NEW PATIENT FORM (please print)

PATIENT INFORMATION

Full Name:____ Nickname:____________
First Middle Last

Social Security Number (SSN):______________________

Birthdate:_____________________ Age:____________ Male:_____ Female:______

Street Address:_______________________________ City:__________ State:_____ ZIP:________

Home Phone:__________________ Work Phone:________________ Cell:__________________

E-mail:____________________ Communication Preference: Home Cell Work E-mail Postal Mail
Circle one

Occupation:___________________________ Employer:________________________________

Referring Physician:__________________________ Primary Physician:______________________

Marital status: Married_____ Divorced_____ Single_____ Widowed_____ Separated_____

Preferred language:_____________ Race:________ Ethnicity:________ Prefer not to answer:_____

EMERGENCY CONTACT

Name:__________________________________ Relationship to Patient:____________________

Phone number:______________________

PARENT INFORMATION (Complete if Minor or under 18 years of age)

Father's name:___________________________ DOB:_______________ SSN:_______________

Phone:_____________________ Address:____

Mother's name:___________________________ DOB:_______________ SSN:_______________

Phone:_____________________ Address:____

INSURANCE INFORMATION

Primary Insurance:________________________ Subscriber Name:________________________

Group Number:__________________________ Subscriber Number:_______________________

Secondary Insurance:_____________________ Group/Subscriber Number:____________________

HOW DID YOU HEAR ABOUT UPSTATE DERMATOLOGY?

____

UPSTATE Dermatology

HEALTH AND MEDICATION INFORMATION

Patient Name:________________________________ **Date of Birth:**___________________________

Preferred Pharmacy:____

Alerts: (check all that apply)

- ☐ Allergy to adhesive
- ☐ Allergy to lidocaine/Xylocaine/epinephrine
- ☐ Allergy to topical antibiotics
- ☐ Allergy to rubber or latex
- ☐ Artificial heart valve
- ☐ Artificial joint placement
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ History of MRSA
- ☐ Pacemaker
- ☐ Require antibiotic prophylaxis prior to surgery or dental procedures
- ☐ Are you pregnant, or currently trying to become pregnant?

Past and Present Health Conditions: (check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD/Emphysema
- ☐ Coronary Artery (heart) Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End-stage Renal Disease
- ☐ GERD/Acid Reflux
- ☐ Hearing Loss
- ☐ Hepatitis B or C
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE

Any other conditions:____

Past Surgical History: (check all that apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (Right, Left, Bilateral)
- ☐ Lumpectomy (Right, Left, Bilateral)
- ☐ Breast Biopsy (Right, Left, Bilateral)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee (Right, Left, Bilateral)
- ☐ Joint Replacement, Hip (Right, Left, Bilateral)
- ☐ Joint Replacement within Last 2 Years
- ☐ Kidney Biopsy
- ☐ Kidney Removed/Nephrectomy (Right, Left)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy

UPSTATE Dermatology

- ☐ Spleen Removed
- ☐ TURP (Prostate Removal)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ NONE

Any other surgeries:____

Skin Disease History: (check all that apply)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Atopic dermatitis
- ☐ Basal Cell Carcinoma
- ☐ Blistering Sunburns
- ☐ Cold Sores/Fever Blisters
- ☐ Dandruff
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Keloid(s)
- ☐ Large Scar(s)
- ☐ Melanoma
- ☐ Poison Oak/Ivy/Sumac
- ☐ Precancerous or Atypical Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma

Any other skin conditions:____

Do you use sunscreen? Yes____ No____. **If Yes, what SPF?** ________

Do you currently use tanning beds? Yes____ No____. **Used tanning beds in the past?** Yes____ No____.

Do you have a family history of melanoma? Yes____ No____.
If yes, which relative(s)?____

Do you have any medication allergies? Yes____ No____.
If yes, please list allergy and type of reaction:

____ ____
____ ____
____ ____

Please list all prescription and non-prescription medications you are currently taking.

____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____

Social History:

- **Do you currently smoke?** Yes____ No____.
- **If Yes, how much? _______________. Were you a former smoker?** Yes____ No____. **Quit date? ___________**
- **Do you drink alcohol?** Yes____ No____. **If Yes, how much per week/day? _______________.**

1a. Have you had a flu vaccination this flu season (September 2021 – March 2022)? Yes____ No____.

1b. If you have NOT had a flu vaccination, please explain why you have not received it. (For example….*"I am allergic,"* or *"I have had a negative reaction in the past,"* or *"I prefer not to take vaccines."*)

____

Complete this section below if you are 65 YEARS OLD, OR OLDER

The Center for Medicare & Medicaid Services (CMS), is a federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program.

CMS requires that we ask the following questions regarding pneumonia vaccination and advance care directives to **all patients 65 or older**. In order to meet compliance guidelines for health information continuity and portability purposes, we must collect and keep this data in our records.

1a. Have you had a pneumonia vaccination (ex., Pneumovax, Prevnar)? Yes____ No____.

1b. If you have NOT had the pneumonia vaccination, please explain why you have not received it. (For example….*"I am allergic,"* or *"I have had a negative reaction in the past,"* or *"I prefer not to take vaccines."*)

____

……

Health Care Proxy **-** An advance medical directive is a type of legal document that designates another person (a proxy) to make health care decisions for you in case you are rendered incapable of making your medical wishes known. The health care proxy has the legal right to speak on behalf of a patient who is unable to speak for themselves, or who is unable to make their wishes known.

2a. Do you have an advance care directive with a designated health care proxy in the event you cannot answer for yourself, or become unable to make your healthcare wishes known? Yes____ No____.

2b. If you have a health care proxy, please list the designee's name:_____________________________

2c. Your health care proxy's relationship to you: ____

2d. Your health care proxy's phone number:____

HIPAA POLICY STATEMENT

Upstate Dermatology, P.A.'s Privacy Notice to Patients

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED BY UPSTATE DERMATOLOGY AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Effective Date: October 10, 2016
Under the HIPAA Privacy regulations, Upstate Dermatology and all similar health care providers are required by federal law to maintain privacy of your protected health information (PHI) and will abide by the terms in the Privacy Notice. Please be advised that Upstate Dermatology may use your PHI in rendering treatment. For example, we are permitted to use your PHI in providing you with medical care/treatment when you visit our office or when we treat you in a hospital or nursing facility. Under federal law, we may disclose your PHI to you or we can disclose your PHI to third parties for treatment. For example, if we refer you (or send a tissue specimen) to a specialist, we will forward your medical information to such specialists. We can disclose your PHI for payment purposes. For example, we will disclose your PHI to your insurance provider, your employer, Medicare, Medicaid, or other parties responsible for providing you with health insurance coverage in order for Upstate Dermatology to be reimbursed for our services rendered to you. We will also use or disclose your PHI for health operations. For example, we may use your PHI when we engage in quality assurance and medical chart reviews, which are part of our health care operations. We may also disclose your PHI, when required by the Secretary of the US Department of Health & Human Services. Unless disclosure is required under federal/state law, or certain other exceptions, including law enforcement, we are prohibited from disclosing your PHI without your authorization. Our practice may use or disclose your PHI in accordance with the specific requirements of the HIPAA rules without Upstate Dermatology needing to obtain your authorization if the information is:

1. Required by law
2. Required for public health purposes
3. Required disclosures about victims of abuse, neglect or domestic violence
4. Required by health oversight agency for oversight activities authorized by law
5. Required in the course of any judicial or administrative proceeding
6. Required for a law enforcement purpose to a law enforcement official
7. Required by a coroner or medical examiner
8. Required by an organ procurement organization for research, and
9. Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Additionally, if you are a member of the armed forces, Upstate Dermatology is permitted to disclose your PHI without consent if deemed necessary by appropriate military command authorities to assure an appropriate military mission. We may also contact you via mail, email, or phone to remind you of appointments with our office or to discuss treatment alternatives. If, for any reason, you do not wish to be contacted via mail, email, or phone, our office personnel with note your request in your chart. In the event our practice wishes to disclose your PHI to another entity besides those referenced above, we are required to obtain your authorization. We would seek to obtain your authorization if Upstate Dermatology decided to release your PHI for reasons other than treatment, payment, or for our practice's operations. For example, if we desired to participate in outside research or a drug study, we would need your written authorization prior to being permitted to release your PHI to such outside research facility or drug manufacturer. If you provide us with an authorization, you have the ability to revoke such authorization at any time by sending Upstate Dermatology a written revocation. However, if we have already released such information pursuant to your prior authorization, the revocation will be effective for all future disclosures. Please be further advised that you have the ability to access, obtain a copy, inspect, and request amendment to your medical information that we maintain. Additionally, if you desire, Upstate Dermatology can provide you with an accounting of all disclosures for treatment, payment, or healthcare operations pursuant to authorization. If you have a dispute with our practice regarding the use of your PHI or a disclosure by Upstate Dermatology and believe that your primary rights have been violated, please contact Upstate Dermatology to file a complaint or you may contact the U.S. Secretary of Health and Human Services. We welcome feedback from our patients via mail to our address (420 The Parkway, Suite M, Greer, SC 29650). Please understand that Upstate Dermatology will not retaliate against you in any way for filing a complaint. Lastly, please be advised that you have the right to designate a personal representative or request restrictions on certain uses and disclosures of your PHI to carry out treatment, payment, or healthcare operations or disclosures by Upstate Dermatology of your PHI to a family member, relative, or a close personal friend. However, we are not required by federal law to agree to your requested designation or restriction. If you request a copy of your PHI, you also have the ability to request that we send it to an alternative location (different address) and by alternative means. Additionally, if you have received this notice in an electronic form and you would like a paper copy, please contact Upstate Dermatology's Practice Manager. Upstate Dermatology reserves the right to amend this notice as revised. Notices will be posted on our website (www.upstatedermatology.com) and in our office and provided to you upon request. Thank you, and if you have any questions, please contact Upstate Dermatology at 864-877-0776.

PATIENT PRIVACY FORM

Patient Name:____

Date of Birth:____

SHARING INFORMATION

Please list who has permission to receive information from Upstate Dermatology other than the patient.

____ ____________________

Name of person who has permission to receive the above patient information *Relationship to patient*

____ ____________________

Name of person who has permission to receive the above patient information *Relationship to patient*

COMMUNICATION

I authorize Upstate Dermatology to leave a message regarding: Check ONLY ONE

- ☐ All information including appointments, general information, updates, billing, etc.
- ☐ Appointment information ONLY

On my voicemail on the: Check ALL that apply

- ☐ Cell Phone Number
- ☐ Home Phone Number

RIGHTS OF THE PATIENT

I understand that I have the right to revoke this authorization at any time by sending notification to Upstate Dermatology (420 The Parkway, Suite M Greer, SC 29650). I understand that a revocation is not effective in cases where the information has already been used or disclosed, but will be effective going forward. I understand that information used or disclosed as a result of this authorization may result in re-disclosure by the recipient and may no longer be protected by federal or state law. Information received by this office is for our own use and will continue to be protected by our Privacy Policy. I understand that I have the right to inspect or copy the protected health information disclosed as described in this document. I can do this by sending written notification to: Upstate Dermatology (420 The Parkway, Suite M, Greer, SC 29650). I understand that I have the right to refuse to sign this authorization.

I have read and received a copy of the Notice of Privacy Practices for Upstate Dermatology.

______________________________________ _______________ ____________________

Signature ***Date*** ***Relationship if not patient***

RESPONSIBLE PARTY ACKNOWLEDGEMENT

RESPONSIBLE PARTY

The Responsible Party is the person who is FINANCIALLY responsible for the patient's account(s) and who will receive all account statements to their address. By signing, I understand that I am the responsible party and will adhere to the requirements outlined in the policies provided to me for the following patient(s) as well as future patients registered in my name at Upstate Dermatology. If you are age 18 or older, you are your own responsible party.

Name of Responsible Party (PLEASE PRINT) ***Relation to Patient(s)***

PATIENT(S) COVERED BY RESPONSIBLE PARTY

Patient's Last Name (PLEASE PRINT) ***First Name*** ***Date of Birth***

Patient's Last Name (PLEASE PRINT) ***First Name*** ***Date of Birth***

Patient's Last Name (PLEASE PRINT) ***First Name*** ***Date of Birth***

WAIVER OF LIABILITY

__________ I understand that the treatment/service from the providers and physicians at Upstate Dermatology for the patient(s) listed above may not be a covered treatment/service or may not be covered at 100%. I agree to be personally and fully responsible for any balance due.

Responsible Party Initials

PAYMENT POLICY

__________ Upstate Dermatology is committed to providing the best treatment for our patients. Our pricing structures are representative of the usual and customary charges for our area. Thank you for adhering to our payment policy. Signing below indicates that you are the responsible party, which means you are financially responsible for this patient and have read and understand the payment policy and agree to abide by its guidelines.

Responsible Party Initials

RESPONSIBLE PARTY ACKNOWLEDGEMENT

I understand that I am the responsible party for the patient(s) listed above and any future patient(s) registered in my name at Upstate Dermatology and I agree to the terms of the Waiver of Liability and Payment Policy. I have been given a copy for review and I am aware of the availability of these documents in the office of Upstate Dermatology as well as online at www.UpstateDermatology.com.

Signature of Responsible Party ***Date***

OFFICE AND PAYMENT POLICY

Thank you for choosing Upstate Dermatology for your skin care needs.

Please review the following office policies:

- ✓ Payments are required at the time of service, including co-pays, coinsurance, deductibles, and any other unpaid balances.
- ✓ It is the patient's responsibility to ensure that the proper referral is completed before the visit/treatment. The visit may be rescheduled if the proper referral is not obtained.
- ✓ Be prepared to provide your insurance card at every visit (to ensure we have the most up-to-date information).
- ✓ Any biopsies performed will be sent to MGPO Dermatopathology Associates for slide preparation and interpretation unless otherwise specified. You will receive a separate bill from this company for their services. We will provide MGPO Dermatopathology Associates with your insurance information.
- ✓ A parent or legal guardian must accompany minors (under age 18) for their appointments; depending on the visit, you may be asked to reschedule if an adult is not present.
- ✓ No food or drink is allowed into the reception area or exam rooms.
- ✓ All cellular phones must be turned off or in silent mode in the exam rooms.

Please review the following financial policies:

- ✓ We participate in most insurance plans; however, each insurance plan has different benefits and policies. **You are responsible, as the insured party, to verify your benefits and coverage with your insurance company prior to your appointment. Our policy is to file your medical visits with your insurance company, but as the insured party, you are responsible for any unpaid balance, which may include co-pays, coinsurance, deposits, and/or deductibles.**
- ✓ Patients who need to cancel or re-schedule their appointment must do so at least 24 hours in advance, or they will be deemed 'no-show.'
- ✓ After 1 grace no-show, missed appointments that are not canceled/rescheduled at least 24 hours in advance may result in a $50 fee.
- ✓ Patients who arrive more than 15 minutes late to their scheduled appointment are considered to have lost their slot (no-show). They will be given the options to wait until a slot opens (based on availability, non-guaranteed) or to re-schedule the visit.
- ✓ Missed procedures/surgery appointments not canceled/rescheduled at least 24 hours in advance may result in a $150 fee.
- ✓ Balances aged more than 90 days from the date of the first statement ("date debt incurred") will be considered overdue and may be turned to an outside collections agency.

______________________________________ __________________________________

Patient/Legal Guardian ***Date***