DERMATOLOGIC SURGERY
OF THE CAROLINAS, LLC

You are scheduled at our Mooresville 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.

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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:_____/_____/_____

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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.

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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 (Year_____)
- ❑ Artificial joints or metal implant (Year_____)
- ❑ 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
  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 **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: _____
- ❑ Skin Cancer (Basal/Squamous cell): _____
- ❑ Other Cancers: _____
- ❑ Psoriasis: _____
- ❑ Eczema: _____
- ❑ Other: _____

Do you smoke? ❑ Yes ❑ No
Do you use smokeless tobacco? ❑ Yes ❑ No
Drink alcoholic beverages? ❑ Yes ❑ No
How many drinks on a typical day? _____
Do you use recreational drugs? ❑ Yes ❑ No

Do you use sunscreen on a daily basis? ❑ Yes ❑ No
Have you had at least one blistering sunburn? ❑ Yes ❑ No
Have you ever used a tanning bed? ❑ Yes ❑ No
Do you currently use a tanning bed? ❑ 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 ___

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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 _____

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DIRECTIONS TO OUR LAKE NORMAN OFFICE

140 Leaning Oak Drive
Suite 102
Mooresville, NC 28117
Phone: 704-919-1105
Fax: 704-910-3163

Directions from Statesville / Troutman:

- Take I-77 South
- Take Exit 36 Hwy NC-150 West towards Lincolnton
- Continue on NC 150 West/ W. Plaza Dr.
- At the 2nd stoplight, turn left onto Williamson Road
- Continue for approximately ½ mile and turn right onto Leaning Oak Drive
- Destination will be on the right in 0.1 miles (Corner of Leaning Oak Drive and Joe Knox Avenue)
- Suite 102 is on the right-hand side of the building behind Lake Norman Dermatology

Directions from Charlotte / Huntersville / Cornelius:

- Take I-77 North
- Take Exit 35 Brawley School Road; Keep left at the fork, follow signs for Brawley School Rd W and merge onto NC-1100/Brawley School Rd
- Once on Brawley School Road, at the 2nd stoplight, turn right onto Williamson Road
- Continue on Williamson Road for approximately 0.4mi and turn left onto Leaning Oak Drive
- Destination will be on the right in 0.1 miles (Corner of Leaning Oak Drive and Joe Knox Avenue)
- Suite 102 is on the right-hand side of the building behind Lake Norman Dermatology

Directions from Denver / Sherrills Ford:

- Take Hwy NC-150 East towards Mooresville
- Turn right onto Morrison Plantation Parkway
- At the first stoplight, turn left onto Plantation Ridge Drive
- Continue approximately 0.3 miles and turn left onto Joe Knox Avenue
- In 430 feet, turn right onto Leaning Oak Drive
- Destination is at the corner of Joe Knox Avenue and Leaning Oak Drive
- Suite 102 is on the right-hand side of the building behind Lake Norman Dermatology

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

Thank you for entrusting Dermatologic 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 cancelation. 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