Dermatology Medical History

Patient: _____ Date of Birth: ____/____/____ Today's Date: ____/____/____

Are you allergic to any medications? ☐Yes ☐No If yes, please list: _____

Primary Care Physician: _____ Is this a referral? ☐Yes ☐No

Have you ever had dental anesthesia (Novacaine)? ☐Yes ☐No Any bad reaction? ☐Yes ☐No

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):

1._____ 2._____ 3._____ 4._____

5._____ 6._____ 7._____ 8._____

9._____ 10._____ 11._____ 12._____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

	YES	NO		YES	NO
Bronchitis	☐	☐	Diabetes	☐	☐
Emphysema	☐	☐	Excessive thirst/hunger	☐	☐
Asthma	☐	☐	Amputation	☐	☐
Chronic Cough	☐	☐	Thyroid	☐	☐
Morning Cough	☐	☐	Kidney	☐	☐
Shortness of Breath	☐	☐	Dialysis	☐	☐
Wheezing	☐	☐	Bladder	☐	☐
High Blood Pressure	☐	☐	Frequency/burning	☐	☐
Chest Pain	☐	☐	Yeast infection when taking antibiotics	☐	☐
Heart Attack	☐	☐	Arthritis/Joint Deformity	☐	☐
Heart Murmur	☐	☐	Arthralgia	☐	☐
Irregular Heartbeat	☐	☐	Limited motion	☐	☐
Phlebitis	☐	☐	Artificial Joint	☐	☐
Inflammation of vein	☐	☐	Gastrointestinal	☐	☐
Blood Clots	☐	☐	Nausea, vomiting, diarrhea when taking antibiotics	☐	☐
Convulsions, Epilepsy, Fainting or seizures	☐	☐	Stomach absorptive disorder	☐	☐
Pacemaker	☐	☐	**Defibrillator**	☐	☐

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin: Have you ever had skin cancer? ☐Yes ☐No If YES, what type? _____

_____

_____

Do you have problems healing? ☐Yes ☐No Do you develop keloids (scars) after surgery? ☐Yes ☐No

Do you bleed easily? ☐Yes ☐No

Has anyone in your family had skin cancer? ☐Yes ☐No If YES, what type? _____

Do you have a history of any specific skin diseases? ☐Yes ☐No If YES, what type? _____

Do you develop skin rashes in reaction to: ☐Medications ☐Food ☐Environment ☐Bandages ☐Topical ☐Neosporin ☐Other: _____

Social History:

Do you drink alcohol? ☐Yes ☐No If YES, number of drinks per day _____ Do you smoke? ☐Yes ☐No If YES, how much: _____

Have you had or have you been exposed to HIV (AIDS) or Hepatitis? ☐Yes ☐No If YES, explain: _____

(Women) Are you pregnant or trying to become pregnant? ☐Yes ☐No If YES, due date: ____/____/____

Occupation: _____ Hobbies? _____

Completed by: ☐Patient ☐Med. Asst. _____ M.A. Init. _____ Signed by Patient Date: ____/____/____

_____ Reviewed by Date: ____/____/____

____/____/____ Updated	____ Init.	____/____/____ Updated	____ Init.	____/____/____ Updated	____ Init.	____/____/____ Updated	____ Init.	____/____/____ Updated	____ Init.
____/____/____ Updated	____ Init.	____/____/____ Updated	____ Init.	____/____/____ Updated	____ Init.	____/____/____ Updated	____ Init.	____/____/____ Updated	____ Init.
____/____/____ Updated	____ Init.	____/____/____ Updated	____ Init.	____/____/____ Updated	____ Init.	____/____/____ Updated	____ Init.	____/____/____ Updated	____ Init.

Carolina Dermatology Clinic, PA
Edward A. Kotz, III M.D. • Amanda H. Wright, PA-C

Consent for Dermatologic Procedures
(Operations, Anesthetics and other Medical Services)

1. I hereby give my informed consent to Dr. Kotz or anyone under the supervision of Dr. Kotz to perform dermatologic procedures for the purpose of skin growth removal/biopsy, local anesthesia, surgery, or cosmetic procedures.

2. I understand that the most common complications of procedures performed on the skin are bleeding, infection, and discoloration. I also understand that the skin heals by scarring and that the degree to which scarring may be visible cannot be determined in advance. It is also possible that nerves may be damaged, especially when performing facial surgery. This may result in impairment of muscles of facial expression.

3. I know that the practice of medicine and surgery is not an exact science and that, therefore, reputable practitioners cannot guarantee results. No guarantee or assurance has been given by Dr. Kotz or anyone in this office as to the results that may be obtained from this procedure.

4. I consent to photographs of my skin and body parts or of the procedure being performed for medical, scientific, or educational purposes provided my identity is not revealed by the picture or by the accompanying descriptive text.

5. I consent to the disposal by Dr. Kotz or whomever he may designate of any tissue which may be removed.

6. I understand that I will receive a separate statement for pathology services should they be required for the examination of any removed tissue.

I have read and understand all of the above.

Signed: _____ **Date:** _____

Witness: _____ **Date:** _____

Updated:

_____ Initials	___/___/___ Date	_____ Initials	___/___/___ Date	_____ Initials	___/___/___ Date
_____ Witness	___/___/___ Date	_____ Witness	___/___/___ Date	_____ Witness	___/___/___ Date
_____ Initials	___/___/___ Date	_____ Initials	___/___/___ Date	_____ Initials	___/___/___ Date
_____ Witness	___/___/___ Date	_____ Witness	___/___/___ Date	_____ Witness	___/___/___ Date

Carolina Dermatology

Edward A. Kotz III, M.D. • Amanda H. Wright, PA-C • Danielle S. DuBiel, PA-C

PATIENT INFORMATION

Last Name: _____ ☐ Male ☐ Female

First Name: _____ MI: _____

DOB: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Ph: (____) _____ Cell Ph: (____) _____

E-mail Address: _____

Employer: _____

Work Phone: (____)_____ Ext. _____

Marital Status: ☐ Single ☐ Married ☐ Divorced

☐ Widowed ☐ Separated ☐ Partner

Emergency Contact:

Name:_____

Phone: (____)_____ Alt. Phone: (____)_____

Pharmacy Information:

Name _____

Phone Number: _____

NEW PATIENTS: complete information below
EXISTING PATIENTS: only complete below if insurance has changed

INSURANCE INFORMATION:

We will take a copy of your card(s) at check in.

Primary Insurance: _____

Secondary Insurance: _____

Does your insurance require a referral to see a specialist? ☐Yes ☐No

Please note: It is the patient's responsibility to obtain any required referrals. Failure to do so may result in denied claims for which the patient will be responsible.

POLICY HOLDER: Only fill out this section if the patient is NOT the insurance policy holder

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ ☐ Male ☐ Female

SSN: _____

Phone: (_____) _____

Carolina Dermatology
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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Carolina Dermatology Clinic, P.A. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Carolina Dermatology Clinic, P.A.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.
Carolina Dermatology Clinic, P.A. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Carolina Dermatology Clinic, P.A., attention Privacy Officer, at 933 St. Andrews Boulevard, S.C. 29407.

I have initialed and given my consent authorizing Carolina Dermatology Clinic, P.A. to disclose protected health information via the following:

_____ Leave information on my voice mail. (Carolina Dermatology can only leave information if your voicemail states your full name)

_____ Leave information with my spouse.

_____ Send text message appointment reminders (standard text messaging fees apply).

_____ Send electronic statements. E-mail address: _____

_____ Leave information with the following person(s):

_____

Description of information to be released:

_____ Information regarding results from any tests (skin biopsies, bloodwork, etc.)

_____ Appointment information

_____ Other information as described: _____

_____

With my consent, may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Carolina Dermatology Clinic, P.A. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Carolina Dermatology Clinic, P.A.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Carolina Dermatology Clinic, P.A. may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

Carolina Dermatology
Edward A. Kotz, III M.D. • Amanda H. Wright, PA-C

Payment Policy

Thank you for choosing Carolina Dermatology for your dermatology needs. We are committed to providing you with quality health care. Please read this updated payment policy, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate with most insurance plans, including Medicare. We are not in-network with any Medicaid plans including Medicaid combined plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Estimates for services will be calculated based on in-network benefits. **Knowing your insurance benefits and obtaining necessary referrals is your responsibility**. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment and/or deductible amounts at each visit. Our office accepts cash, check, all major credit cards, and Care Credit. If you receive your EOB from your insurance and believe you are owed a refund, please contact our office.

3. Pathology and lab fees. Please be aware that any pathology and/or lab fees will be billed separate from your visit. If you have a procedure that requires us to send a specimen to the lab on your behalf, you will receive a statement from that lab. We process and diagnose some specimens in office; you will also receive a separate statement from us for those services. Please advise us at the time of your visit if your insurance company requires you to use a specific lab.

4. Non-covered services. Please be aware that some of the services you receive may be non-covered or not considered medically necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

5. Proof of insurance. All patients must complete our patient information form before being seen. We must obtain a valid copy of your driver's license, or picture ID, and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

6. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information to them directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. Nonpayment. If your account is over 90 days past due, we may refer your account to a collection agency. Partial payments will not prevent your account from being turned over to a collection agency unless otherwise negotiated.

8. Missed appointments. Our policy is to charge for missed appointments. If you are unable to keep your appointment you must provide at least 24 business hours' notice for all regular appointments and 48 business hours' notice for all surgical and cosmetic appointments. Missed regular appointments will be charged a fee of $50, missed surgical or cosmetic appointments will be charged a fee of $100. These charges will be your responsibility and billed directly to you. Please help us to better serve all of our patients by keeping your regularly scheduled appointments.

9. Uninsured patients. We will provide discounted fees to patients who are not covered under any insurance policy.

Our practice is committed to providing the best care for our patients. Our charges are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____
Signature of patient or responsible party **Date**

_____
Print Name