Anderson Dermatology & Skin Surgery Center, LLC

1501 N. Main Street
Camp Center
Anderson, SC 29621
(864) 716-0063, (864) 716-0073 fax

112 John Street, Suite 105
Easley, SC 29640
(864) 855-2052, (864) 855-2518 fax

_____ New
_____ Est.
_____ New (3 yrs.)

IMPORTANT NOTICE

Due to HIPAA requirements, this form must be filled out completely. Please ask for help if you have questions about any field. We will be unable to file insurance for incomplete forms. Thank you.

Last Name _____ First _____Middle_____

Male ____ Female ____ Date of Birth _____Social Security _____

Driver's License #_____ Email _____

Mailing Address _____ City _____State___ Zip Code _____

Home Address_____ City _____State___ Zip Code _____

Home Phone _____Cell Phone_____Work Phone_____

Employer Name _____

Employer Address_____

Referred By_____Primary Care Physician Name:_____

Have you been previously treated for this condition? If so, by whom and with what medicines?_____

Emergency Contact

Name_____ Relationship _____

Phone Number _____

I AUTHORIZE THE FOLLOWING PEOPLE ACCESS TO MY PROTECTED HEALTH OR MEDICAL INFORMATION:

_____Spouse _____
_____Child(ren):Name of those authorized to receive information:_____
_____
_____Other (non-Physician)_____

CONSENT TO TREAT, BENEFIT ASSIGNMENT, RELEASE OF INFORMATION AND FINANCIAL POLICY

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment as ordered by a physician and certify that the insurance information listed above is correct and that all insurance benefits for services rendered are directly assigned to this physician practice site. I understand that I am financially responsible for all charges regardless of benefits. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance claim submissions. Should this account be turned over to a collection agency for collection, I understand and agree that I will be obligated to pay all collection costs, including, but not limited to, reasonable attorney's fees.

The policy of Anderson Dermatology is that the patient has the ultimate responsibility for payment of his/her account. Payment is due at the time services are rendered unless specific arrangements have been made prior to treatment. Our office does participate with a number of insurance plans. Please contact your insurance company to verify participation. If we participate with your insurance carrier, you will be expected to pay your portion of the charge and/or a predetermined co-pay amount on the date of service, and we will file your insurance claim. We will allow a period of forty-five (45) days from the filing date for your carrier to process and pay your claim. If your claim has not been paid within that period, full payment of the charges, as well as any follow-up with the insurance company becomes your responsibility.

If we do not participate with your insurance carrier, we will file your claim as a courtesy, but you will be responsible for any out of network fees and co-insurance amounts at the time of service.

If we refer you to a specialist or schedule procedures/tests, we will try to send you to a facility that participates with your insurance. Ultimately, it is your responsibility to contact the insurance company to confirm the provider is in the network and the procedures/tests are authorized.

If you are not covered by an insurance plan, payment in full will be expected at the time of service. If this creates a financial hardship for you, please inform the receptionist before services are rendered so that satisfactory arrangements for payment can be made.

_____ _____ _____

Signature of Patient or Legal Guardian | Printed Name of Patient or Legal Guardian | Date

Anderson Dermatology & Skin Surgery Center, LLC

Patient Name: _____

Primary Insurance

Company_____

Insured's Name_____ Date of Birth_____ Male__ Female_____

Insured's Social Security No._____ Insured's Relationship to Patient_____

Group #_____ Employer Insurance # _____ Effective Date_____

Employer_____ Telephone # _____

Employer Address_____

Secondary Insurance

Company_____

Insured's Name_____ Date of Birth_____ Male__ Female_____

Insured's Social Security No._____ Insured's Relationship to Patient_____

Group #_____ Employer Insurance # _____ Effective Date_____

Employer_____ Telephone # _____

Employer Address_____

Please Answer the Following:

You may leave a message with someone answering the phone number I have provided regarding an upcoming appointment. _____Yes _____No

You may leave a message on my answering machine or voicemail concerning my pathology results. _____Yes _____No

You may leave a message with someone answering the phone number I provided concerning my pathology results. _____Yes _____No

You may leave a message on my answering machine or voicemail that I need to call your office concerning any test result or financial matters. _____Yes _____No

You may leave a message with someone answering the phone number I provided that I need to call your office concerning any test results or financial matters.
_____Yes_____No

You may release any photographs or slides of me for consultation and/or training purposes as deemed appropriate by Dr. Knoepp, Dr. Shew, Caroline Brown, PA-C, and/or Stephanie Kirby Davis, PA-C _____Yes _____No

Signature of Patient or Legal Guardian | Printed Name of Patient or Legal Guardian | Date

Anderson Dermatology & Skin Surgery Center, LLC

Name:_____**Today's Date:** _____
Date of Birth:_____**Race:** _____**Marital Status:** _____
Height: _____ **Weight:** _____
Reason for today's visit: _____

Personal Medical History:
Please circle any condition you have had or are currently being treated for:

Allergies/Hayfever/Sinus
Arthritis
Asthma
AIDS/HIV
Bleeding Disorder
Blindness
Breathing or Lung Problems
Cancer (other than skin): _____
_____
Diabetes
Fainting
Fibromyalgia
Hearing problems
Hepatitis (Liver trouble)
High Blood Pressure
High Cholesterol/Triglycerides
Thyroid Disorder
Other Health Issues: _____
_____

Genetic Disorder/Birth Defects
Lupus
Mental Health Problems: _____
_____
Psoriasis
Seizures
Stomach Ulcer
Skin Cancer:
Kind: Basal Cell
Squamous Cell
Melanoma
Unknown
Heart Disease/Murmur/Heart Attack
Pacemaker/Defibulator
Are you pregnant: Yes____ No ____
Are you nursing: Yes____ No ____

Have you fallen in the last 3 months: Yes____ No ____

Family History of Skin Cancer: No ___ Yes___

If YES, which family member(s):
Mother/Father/Sister/Brother/Grandmother/Grandfather/Aunt/Uncle

Do You Smoke or Use Tobacco: Yes____ No ____ If yes, are you ready to quit: Yes____ No ____
Do You Use Alcohol: Yes ____ No ____
Do You Use Recreational Drugs: Yes ____ No ____

Pneumonia Vaccine Date: _____
Flu Shot Date: _____

List ALL medications you take on a regular basis, include over the counter medicines, vitamin suppliments and herbals: NAMES ONLY

1._____	7._____	13._____
2._____	8._____	14._____
3._____	9._____	15._____
4._____	10._____	16._____
5._____	11._____	17._____
6._____	12._____	18._____

Drug allergies: _____
Pharmacy you use_____

Anderson Dermatology & Skin Surgery Center, LLC

Our *Notice of Privacy Practices* provides information about how we may use and disclose protected health information about you and your rights with respect to your health information. You have the right to review our notice before signing this consent. As stated in our notice, the terms may change. If we change our notice, you may obtain a revised copy by requesting one from the front desk personnel. The revised notice will also be posted in our waiting room.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you also acknowledge that you have received or reviewed a copy of the *Notice of Privacy Practices*.

Patient Signature or Legal Guardian Signature if patient is a minor.

Printed Name of Patient

Printed Name of Legal Guardian

Date

Time

FAX & EMAIL PRIVACY WAIVER

I understand that my medical records may be transmitted electronically by fax and may be received in error by a third party. In the event that this should occur I absolve this practice of all liability.

I give my consent to fax my records for the purposes of treatment, payment or healthcare operations and understand that I may withdraw this consent at any time in writing.

If I choose to email my healthcare provider(s), I understand that email is considered a convenience and is not appropriate for emergencies or time-sensitive issues. I, also, understand that highly sensitive or personal information should not be communicated via email.

I understand that although safeguards will be made to protect the confidentiality of any information contained within email, no one can guarantee the absolute privacy of email messages and that depending on their job function, staff may have the right to access any email sent or received by my healthcare provider(s).

I give my consent to include any emails pertinent to the treatment, payment or healthcare operations in my medical record. Finally, I understand that I may withdraw this consent at any time in writing.

Patient Signature or Legal Guardian Signature if patient is a minor.

Printed Name of Patient

Printed Name of Legal Guardian

Date

Time