Columbia Dermatology

NEW PATIENT REGISTRATION

Patient Name: _____ Sex: M / F Age: _____ Date of Birth:_____

Address: _____ City/State: _____Zip Code: _____

Home Phone #: _____ Cell Phone #: _____ (Circle preferred contact #)

SSN: _____ E-Mail: _____

Driver's License #: _____ Employer: _____

Primary Care Doctor: _____ Who referred you to our office? _____

Emergency Contact: _____ Relationship: _____ Phone #:_____

If patient is a minor (under 18):		
Parent Name/Guardian:	DOB:	SSN:

Insurance Information:

Primary Insurance Company Name:	Secondary Insurance Company Name:
_____	_____
Insured Name: _____	Insured Name: _____
Insured DOB: _____	Insured DOB: _____
Policy #: _____	Policy #: _____
Insured Employer: _____	Insured Employer: _____
Relationship to Insured: _____	Relationship to Insured: _____

Preferred Pharmacy Name: _____Phone #: _____ City/Zip: _____

What skin problems can we help you with today? _____

For All Women:	**(Please Circle)**	
Are you currently pregnant?	YES	NO
Are you currently taking birth control pills?	YES	NO
If NO, are you using another form of contraception? Please specify: _____	YES	NO
Are you currently breastfeeding?	YES	NO

I hereby authorize the physician to provide information to insurance carriers concerning my medical care and I hereby irrevocably assign to the doctor all payments for all the medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. I certify this information is true and correct to the best of my knowledge. I also give consent for my photo to be taken and used as part of my plan of treatment and confidential medical record.

Signature: _____ Date: _____

1600 Lake Murray Blvd., Columbia, SC 29212 Ph: (803) 731-9600 | Fax: (803) 731-0297

Medical History

Past Medical History (Please Circle All That Apply)			
Anxiety	Arthritis	Coronary Artery Disease	Depression
Diabetes	Hepatitis	High Blood Pressure	High Cholesterol
HIV / AIDS	Hyperthyroidism	Hypothyroidism	Renal / Kidney Disease
Seizures	Stroke	Transplantation	Other:

Do you have a History of Cancer? Y / N

If YES, please explain _____

Do you have a family History of Cancer? Y / N

If YES, please explain _____

Do you have a History of Skin Cancer: Y / N

If YES, please explain _____

Do you have a family History of Melanoma? Y / N

If YES, which relative(s)? _____

Medications: (please list all current medications)

_____

_____

_____

_____

Allergies: (please list all allergies)

_____

_____

Social History:

Do you drink alcohol? Y / N

Do you use illegal drugs? Y / N

Smoking History: (Please Check the Answer That Applies Below)

Never Smoked	Former Smoker Date Quit Smoking: _____	Current Smoker Packs per Day: _____

Other Family History (First Degree Relative):

_____

Signature: _____ Date: _____

Patient Name: _____ **DOB:** _____

Preferred Phone Number:_____

Patient Financial Policy

Thank you for choosing Columbia Dermatology, LLC for your dermatologic care. We are committed to providing you with the highest quality medical care possible in a cost effective manner. Our professional fees have been determined through careful consideration in addition to being reasonable and customary within our geographical area.

We accept cash, check, Visa, MasterCard, Discover, American Express, and CareCredit. There will be a $35 charge for returned checks. We require a credit card number to be kept on file in order to schedule an appointment, and for the enforcement of our No-Show/Cancellation policy. By signing this Financial Policy, you consent Columbia Dermatology, LLC to securely save your encrypted credit card information for use at future appointments, for payment plans, collections, and to be charged in the event of a violation of our No Show/Cancellation Policy. While the filing of your insurance claim is a courtesy we extend to you, all charges are your financial responsibility from the date services are rendered. Please note: Any remaining patient balances not covered by insurance entering Pre-Collections at 90 days will be charged to the patient's card on file. Prior arrangements for payment must be made prior to 90 days to avoid auto-payment. **You will receive a separate bill from a pathology lab for any tissue specimens that you consent to be removed during your visit with us.** Our billing/insurance specialist is available to discuss any questions you may have regarding your insurance or your account at Columbia Dermatology, LLC.

Items to bring with you to each appointment:

- Health Insurance Card(s)
- Driver's License or ID Card
- Method of Payment

If you are unable to provide us with this information, we ask that you reschedule your appointment.

Appointments: We do our best to run on schedule, as we realize that your time is also valuable. Please arrive for your appointment 15 minutes early to allow for registration. If you arrive late for your appointment, you may be marked as a No Show and asked to reschedule your appointment. Please inform the receptionist of any demographic changes (phone numbers, address, insurance information, etc.) Failure to notify us immediately of any changes in demographic information, financial status and/or insurance coverage may result in you being responsible for any services not covered by your insurance carrier.

No-Show | Cancellation Policy: If you are unable to make your scheduled appointment, we ask that you call and cancel your appointment at least **24 hours** prior to the appointment. There is a $25.00 fee for all office visit appointments and a $75 fee for surgical procedures/cosmetic appointments not cancelled with at least 24 hours notice. This fee is not reimbursed by insurance companies and will be your responsibility. Any such fees must be paid prior to rescheduling your appointment and may be charged automatically to your credit card on file. No Shows for cosmetic appointments will be charged full price for services scheduled. After **2 missed, un-cancelled appointments**, you will unfortunately be dismissed from our practice.

Medicare: We accept Medicare assignment. As a Medicare patient, you are responsible for your deductible and for the difference between the approved charge and the amount Medicare pays. If you have supplemental insurance, we will bill it for you. Any remaining balance will be your responsibility and billed to you.

HMO/PPO/Commercial: All co-pays are due at the time of service; we are members of most, but not all, plans. You are responsible for verifying what your insurance plan will cover and that we are in-network providers for your plan. You are responsible for referrals, payment of all deductibles and co-payment/coinsurance, procedures without authorization, and non-covered charges as determined by your contract with your insurance carrier. All payments are due at time of service.

Self-Pay: If you do not have health insurance or we do not participate with your insurance company, you will be responsible for all medical services rendered at Columbia Dermatology, LLC. Payment in full is due at the time of service.

Minor Patients: The parent(s) or guardian(s) accompanying a minor are responsible for providing current insurance information for the minor as well as the payment in full for services provided. Parent(s) or guardian(s) must have an Authorization for Medical Treatment form signed each time a minor arrives unaccompanied for an appointment. Both parents/legal guardian(s) are responsible for payment for services rendered to the minor patient.

Delinquent Accounts: There will be a $35 charge added to your account for any balances that are 90 days past due and not paid in full. If your account becomes delinquent, Columbia Dermatology, LLC, will take the necessary steps to collect the debt, including but not limited to collection agency, lawyers, and reporting to a Credit Bureau where you agree to pay all of the collection costs incurred.

Medical Records: Your medical records will be held in the strictest confidence. If you request a copy of your medical records to be sent to another provider or to yourself, a written authorization will be required. A processing fee and additional costs may apply. Only the records requested will be forwarded. Note: Any additional forms or paperwork that you request to be completed by the practice on your behalf may be subject to a $25 administration fee to compensate for time and processing.

Cosmetic/Elective Procedures: By definition, these procedures are not covered by insurance companies; and our office does not submit claims on their behalf. Payment in full is required on the day of the scheduled procedure. Deposits may be required for these procedures. Patients scheduled for these procedures are required to give at least 48 hours notice of cancellation to avoid forfeiture of deposit.

I have read, understand, and agree to abide by its guidelines the payment policy regarding my financial responsibility to Columbia Dermatology, LLC, for providing medical services to me or the above named patient. I certify that the information I provide to Columbia Dermatology, LLC, is, to the best of my knowledge, current, true, and accurate.

Patient Signature: _____ Date: _____

Guarantor Signature: _____Date: _____

HIPAA Release Form & Notice of Privacy Practices Acknowledgment

With my consent, Columbia Dermatology, LLC may use and disclose protected health information (PHI) about me, including diagnosis, records, examination rendered to me, and claims information, to carry out treatment, payment and healthcare operations (TPO). Please refer to Columbia Dermatology, LLC 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. Columbia Dermatology, LLC 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 the Privacy Officer of the Practice.

By signing this agreement, I am consenting Columbia Dermatology, LLC to use and disclose my PHI to carry out TPO.

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 this consent, Columbia Dermatology, LLC may decline to provide treatment to me.

I have had the opportunity to read and receive a copy of the Notice of Privacy Practices by Columbia Dermatology, LLC.

_____ _____

Signature of Patient or Guardian **Date**

_____ _____

Print Patient's Name **Patient's Date of Birth**

Authorization to Release Information to Family Member

Many of our patients allow family members to call and request the results of tests and procedures. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. Signing this form gives us permission to speak to a family member pertaining to test results, care, and treatment given here in the office.

Information may be released to:

Name: _____

Relationship to Patient : _____

Messages: I consent to receive messages (voice/SMS) regarding my appointments and medical care.

If unable to reach me: (Select an option below)

__ You may leave a detailed voice message

__ Please leave a message asking me to return your call

__ Do not leave a message

_____ _____

Signature of Patient or Guardian **Date**