



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: _____

Subscriber DOB: _____ Subscriber Number: _____

Secondary Insurance: _____ Group/Subscriber Number: _____

HOW DID YOU HEAR ABOUT UPSTATE DERMATOLOGY?

HEALTH AND MEDICATION INFORMATION

Patient Name: _____ Date of Birth: _____

Preferred Pharmacy: _____

Alerts: (check all that apply)

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

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

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

Any other conditions: _____

Past Surgical History: (check all that apply)

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



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? _____.

***PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE ONLY IF YOU ARE 65 YEARS OF AGE OR OLDER.**

(The Centers 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 to meet compliance guidelines for health information continuity and portability purposes.)

1. Have you had a pneumonia vaccination? ___ Yes ___ No.
2. Do you have an advanced care directive with a designated health care proxy in the event you cannot answer for yourself to make your health care wishes known? ___ Yes ___ No.

NOTE: Health care proxy - An advance medical directive is a type of legal document that designates another person (a proxy) to make health care decisions in case a person is rendered incapable of making his or her wishes known. The health care proxy has, in essence, the same rights to request or refuse treatment that the person would have if he or she were capable of making and communicating decisions.

- a. If you have a health care proxy, please list the designee here:

- b. Your health care proxy's relationship to you: _____

- c. Your health care proxy's contact 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.

Patient/Legal Guardian

Date