



**You are scheduled at our Rock Hill office on \_\_\_\_\_ Please arrive at the office at \_\_\_\_\_.**  
**Thank you**

**KINDLY GIVE 48 BUSINESS HOURS NOTICE IF YOU MUST CANCEL OR RESCHEDULE (704) 919-1105**

## **Welcome to Dermatologic Surgery of the Carolinas!**

Enclosed you will find several information forms to fill out prior to your arrival at our office for your appointment. **Please bring completed forms 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 or insurance coverage, please do not hesitate to contact our office at (704) 919-1105. 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** (We 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.



**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: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**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 ([www.dsc-charlotte.com](http://www.dsc-charlotte.com)) 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: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Consent to Receive Text Messages**

By signing below, I authorize Dermatologic Surgery to contact me by SMS text message for health-related notifications and appointment reminders.

I understand that message/data rates may apply to messages sent by Dermatologic Surgery of the Carolinas under my cell phone plan.

I know that I am under no obligation to authorize Dermatologic Surgery of the Carolinas to send me text messages. I may opt-out of receiving these communications at any time by calling the main line 704-919-1105 and speaking with a representative.

I understand that text messages are not a substitute for professional or medical attention.

By signing below, I indicate I am the person legally responsible for all use of mobile accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services.

- Yes, sign me up for SMS text messages Cell number: \_\_\_\_\_
- No thanks, I choose not to participate in SMS text messages.

Signature:

\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_



## **Financial Policy**

Payment is required for all services at the time they are rendered. **An estimate of ALL co-payments, deductibles, co-insurances not covered by your insurance carrier will be collected up front and due on the date of service.** Failure on our part to collect these from patients may be considered insurance fraud.

**When calling to confirm your appointment, we will notify you of the amount due at the time of service – this is only an ESTIMATE.** Due to the possible extensive nature of some dermatologic procedures, there may be instances where additional procedures may be necessary in order to fully remove or treat your condition and/or lesion. This would result in additional fees.

To provide the best care possible, Dermatologic Surgery of the Carolinas may, on occasion, send specimens to an outside source for processing. Examples of these services are pathology and laboratory testing. Should we send a specimen to other providers, you will receive a separate billing statement from the outside pathologist and/or laboratory; these charges will be in addition to those services rendered by Dermatologic Surgery of the Carolinas.

We accept payment in the form of **cash, check, Visa, MasterCard, Amex and Care Credit.** 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: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

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



MEDICAL HISTORY

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Please list any medications, herbal supplements and/or vitamins you are currently taking and dosage (mg): · None

\_\_\_\_\_  
\_\_\_\_\_

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

- Acne, Anxiety, Artificial heart valve, Artificial joints or metal implant, Atopic Dermatitis/Eczema, Atypical moles, Autoimmune disease (lupus, rheumatoid arthritis), Bleeding disorder, Blood clots, Cold sores/herpes, Depression, Diabetes, Heartburn/Reflux, High Blood Pressure, HIV, Keloids or scarring problems, Kidney disease, Liver disease or hepatitis, Lung disease, Muscle aches, Pacemaker/Defibrillator, Plastic/cosmetic surgery, Psoriasis, Seasonal allergies/asthma, Skin Cancer (melanoma), Skin Cancer (basal/squamous cell carcinoma), Skin Pre-Cancers (actinic keratoses), Skin disorders (other), Systemic problems (fever/chill/etc.), Thyroid trouble, Ulcers (stomach), Transplant (lung, heart, kidney, liver etc), Other conditions

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

Are you allergic to any medications/anesthetics?  Yes  No Latex glove/bandage allergy?  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):

- Skin Cancer-Melanoma: \_\_\_\_\_ Psoriasis: \_\_\_\_\_  
Skin Cancer (Basal/Squamous cell): \_\_\_\_\_ Eczema: \_\_\_\_\_  
Other Cancers: \_\_\_\_\_ Other: \_\_\_\_\_

Do you smoke?  Yes  No Do you use sunscreen on a daily basis?  Yes  No  
Do you use smokeless tobacco?  Yes  No Have you had at least one blistering sunburn?  Yes  No  
Drink alcoholic beverages?  Yes  No Have you ever used a tanning bed?  Yes  No  
How many drinks on a typical day? \_\_\_\_\_ Do you currently use a tanning bed?  Yes  No  
Do you use recreational drugs?  Yes  No Did you have a flu vaccine within the past year?  Yes  No Approx Date \_\_\_\_\_  
Did you have a pneumonia vaccine in the past year?  Yes  No Approx Date \_\_\_\_\_



<p>Last Name: _____</p> <p>First Name: _____ MI: _____</p> <p>Previous Name: _____ (Maiden name, former married name, etc.)</p> <p>Mailing Address: _____ (if PO Box, complete <u>Home Address</u> below)</p> <p>City: _____</p> <p>State: _____ Zip Code: _____</p> <p>Home Phone: (____) _____ Cell Phone: (____) _____</p> <p>Work Phone: (____) _____ Extension: _____</p> <p>Email: _____</p>	<p>Primary Care Physician: _____</p> <p>Referring provider: _____</p> <p>Patient Date of Birth: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> White</p> <p>Sexual Orientation: <input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Do not wish to disclose</p> <p>Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Female to Male Transgender <input type="checkbox"/> Male to Female Transgender <input type="checkbox"/> Do not wish to disclose</p> <p>Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Do not wish to report</p> <p>Preferred Language: _____</p>
--	---

<p><b>Responsible Party (if different from patient above):</b> Statements will be mailed here. This does not change legal responsibility.</p> <p>Name: _____</p> <p>Address: _____</p> <p>City: _____</p> <p>State: _____ Zip Code: _____</p> <p>Phone: (____) _____ Email: _____</p> <p>Relationship to patient: _____</p>	<p><b>Adult Emergency Contact:</b></p> <p>Name: _____</p> <p>Address: _____</p> <p>City: _____</p> <p>State: _____ Zip Code: _____</p> <p>Phone: (____) _____ Alt. Phone: (____) _____</p> <p>Relationship to patient: _____</p>
---	--

<p><b>HOME ADDRESS</b> (REQUIRED if PO Box given as mailing address):</p> <p>Address: _____</p> <p>City: _____</p> <p>State: _____ Zip Code: _____</p>	<p><b>PHARMACY INFORMATION:</b></p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone: (____) _____</p>
--	---

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.

**Do we have your permission to leave a detailed message/appointment reminder on your:**

Home phone:  Yes  No Cell:  Yes  No Work phone:  Yes  No Email:  Yes  No

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** \_\_\_\_\_



## **DIRECTIONS TO OUR ROCK HILL 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 2.3 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 in approximately 0.5miles- turn into Herlong Professional Park (2<sup>nd</sup> medical park past the hospital on the right).
- Enter this medical park and proceed to the middle building, Building 420. Our office is on the far right of this building, Suite 103.

### **Directions from West (York)**

- Take Highway 5 East toward Rock Hill. Proceed approximately 8 miles.
- Take a left on South Herlong Avenue.
- Proceed 0.9 miles until you see Herlong Professional Park on your left.
- Enter this medical park and proceed to the middle building, Building 420. Our office is on the far right of this building, Suite 103.

### **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 0.9 miles until you get to Herlong Professional Park on your left.
- Enter this medical park and proceed to the middle building, Building 420. Our office is on the far right of this building, Suite 103.

**Dermatologic Surgery of the Carolinas  
420 S. Herlong Ave, Ste 103  
Rock Hill, SC 29732  
Phone: 704-919-1105**



## Dermatologic Surgery of the Carolinas, LLC Medical Appointment Cancellation/ No Show Policy

Thank you for entrusting Dermatology of the Carolinas with your care. When you schedule an appointment with DSC, we reserve that time to provide you with the highest quality of medical care. We understand that life happens, and you will need to cancel or reschedule an appointment. If you need to do so, please do so as soon as possible. This allows us to offer the time you cannot use to someone else who is waiting for care, remaining a good steward of our time to ensure we can maintain our promise to you.

### **Please review the appointment cancellation and no-show policy below:**

Effective 01/17/2022 any established patient who fails to show up or cancels/ reschedules an appointment without proper notice will be subject to a fee. This fee is billed directly to the patient and not covered by insurance.

- **Non-Surgical Appointments** will be charged **\$50** if no shown, cancelled or rescheduled within 24 hours of the scheduled appointment.
- **Surgical Appointments** will be charged **\$150** if no shown, cancelled or rescheduled within 48 hours of the scheduled appointment.
- Patients 15 or more minutes late for any appointment they will be considered a no show and will be charged appropriately.

### **Patient acknowledgment:**

By signing this document, I confirm that I have read and understand the above information and will be subject to a fee if I no show, cancel, or are late to a confirmed appointment without providing at least 48 hours' notice of cancellation. This fee is directly billed to the patient, not the insurance company, and must be paid before rescheduling their appointment or before their next scheduled appointment- whichever comes first. Patients may cancel or reschedule any appointment for any reason, providing greater than 48 hours' notice **without** charge.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (Patient or Legal Guardian)

\_\_\_\_\_  
Relationship to the Patient