs and fees relating to the collection of your debt. If an account is sent to a collection agency, an additional fee (45% collection fee/interest) will be added to the ending balance of the account sent to the agency.
11. Laboratories: If your insurance company requires a specific laboratory, it is your responsibility to notify us. Otherwise, we will send your specimen to a cooperating laboratory. If there are any costs related to the biopsy, pathology, cultures, or other lab work that your insurance carrier does not cover you will be responsible for those costs.
12. If you are enrolled in a Managed Care Insurance Plan (HMO) it is YOUR responsibility to obtain or ensure that a referral and/or authorization is supplied to our office from your primary care physician prior to the time of your appointment. We commonly schedule routine follow up exams as a courtesy to you upon checking out. Unfortunately, these future appointments may be outside of authorization extension allowance and require new authorization that our office is unable to complete on your behalf.
13. We are committed to providing you with the best possible care, and we are willing to discuss our professional fees at any time. Your clear understanding of our Financial Policy is important to our relationship. Please ask if you have any questions about our fees, Financial Policy, or your financial responsibility.

PATIENT/GUARDIAN SIGNATURE DATE

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HIPAA: Private Information Release Authorization

I, _____, hereby authorize Seaside Dermatology, P.A. to discuss with the following people information concerning my health treatment, billing, insurance information, and appointments.

☐ Spouse Name:_____ Phone : (_____) _____-_____

☐ Parent / Legal Guardian: Name:_____ Phone : (_____) _____-_____

☐ Significant Other Name:_____ Phone : (_____) _____-_____

☐ Any Specified Person Name:_____ Phone : (_____) _____-_____

Restrictions:

☐ No Restrictions

☐ Do not discuss any information regarding my health including appointment time, test/lab/pathology results, pre and post surgery instructions, billing/insurance, or account information with anyone except me.

☐ Only discuss my appointment time with the above named individual(s).

☐ Only discuss my test/lab/pathology results with the above named individual(s).

☐ Only discuss my pre and/or post surgery instructions with the above named individual(s).

☐ Only discuss issues concerning my account, including insurance, and/or billing with the above named individual(s).

Messages may be left on my answering machine/voicemail regarding the above

☑ Yes

☑ No

I understand I may terminate this consent at any time by giving written notice to Seaside Dermatology, P.A.. Any changes to this form will require a new consent form to be completed, signed, and dated.

Signature: _____ Date: _____

Printed Name: _____