

Welcome to our Practice!

We are honored that you have chosen our practice for your dermatology care. Whether you are coming to us for general skin care concerns or for cosmetic services in our Palmetto Breeze Med Spa, our number one priority is you, your healthy skin, and your time. You will find that you are not just another patient. You are an individual with individual needs and concerns. So please, feel free to ask questions and take an active part in your skin's health.

We encourage you to get to know our practice by visiting our website at www.PalmettoSkinCenter.com. You can browse at your leisure and learn more about our philosophy on patient care, our physicians and their expert credentials, our state-of-the-art facility and directions to our office. Please also use our website as a resource as we have an abundance of information on common skin diseases, what to expect with the treatments, and a comprehensive listing of our services and procedures.

Unique to our practice is the Palmetto Breeze Med Spa where we help you improve your skin's cosmetic health. We want your skin to be healthy and for you to be happy with how it looks and feels. We offer treatments to decrease the appearance of wrinkles and uneven pigmentation, as well as procedures to remove unsightly veins and permanently remove unwanted hair. All of the procedures including microdermabrasion and chemical peels are overseen by our physicians in a spa-like environment. Please browse our website to get a full description of services we offer or you may simply schedule a free cosmetic consultation at your convenience.

In this packet, you will find registration, medical history, office policy, and privacy forms. Please complete each of the forms, bring the packet with you to your first appointment, and plan to arrive at least **fifteen minutes** early. If appropriate, please remove your makeup prior to your appointment.

We look forward to meeting you soon!

REGISTRATION

(PLEASE PRINT)

The Palmetto Skin and Laser Center

1563 Health Care Drive
Rock Hill, SC 29732
803-329-6030

PATIENT INFORMATION

Date _____ Driver's License No _____ Home Phone _____

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Cell Phone _____ E-mail _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc Sec # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Occupation _____

Insurance Company _____ Soc Sec # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____

The Palmetto Skin and Laser Center

Office Policy

Welcome to The Palmetto Skin and Laser Center. We would like to share the following policies with you so that you understand your responsibilities as a patient. Please take a moment to carefully review the following policies.

Appointments

The Palmetto Skin and Laser Center respects your time and makes every effort to reduce both the wait to get an appointment and the wait to be seen on your scheduled appointment date. As a result, our office policy is to not overbook appointments. In order to continue to bring you efficient and streamlined service, please note that appointments that cannot be kept and are not cancelled or rescheduled two business days prior to the appointment time will result in a fee, which must be paid prior to future appointments. The minimum fees are as follows:

- New Patient: \$50.00
- Established Patient: \$25.00
- Surgery or Procedure Patient: \$75.00

Insurance

If we are contracted with your insurance company, we will file your claim as a courtesy. Please keep in mind, however, that you are ultimately responsible for the charges. If we are not contracted with your insurance company, we will ask you to pay for the visit in full and will provide you a receipt so that you can file the claim with your insurance company. We accept cash, checks or a major credit card for payment.

In the unlikely event that your account must be turned over to a collections agency or we receive a returned check from you, please be aware that the cost incurred by our office will be added to your account.

Authorizations/Referrals

You will be responsible for obtaining and keeping current authorizations if required by your insurance company. Please check with your insurance company to determine if authorization is required to see us. It is your responsibility to keep a record of the number of visits authorized, the problem for which you were referred, and the date on which the authorization expires. If you do not have the required authorization for the visit, the total charge will become your responsibility.

Medical Necessity

Please note that insurance companies only pay for what they consider medically necessary. This typically excludes the removal of benign skin growths. Every insurance company has its own policies and these change frequently, therefore, we cannot be responsible for assuring that a procedure, which you are requesting, will be covered. If your insurance does not cover the procedure, you may still pay out-of-pocket to have it done. We will be happy to discuss fees with you at any time.

Procedures

To allow for adequate time with each patient, we must focus on the primary problem for which you made the appointment. The initial appointment is generally for evaluation only. We cannot guarantee that a desired procedure will be performed. If you have multiple concerns or require a procedure, it may be necessary to schedule additional appointments.

The Palmetto Skin and Laser Center

Office Policy

Prescriptions

You may require a prescription medication during your visit. The physician will indicate on that prescription the number of refills you are allowed. If you need the medication refilled, first check with your pharmacy to see if there are remaining refills on the original prescription. If there are not any refills available, you may contact the pharmacy who will fax a refill request to our office or call our refill line and leave your name, date of birth, the medication, your pharmacy name and phone number, and a number where you can be reached. In order to receive a prescription refill, we require that you be seen in the office at least yearly. Some prescriptions require more frequent monitoring. Please note that prescription refill requests may take up to 2 business days. If the refill is approved, we will call it into your pharmacy. If the refill is not approved, we will contact you. Please do not page our physicians after hours to have medications refilled.

Medical Records Release

With the proper authorization, we will provide at no charge, copies of your medical records to other physicians that are participating in your care. These records must be released directly to the physician requesting the information. If you would like to obtain a copy of your medical records for private use, a \$15.00 copying charge will apply. Please note that all releases required a signed authorization form on file.

We sincerely thank you for allowing us to participate in your healthcare needs.

I have read the above and agree to abide by these policies.

Signature of Patient/Guardian

Date

The Palmetto Skin and Laser Center

Medical History

We appreciate your effort in completing the following questions.

NAME: _____ **Date of Birth:** _____ **Chart #** _____ **Date:** _____

MEDICATION ALLERGIES: _____

Have you had an allergic reaction to: Latex/rubber: Yes No Adhesive tape: Yes No Local anesthesia: Yes No

MEDICATIONS: (Please list ALL medications):

MEDICAL HISTORY: Do you have now, or have you ever had any of the following symptoms or diseases?

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Poor healing | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Anxiety/Panic attacks |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Anemia | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Stroke | <input type="checkbox"/> Claustrophobia |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Facial weakness | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Vision loss/Eye Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Facial numbness | <input type="checkbox"/> Accutane Therapy |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Hearing loss/ear pain | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver disease | | <input type="checkbox"/> Cancer _____ | |
- Are you required to take ANTIBIOTICS prior to minor surgery? Why? _____

- | | | | |
|--|--|--|--|
| Do you have or have you been exposed to HIV/AIDS? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have artificial joints? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have or have you been exposed to Hepatitis? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Alcoholism/Drug Abuse? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever had dental anesthesia (Novacaine)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you take aspirin or blood thinners daily? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any adverse reaction? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

List any other conditions we should know about: _____

List surgical procedures you have had in the last 6 months: _____

SOCIAL HISTORY

- | | | | |
|---|--|--|--|
| Do you smoke cigarettes or use tobacco? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you pregnant or planning to become pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you drink alcohol? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you use contraception? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you use recreational/street drugs? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

FAMILY HISTORY

- Allergies _____ Eczema _____ Asthma _____ Hay fever _____ Acne _____
- Psoriasis _____ Skin problems (explain) _____ Cancer (other than skin) _____
- Skin Cancer (specify melanoma, squamous cell, basal cell) _____

SKIN HISTORY

When you are exposed to the sun do you: Tan Only Tan more than burn Burn more than tan Burn only

Would you describe your CURRENT (last 2 years) sun exposure history as: Minimal Moderate Maximal

Do you actively seek a tan ('laying out' or tanning bed)? Yes No

Do you regularly use sunscreen? Yes No

Have you had blistering sunburns? Yes No

Do you form keloids or hypertrophic (thick) scars? Yes No

Have you had cosmetic procedures? Yes No What? _____

Were you happy with the results? Explain: _____

Are you interested in cosmetic procedures or treatment of sun damaged or aging skin? Yes No

Have you ever visited a dermatologist? Yes No Reason? _____ Therapy? _____

Do you have a history of any specific skin diseases? Yes No if yes, please explain: _____

Completed by: _____ Date: _____

Patient/Guardian

The Palmetto Skin and Laser Center

Credit Card Authorization

To Our Patients:

As part of our continuing effort to streamline our office making it more efficient and convenient for our patients, The Palmetto Skin and Laser Center utilizes the latest technology regarding bill payment.

We request that you leave a credit card number on file with us until your insurance company has paid their portion and notified us of the amount remaining deemed as your responsibility. At that time, any remaining balanced owed by you will be charged to this credit card, and a copy of the charge will be mailed to you, indicating the balance paid in full.

The obvious benefit to our patients is the convenience it provides to quickly pay the remaining balance due to our office. Because streamlines our payment process, the ultimate benefit is in keeping your health care costs down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Please note that this policy does not affect co-pays that are due at the time of the visit.

Thank you.

I authorize The Palmetto Skin and Laser Center to charge outstanding patient portion balances for me and my dependents to the following credit card:

Visa Mastercard (please circle)

Account Number: _____

Expiration Date: _____ CCV Code (on back) _____

Billing Address: _____

City/State/Zip: _____

Name on Card: _____

Signature of Cardholder: _____

The Palmetto Skin and Laser Center

**Acknowledgement of Receipt
of Notice of Privacy Practices**

(Please return this form to the front office staff)

Patient Name: (please print) _____

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature of Patient/Guardian

Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

_____ An emergency existed and signature was not possible at the time.

_____ The individual refused to sign.

_____ A copy was mailed with request for signature by return mail.

_____ Unable to communicate with the patient for the following reasons:

_____ Other: _____

Prepared by: _____
(Signature)

Date: _____