# Welcome and thank you for choosing May River Dermatology, LLC

Effective treatment requires good communication. It is critical that the
New Patient Packet is completed thoroughly so we can meet your needs.

**Pages 2 & 3** (**Social and Medical History**) -Please provide us with your social, medical, family history and list of current medications. If you already have a list of your medications, please attach it to the new patient packet and we will enter that information into your chart.

**Page 4 (Demographic Information) –** Please document your personal information, emergency contact, pharmacy of preference and medical insurance information. We will scan your insurance cards and photo ID so please bring them in with you to your appointment.

**Page 5 (HIPAA Consent)-** The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule gives individuals a right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their individual rights with respect to their protected health information (PHI). By signing this section of the form you consent to our use and disclosure of PHI, payment and health care operations within medical offices and organizations involved with your care.

**Page 6 (Third Party PHI authorization)** – *This is an optional form*. Please let us know the name of anyone (spouse, children, relatives, or friends) you would like to give permission to access and request your health record. If there is no one you would like to authorize please write "none" or put a line across the page and sign.

**Page 7 (Billing Policy)** – This document outlines our standard billing practices. As a courtesy to our patients we will bill their health insurance carrier(s) for medically necessary visits and procedures. In order to do this properly and in a timely manner, we will need accurate insurance information. We also ask that you pay close attention to our policies regarding 1) coinsurance, co-pays, account balances and insufficient funds, 2) biopsies, and 3) the option to leave a credit card on file.

## We look forward to seeing you soon.

May River Dermatology

6470 East Johns Crossing, Suite 200
Johns Creek, GA 30097
Ph 470.282.5729 | Fax 770.674.5795
Dr. Paola Bonaccorsi | Dr. Dale Sarradet

**Patient name:** _____

**Date of Birth:**_____/_____/_____**Today's Date:**_____/_____/_____

**Reason for today's visit:** _____

**Are you allergic to any medications?** • YES • NO If yes, list below:

1._____ 2._____

**List all medications you are currently taking (including prescriptions, over-the-counter, & vitamins)**

1._____3._____ 5. _____

2._____4._____ 6. _____

**Current weight (pounds):**_____ **Height (feet/inches):** _____

**Occupation:**_____

**Please completely fill circle next to answer choice**

**Social History**

| | | | |
|---|---|---|---|
| Smoking Status: O Current Every Day | O Current Some Days | O Former Smoker | O Never |
| Sunscreen use: | O Yes | O No | |
| At least 1 blistering sunburn: | O Yes | O No | |
| Healthcare worker: | O Yes | O No | |

**Past Medical History – Do you have any history of:**

| | | |
|---|---|---|
| Hypertension: | O Yes | O No |
| Heart Disease: | O Yes | O No |
| Diabetes: | O Yes | O No |
| Asthma: | O Yes | O No |
| Arthritis: | O Yes | O No |
| Cancer: | O Yes | O No |
| Pacemaker: | O Yes | O No |
| Artificial valves: | O Yes | O No |

# MEDICAL HISTORY (continued)

| | | | |
|---|---|---|---|
| Are you pregnant or breast feeding?: | O Yes | O No | O N/A |
| Keloid scarring: | O Yes | O No | |
| Problems with healing: | O Yes | O No | |
| Skin disease (eczema, psoriasis, etc.) | O Yes | O No | |
| Atypical moles: | O Yes | O No | |
| HIV positive: | O Yes | O No | |
| Hepatitis C positive: | O Yes | O No | |
| Problems with anesthesia: | O Yes | O No | |

**Surgical History**

| | | | |
|---|---|---|---|
| Artificial hip joint: | O Yes | O No | |
| Artificial knee: | O Yes | O No | |

**Family History**

| | | | |
|---|---|---|---|
| Family history of skin cancer: | O Yes | O No | O Unknown |
| Family history of melanoma: | O Yes | O No | O Unknown |
| Family history of other skin diseases: | O Yes | O No | O Unknown |

**Any Surgery:** _____

**Any Hospitalization (Last 6 months):** _____

**Any Skin Cancer (Type: Basal Cell, Squamous Cell, Melanoma, etc):** _____

_____

_____

**If you are 65 years or older, do you currently have a living will (advance directive) or durable power of attorney for healthcare?**

**Yes / No**

**Any other information you would like us to know:**

_____

_____

# PATIENT DEMOGRAPHICS

**Patient's Name**:_____
First Name MI Last Name

**Date of Birth**_____ **Male: ___ Female: ___ Unknown: ___** **Social Security #**: _____

**Street Address:**_____

**City /State/ Zip Code:**_____

**Primary Phone w/ Area Code:**_____**Cell Phone w/ Area Code**:_____

**Preferred Language:**_____**Race (Black, Hispanic,White, etc):**_____ **Ethnicity :** _____

**Spouse's Name**:_____ **Spouse's Date of Birth:** _____

**Responsible Party:**_____**Relationship:**____Self____Spouse____Parent____Other:_____

**If patient is a Minor,** are parents __Married ___Divorced Custodial Parent:_____

**Custodial Parent's Home Phone w/Area Code:**_____**Work Phone w/ Area Code:**_____

**Custodial Parent's SS #:**_____**Date of Birth:**_____

**In case of emergency, contact:**_____

**Phone Number w/Area Code:**_____**Relationship to Patient:**_____

**(Circle One) Primary Care or Referring Physician:**_____**City:**_____**State:**_____

**Pharmacy Name and Street:**_____

**How did you hear about our practice**?____Primary Care Doctor_____ZocDoc_____Website_____Google/Internet_____Other_____

**Would you like to have access to your medical records, receive appointment reminders and other notifications via a secured patient portal and email?_____Yes_____No**

**Email address**:_____

**SELF PAY**

I currently do not have health insurance coverage. Therefore, I understand that all charges must be paid on the date of service. My payment today will be made by:

____Cash ____Check ____MasterCard/Visa

_____ _____

***Patient's Signature*** **(If patient is a Minor, must have Responsible Party Signature)** **Date**

**INSURANCE**

Insurance Company# 1:_____PRIMARY INSURED'S NAME:_____

Date of Birth:_____Policy #:_____Group #:_____Relationship:_____

Tricare: Active Duty (Yes / No) Sponsor's Name, Date of Birth, SS #: _____

Insurance Company #2 :_____PRIMARY INSURED'S NAME:_____

Date of Birth:_____Policy #:_____Group #:_____Relationship:_____

Tricare: Active Duty (Yes / No) Sponsor's Name, Date of Birth, SS #: _____

- I hereby authorize the payment of medical benefits to May River Dermatology, LLC for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.
- I further agree to pay all collection costs, attorney fees, and other expenses that may be incurred to enforce the collection of any amounts outstanding.
- I hereby authorize May River Dermatology, LLC to release any medical information necessary to complete and process my insurance claims.

_____ _____

***Patient's OR Insured's Signature*** **(If patient is a Minor, must have Responsible Party Signature)** **Date**

Effective Date: April 26th, 2023

# HIPAA CONSENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by:

| _____ | _____ | _____ |
|---|---|---|
| **Patient Name (PRINT)** | **Patient or Legal Guardian Signature** | **Date** |

_____

Relationship to Patient (if other than patient):

# AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THIRD PARTY

(Complete this form if you would like for May River Dermatology, LLC to disclose certain protected health information to family members)

I,_____, authorize May River Dermatology, LLC to use and/or disclose certain protected health information (PHI) as described herein. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I authorize the following person (s) and/or organization(s) to receive my PHI, as disclosed by the person(s) and/or organizations(s) above.

Name(s) & Relationship(s):_____

_____

Contact Telephone Number: _____

_____

Organization(s) & Address: _____

_____

Specific description of PHI that I authorize for disclosure (complete medical records, progress notes, labs, photos, etc):

_____

Specific description of the purpose for each use or disclosure (or write "At the request of the individual "in this space):

_____

This authorization will expire on (date, event, or indefinite): _____

I have the right to revoke this authorization in writing except to the extent that May River Dermatology, LLC has acted in reliance upon this authorization. My written revocation must be submitted to May River Dermatology, LLC Compliance Officer, 350 Fording Island Rd., Suite 100, Bluffton, SC 29910. I further understand that my eligibility for health benefits, my enrollment in a health plan, and my treatment will not be affected by whether or not I sign this authorization.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

_____ _____ _____

**Patient Name (PRINT)** **Patient or Legal Guardian Signature** **Date**

_____

Relationship to Patient (if other than patient)

I,_____, have reviewed this authorization and elected not to complete at this time.

# BILLING POLICY

The following sets forth the general billing policy of May River Dermatology, LLC ("the clinic"). Please review this information and sign where indicated.

- I understand that it is my responsibility to provide the clinic with current, accurate billing information at the time of check in and to notify the clinic of any changes in this information.
- I understand and acknowledge that my credit card on file will be charged the $100 no show fee for each missed appointment and $500 for any surgical missed appointment that is not cancelled within a minimum 24-hour notice. I also consent to my credit card on file being charged for any and all charges for medical services and fees for which I am financially responsible for within 30 days of the statement date.
- A late fee of 1.5% per month (18% APR) may be assessed to any balance which remains unpaid 30 days after the statement date on which the balance first appears.
- I understand that I may be responsible for a 3% surcharge for statements paid via credit card. Should additional account balance information be requested by myself I may be charged $0.50 per page.
- I understand that I am responsible for payment of my account at the time of service for deductibles, non-covered services, medically unnecessary services, copayments and insurance balances. It is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment). I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and the clinic is required to report to the carrier any enrollees failing to pay the co-pay.
- I understand that the clinic will attempt to obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.
- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $30 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check, or credit card.
- I understand if my account is delinquent (sent to an outside collection agency) that I will be responsible for payment in full prior to scheduling future visits.
- I understand that there may be a small fee to copy and mail medical records.
- I understand it is the policy to collect the deductible and/or coinsurance prior to scheduling my surgical procedure. I further understand that THE FEE I AM QUOTED IS AN ESTIMATE based on 1) anticipated surgery to be performed and 2) current information provided to clinic by my insurance carrier.
- Surprise Billing Act – The DHHS has mandated that self-pay and patients with non-participating insurance plans must be given a notice of non-participating status, consent for treatment and a good faith estimate of costs by the healthcare facility or provider. These documents must be provided within 72 hours in advance of scheduled services. Emergency services are exempt from the good-faith estimate requirement, since such services are not scheduled in advance. If notice, consent, and estimate are not obtained in accordance with the Surprise Billing Act, the non-participating healthcare facility or provider must not bill, must not hold liable the participant, beneficiary, or enrollee. If a patient feels that a non-participating facility or provider has violated any provision of the Surprise Billing Act, they may file a dispute with the DHHS. The dispute resolution process must start within 120 calendar days of the date on the original bill. If the agency agrees with the patient, the patient will pay the amount on the good faith estimate. If the agency agrees with the healthcare facility or provider, the patient will pay the higher fee shown on the bill. There is a $25 fee to use the dispute process.

  To learn more or obtain a form to start the dispute process, call 1-877-696-6775 or visit the DHHS website.

**Initials**

_____ Please be aware that if a biopsy is required at your visit, you will receive a separate bill for this service. The specimen is sent to a pathology lab, where a physician (pathologist) interprets the tissue. This physician will bill you directly for this service. If your insurance requires us to use a specific lab, you must notify us in advance of your visit and we will do our best to accommodate your needs. If you have any problems with your bill from the pathologist, please call our office and we will be happy to help you resolve the matter.

_____ I understand that I will be billed for any amounts due by me (copayments/coinsurance/deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I understand should my account become delinquent, May River Dermatology, LLC will refer my account to a collections agency and I agree to pay all of the collection costs that are incurred. May River Dermatology reserves the right to report my account status to any credit reporting agency such as a credit bureau. The collection agency shall not engage in any collection actions until 180 days after the past due bill has been sent to me. I further understand I may be contacted at any telephone number associated with my account, including wireless phone numbers which could result in charges to me.

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My signature below confirms that I have read these billing policies and my financial obligation as pertains to May River Dermatology, LLC.

_____ _____

***Patient's OR Insured's Signature*** **Date**

(If patient is a Minor, must have Responsible Party Signature)

Effective Date: April 26th, 2023