



You are scheduled at our Charlotte office on _____ Please arrive at the office at _____.
Thank you

KINDLY GIVE 48 BUSINESS HOURS NOTICE IF YOU MUST CANCEL OR RESCHEDULE

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) 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

- | | | |
|--|---|--|
| <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"/> High Blood Pressure | <input type="checkbox"/> Skin Pre-Cancers (actinic keratoses) |
| <input type="checkbox"/> Atypical moles | <input type="checkbox"/> HIV | <input type="checkbox"/> Skin disorders (other) |
| <input type="checkbox"/> Autoimmune disease (lupus,
rheumatoid arthritis) | <input type="checkbox"/> Keloids or scarring problems | <input type="checkbox"/> Systemic problems (fever/chill/etc.) |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid trouble |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Liver disease or hepatitis | <input type="checkbox"/> Ulcers (stomach) |
| | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Transplant (lung, heart, kidney, liver etc) |
| | <input type="checkbox"/> Muscle aches | <input type="checkbox"/> Other conditions |
| | <input type="checkbox"/> Pacemaker/Defibrillator | Please list: _____ |
| | <input type="checkbox"/> Plastic/cosmetic surgery | |

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):

- | | |
|---|---|
| <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 |
| How many drinks on a typical day? _____ | Do you currently use a tanning bed? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you use recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No | Did you have a flu vaccine within the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No Approx Date _____ |
| | Did you have a pneumonia vaccine in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No Approx Date _____ |



Last Name: _____
First Name: _____ MI: _____
Previous Name: _____
(Maiden name, former married name, etc.)
Mailing Address: _____
(if PO Box, complete Home Address below)
City: _____
State: _____ Zip Code: _____
Home Phone: (____) _____ Cell Phone: (____) _____
Work Phone: (____) _____ Extension: _____
Email: _____

Primary Care Physician: _____
Referring provider: _____
Patient Date of Birth: _____ Male Female
Sexual Orientation: Heterosexual Homosexual Bisexual
 Do not wish to disclose
Gender Identity: Male Female Female to Male Transgender
 Male to Female Transgender Do not wish to disclose
Race: American Indian/Alaskan Native
 Asian/Pacific Islander Black White
Ethnicity: Hispanic Non-Hispanic Do not wish to report
Preferred Language: _____

Responsible Party (if different from patient above):
Statements will be mailed here. This does not change legal responsibility.
Name: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Phone: (____) _____ Email: _____
Relationship to patient: _____

Adult Emergency Contact:
Name: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Phone: (____) _____ Alt. Phone: (____) _____
Relationship to patient: _____

HOME ADDRESS (REQUIRED if PO Box given as mailing address):
Address: _____
City: _____
State: _____ Zip Code: _____

PHARMACY INFORMATION:
Name: _____
Address: _____
Phone: (____) _____

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 CHARLOTTE OFFICE

Ballantyne Medical Two Building
15830 Ballantyne Medical Place (Formerly John J. Delaney Dr)
Suite 225
Charlotte, NC 28277
Phone: 704-919-1105
Fax: 704-910-3163

Directions from Mint Hill / Matthews / Indian Trail:

- Take I-485 South/Inner towards Pineville
- Take Johnston Road South (US-21) Exit 61B
- At the 3rd stoplight, turn right onto Ballantyne Commons Parkway
- At the first stoplight, turn right onto Ballantyne Medical Place (formerly John J. Delaney Drive)
- Look for the blue marquee on the left called Ballantyne Medical Two, building number 15830
- Turn left at the blue Ballantyne Medical Two marquee sign and make a left into the parking lot for building 15830
- Our office is on the 2nd floor, suite 225

Directions from Rock Hill / Fort Mill/Gastonia:

- Take I-485 Outer towards Pineville
- Take Johnston Road Exit 61A
- Make a right onto Johnston Road South (US-21/521)
- At the 2nd stoplight, turn right onto Ballantyne Commons Parkway
- At the 1st stoplight, turn right onto Ballantyne Medical Place (formerly John J. Delaney Drive)
- Look for the blue marquee on the left called Ballantyne Medical Two, building number 15830
- Turn left at the blue Ballantyne Medical Two marquee sign and make a left into the parking lot for building 15830
- Our office is on the 2nd floor, suite 225

Directions from North Charlotte/University:

- Take I-85 South to I-77 South
- Merge onto I-485 Outer towards Pineville
- Take Johnston Road Exit 61A
- Make a right onto Johnston Road South (US-21/521)
- At the 2nd stoplight, turn right onto Ballantyne Commons Parkway.
- At the first stoplight, turn right onto Ballantyne Medical Place (formerly John J. Delaney Drive)
- Look for the blue marquee on the left called Ballantyne Medical Two, building number 15830
- Turn left at the blue Ballantyne Medical Two marquee sign and make a left into the parking lot for building 15830
- Our office is on the 2nd floor, suite 225

Directions from central Charlotte Area:

- Follow Park Road South out of the city until you reach the Pineville area
- When Park Road turns right (3 blocks after South Mecklenburg High School) continue straight on Johnston Road
- Continue on Johnston Rd past Hwy 51 (Pineville-Mathews Road) and over the I-485 overpass.
- After crossing the I-485 overpass, make a Right at the 3rd stoplight onto Ballantyne Commons Parkway.
- At the first stoplight, turn right onto Ballantyne Medical Place (formerly John J. Delaney Drive)
- Look for the blue marquee on the left called Ballantyne Medical Two, building number 15830
- Turn left at the blue Ballantyne Medical Two marquee sign and make a left into the parking lot for building 15830
- Our office is on the 2nd floor, suite 225



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

Thank you for entrusting Dermatology Surgery 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