



Welcome to Dermatologic Surgery of the Carolinas!

Enclosed you will find several informational forms to fill out prior to your arrival at our office for your appointment. You may fax these forms to prior to your appointment to (803)329-0688 but please also bring them with you on your appointment day. The enclosed forms include:

- Patient information form
- Medical history form
- Signature form for Privacy Policy (HIPAA), Financial Policy, and Release of Medical Information
- Directions to our office

If you should have any questions regarding your appointment, insurance coverage or the Mohs procedure, please do not hesitate to contact our office at (803)329-0888. Here at Dermatologic Surgery of the Carolinas we strive to provide top-quality, cutting-edge treatment of skin cancer and other dermatological conditions so please do not hesitate to contact us if you have any questions or concerns.

Along with the enclosed forms, please bring the following to your upcoming appointment:

- **Insurance card** (Dr. Lane cannot see you without verifying your insurance with your insurance card)
- **Co-pay or Deductible** (We will verify this with you prior to your appointment time)

Completing these forms with their required signatures and having your insurance card and co-pay/deductible can dramatically decrease the time required for check-in, so we appreciate your assistance and we look forward to your visit.



Patients MUST sign and date all paragraphs below before medical care can be rendered.

PATIENTS WHO ARE MINORS: If the patient is younger than eighteen, then the paragraphs must be signed by a parent or legal guardian. A parent or legal guardian must be present for any patient younger than sixteen.

Release of Medical Information

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions.

Signature: _____ Date: ____/____/____

Financial Policy

Payment is required for all services at the time they are rendered unless the patient is in an insurance plan with which we participate. We accept payment in the form of cash, check, Visa and MasterCard. In the event that your account must be turned over to collections, a \$25.00 collection fee will be added to your account. There is a \$30 fee for any returned check. Your signature below signifies your understanding and willingness to comply with this policy.

I have read and understand this financial policy statement. I agree to make in-full prompt payment to Dermatologic Surgery of the Carolinas when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered.

In addition to the above, if I am a Medicare patient, I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature: _____ Date: ____/____/____

Privacy Practices (HIPAA)

By signing below, I acknowledge that I have read and understand Dermatologic Surgery of the Carolinas' Notice of Privacy Practices. This document is posted on our website and made available at our check-in desk. We would also be happy to provide you with a copy of this policy for you to take home with you.

Signature: _____ Date: ____/____/____



DERMATOLOGIC SURGERY OF THE CAROLINAS, LLC

How did you find us?

- Family/Friend - Name: Physician - Name: Insurance Provider List Other Internet Search

PATIENT INFORMATION

Form with two columns: Patient personal info (Last Name, First Name, MI, etc.) and Medical info (Primary Care Physician, Referring provider, etc.).

INSURANCE INFORMATION: If the patient is not the primary policy holder, the Responsible Party section above must be completed.

- Self Pay Patient IS the policy holder Patient IS NOT the policy holder

Primary Insurance Co.: Policy Number

Secondary Insurance Co.: Policy Number

Does your insurance plan require you to have a referral to see a specialist? No Yes I don't know

NOTE: It is the patient's responsibility to get any required referrals. Failure to do so may result in denied claims and the patient will be responsible for all services rendered.

Form with two columns: HOME ADDRESS (REQUIRED if PO Box given as mailing address) and PHARMACY INFORMATION.

By signing below, I authorize Dermatologic Surgery of the Carolinas, LLC to leave messages in reference to any items that assist in carrying out healthcare operations.

Home phone: Work phone: Email: -or list the email address to use:

Please list any persons to whom your protected health information can be disclosed (e.g., spouse, parent, etc):

Name: Phone Number(s): Relationship:

Name: Phone Number(s): Relationship:

Patient or Responsible Party Signature Date



DERMATOLOGIC SURGERY
OF THE CAROLINAS, LLC

MEDICAL HISTORY

Patient _____ **Appointment Date:** _____ **Referred by:** _____

Reason for visit: _____ **How long has it been present?** _____

Previous treatment? (Please list) _____

Please list any medications, herbal supplements and/or vitamins you are currently taking: None

Do you have or have you had any of the following? (if yes, please check). None

- | | | |
|--|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Cold sores/herpes | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Seasonal allergies/asthma |
| <input type="checkbox"/> Artificial heart valve
(Year _____) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin Cancer (melanoma) |
| <input type="checkbox"/> Artificial joints or metal
implant (Year _____) | <input type="checkbox"/> Heartburn/Reflux | <input type="checkbox"/> Skin Cancer (basal/squamous cell
carcinoma) |
| <input type="checkbox"/> Atopic Dermatitis/Eczema | <input type="checkbox"/> HIV | <input type="checkbox"/> Skin Pre-Cancers (actinic keratoses) |
| <input type="checkbox"/> Atypical moles | <input type="checkbox"/> Keloids or scarring
problems | <input type="checkbox"/> Skin disorders (other) |
| <input type="checkbox"/> Autoimmune disease (lupus,
rheumatoid arthritis) | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Systemic problems (fever/chill/etc.) |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Liver disease or hepatitis | <input type="checkbox"/> Thyroid trouble |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Ulcers (stomach) |
| | <input type="checkbox"/> Muscle aches | <input type="checkbox"/> Other conditions |
| | <input type="checkbox"/> Plastic/cosmetic surgery | Please list: _____ |

Female patients (check all that apply): I am: pregnant nursing planning to become pregnant soon

Are you allergic to any medications/anesthetics? Yes No
(if yes, please list)

Personal history of previous skin cancer? Yes No **Location/When treated?** _____

Please list other major illnesses: _____

Please list major surgeries/hospitalizations:

_____ Date: _____ Date: _____
_____ Date: _____ Date: _____

Please list IMMEDIATE FAMILY that have had any of the following (mother, father, maternal or paternal grandmother or grandfather, brother, sister):

- | | |
|---|---|
| <input type="checkbox"/> Skin Cancer-Melanoma: _____ | <input type="checkbox"/> Psoriasis: _____ |
| <input type="checkbox"/> Skin Cancer (Basal/squamous cell): _____ | <input type="checkbox"/> Eczema: _____ |
| <input type="checkbox"/> Other Cancers: _____ | <input type="checkbox"/> Other: _____ |

- | | | | |
|--------------------------------|--|---|--|
| Do you smoke? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you use sunscreen on a daily basis? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you use smokeless tobacco? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you had at least one blistering sunburn? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drink alcoholic beverages? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever used a tanning bed? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you use recreational drugs? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you currently use a tanning bed? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Reviewed: _____, M.D



DIRECTIONS TO OUR OFFICE

Directions from I-77 North (Charlotte/Fort Mill) or I-77 South (Columbia)

Take the 82C exit (Highway 161) toward York. Go west on Celanese Rd/Highway 161 and proceed approximately 1.5 miles to India Hook Rd. Make a left on India Hook road. India Hook Rd. becomes Herlong Avenue and proceed straight on Herlong Avenue. Pass Piedmont Medical Center (Hospital) on your right and turn into Herlong Professional Park (2nd medical park past the hospital on the right). Proceed straight ahead to Building 420 and our practice is in Suite 103 on the right corner of the building.

Directions from West (York)

Take Highway 5 East toward Rock Hill. Proceed approximately 8 miles. Take a left on South Herlong Avenue. Proceed 1 mile until Herlong Professional Park on your left. Enter this medical park and proceed to the middle building in the back (Building 420). Our office is on the far right of this building.

Directions from Gastonia

Take Union Rd. South out of Gastonia. Continue as Union Rd. turns into SC-274 as you enter South Carolina. Stay on SC-274/Hands Mill Hwy until encountering Old York Rd/SC-161. Take a left on Old York Rd/SC-161 and continue on this road as it turns into Heckle Blvd. Take Heckle Blvd to South Herlong Avenue and take a left. Proceed on S. Herlong Avenue until you get to Herlong Professional Park on your left. Enter this medical park and proceed to the middle building in the back (Building 420). Our office is on the far right of this building.

Please see our website (www.dsc-rockhill.com) for a detailed map and driving directions.

Telephone: 803-329-0888