Appointment Time _____ Date_____

1706 St. Julian Place
Columbia SC 29204

Welcome to Carolinas Dermatology Group! Your doctor has referred you to see Dr. Long Quan for the removal of your skin cancer. This procedure is called MOHS (Micrographic Surgery). Below are a few helpful reminders concerning your surgery day.

- THIS IS AN ALL DAY PROCEDURE! Please be prepared to be in our office all day. Please make sure that you do not have any other appointments or places you need to be at, at a certain time.
- We recommend you wear comfortable clothing sine you will be sitting and waiting most of the day.
- Please stop taking **Aspirin** and **Vitamin E** at least two (2) weeks before and two (2) weeks after surgery, unless you have a had a heart attack or stroke, or you have been directed by your doctor to continue taking it. This will control any bleeding before and after your surgery.
- **IF YOU HAVE A HISTORY OF A HEART ATTACK, STROKE, PACEMAKER, OR DEFIBRILLATOR, PLEASE CONTINUE TO TAKE YOUR MEDICATIONS.** If you have any questions concerning the medications you take, please call our office (803) 771-7506 ext. 217.
- We use a local anesthetic so you may eat, drink and take any medications the night before and the morning of the surgery. We recommend you eat a good breakfast before coming to your surgery appointment.
- Please have your photo ID and insurance cards with you so that we may file your insurance for you. Please completely fill out all of the new patient paperwork and bring the paperwork with you to your appointment. **DO NOT MAIL THESE FORMS BACK TO THE OFFICE**
- Please do not wear any perfumes or fragrances (including lotions and oils) the day of the surgery.
- We have enclosed directions to our office. Should you have any questions or concerns, please call our office at (803) 771-7506 ext. 217.

Directions to Carolinas Dermatology Group, P.A.

From I-20:

-Take I-20 to I-77 South (towards Charleston)
-Take exit 12 (Forest Drive exit)
-Take a right onto Forest Drive (away from Ft. Jackson)
-You will go thru two (2) major intersections (Trenholm & Forest Dr and Beltline & Forest Dr)

DO NOT TURN OFF OF FOREST DRIVE

-Take a right into Middleburg Park. This will be St. Julian Place (the 4th light after you cross over Beltline Blvd)
-Carolinas Dermatology Group will be the 4th building on the right

From I-26:

-Take I-26 (towards Columbia)
-Merge onto I-126 (towards downtown Columbia)
I-126 will turn into Elmwood Street
-Take a right onto Bull Street
-Take Bull Street to Taylor Street
-Then make a left onto Taylor Street
Taylor Street will turn into Forest Drive after you cross over Harden Street
-Once on Forest Drive there will be a CVS Pharmacy on your left hand side

CONTINUE STRAIGHT ON FOREST DRIVE

-Take a left onto St. Julian Place (the second stoplight after the CVS Pharmacy)
-Carolinas Dermatology Group will be the 4th building on the right

From I-77:

-Take exit 12 (Forest Drive exit)
-Turn heading away from Ft. Jackson
-You will go thru two (2) major intersections (Trenholm & Forest Dr and Beltline & Forest Dr)

DO NOT TURN OFF OF FOREST DRIVE

-Take a right into Middleburg Park. This will be St. Julian Place (the 4th light after you cross over Beltline Blvd)
-Carolinas Dermatology Group will be the 4th building on the right

CAROLINAS DERMATOLOGY GROUP, P.A. 1706 ST. JULIAN PLACE, COLUMBIA, SOUTH CAROLINA 29204 TELEPHONE: (803) 771-7506

Date: _____

Chart #_____

Payment Policy for Carolinas Dermatology Group, P.A.

Please be advised that payment is due at time of service. This includes ALL co-payments, co-insurances, deductibles and full payment if you do not have insurance. If you need to make payment arrangements please contact our office.

Responsible Party Policy for Carolinas Dermatology Group, P.A.

If the patient that is having a procedure with our office is not the responsible party for themselves, or there is a legal guardian/representative, please provide that information for our records.

Responsible Party Name _____

Relationship to the patient _____

Responsible Party Phone # _____

If the patient lives in an assisted living/nursing home, please call our office to receive additional details on the appointment. **803-771-7506 ext. 217**

Thank you!

CAROLINAS DERMATOLOGY GROUP, P.A. 1706 ST. JULIAN PLACE, COLUMBIA, SOUTH CAROLINA 29204 TELEPHONE: (803) 771-7506

Date: _____

Chart #_____

Full Name: _____ Sex: Male Female Marital Status: S M D W

Date of Birth: _____ Social Security #:_____

Street Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone#: _____ Cell Phone #: _____ Work Phone #: _____

Primary number for appointment reminders/communication #:_____

Emergency Contact: _____ #: _____

Employer Name: _____ Employer Phone #:_____

Employer Address_____ City: _____ State: _____ Zip: _____

☐ CHECK HERE TO DECLINE ANSWERING THE FOLLOWING 3 QUESTIONS

1) My preferred language is:
- A. English
- B. Spanish
- C. Other _____

2) My race is: (please circle one answer)
- A. American Indian/Alaskan Native
- B. Asian
- C. Black or African American
- D. Native Hawaiian or Pacific Islander
- E. White/Caucasian
- F. Other _____

3) My Ethnicity is: (please circle one answer)
- A. Hispanic or Latino
- B. Not Hispanic or Latino

(Information about Your Parent/Spouse)

Parent/Spouse's Full Name: _____ Parent Phone Number: _____

Parent's Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance to File

Insurance Co. Name: _____ Relationship to Patient: _____

Insured's DOB: _____ Insured's Social Security # _____

Insurance Card ID #: _____ Group #: _____

Insured's legal name: _____

Insured's Address (if different from patient): _____

_____

Secondary Insurance to File

Insurance Co. Name: _____ Relationship to Patient: _____

Insurance Card ID #: _____ Group #: _____

Insured's DOB: _____ Insured's Social Security # _____

I understand that payment is due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize this authorization allows Carolinas Dermatology Group, PA to release any information to any of my insurers or physicians as requested by any such insurer or physician.

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED INCLUDING MEDICARE, PRIVATE INSURANCE, GROUP POLICY BENEFITS AND OTHER HEALTH PLANS TO CAROLINAS DERMATOLOGY GROUP, PA**. IF MY INSURANCE REQUIRES A REFERRAL OR PREAUTHORIZATION, IT IS MY RESPONSIBILITY TO OBTAIN THAT**. I HEREBY AGREE TO PAY ALL COSTS AND REASONABLE FEES IN THE EVENT THIS ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY. You agree that the information provided is true, accurate, current and complete contact information about yourself and your health insurer. You agree that it is your responsibility to maintain the accuracy of your information and your health insurers' information. You understand that false information is subject to a criminal penalty under law, and that you are responsible for all and any information provided.

Cancellation/ No Show Policy

We understand that there are times when you must miss an appt due to emergencies or obligations for work or family. However, when you do not call to cancel an appt, you may be preventing another patient from getting much needed treatment. **If an appt is not cancelled at least 24 hours in advance you may be charged a $25 fee; this will not be covered by your insurance company**

Signature: _____ Date: _____

Responsible Party's Signature (if different):_____ Responsible Party's DOB: _____

CAROLINAS DERMATOLOGY GROUP, P.A. 1706 ST. JULIAN PLACE, COLUMBIA, SOUTH CAROLINA 29204 TELEPHONE: (803) 771-7506

Date: _____ **Name:_____**

Chart #_____

Health Questionnaire

Family History (primary relative)

Non-Melanoma Skin Cancer	□**Y**□**N**
Melanoma	□**Y**□**N**
Rheumatoid arthritis	□**Y**□**N**
Lupus or other collagen vascular disease(s)	□**Y**□**N**
Psoriasis	□**Y**□**N**
Other genetic disease(s)	□**Y**□**N**

Medical History

Do *you* have any of the conditions?

AIDS/HIV	□**Y**□**N**	Glaucoma	□**Y**□**N**
Bleeding disorder	□**Y**□**N**	Anemia	□**Y**□**N**
Heart condition(s) or murmurs	□**Y**□**N**	Diabetes	□**Y**□**N**
Hepatitis B/Hepatitis C/cirrhosis	□**Y**□**N**	Thyroid disorder	□**Y**□**N**
Keloid abnormal scar	□**Y**□**N**	Asthma	□**Y**□**N**
Pacemaker	□**Y**□**N**	Defibrillator	□**Y**□**N**
Currently pregnant or Breast feeding	□**Y**□**N**	Tanning bed use	□**Y**□**N**
Join replacement in past 2 years	□**Y**□**N**	Hypertension	□**Y**□**N**
Lupus or other collagen vascular disease(s)	□**Y**□**N**	Hypertension	□**Y**□**N**
Non-melanoma skin cancers	□**Y**□**N**	Rheumatoid arthritis	□**Y**□**N**
Melanoma (If yes, location & depth):_____			□**Y**□**N**
Other Conditions: _____			□**Y**□**N**

Email Address: **_____**

Pharmacy _____ **Pharmacy Phone#: _____**

Pharmacy Address: _____

Referring physician _____ **Primary Care Physician_____**

Do you live in a Skilled Nursing Facility? If yes, name of Facility _____

Have you had a flu shot this flu season? □Y□N If yes, please indicate where: □ doctors office □ work □ hospital □ during surgery

History of pneumococcal vaccination within past 5 years? □Y□N

Smoking status: □ Current smoker □ Former smoker □ Non-smoker

Are you allergic to any medication(s)/food material? □Y□N If yes, check/list □ PCN □ Codeine □ Other: _____

_____

Please list all Current Medications (including all OTC meds): _____

_____

Do you take Aspirin/Motrin: □Y□N If yes, Dosage: _____

Signature of Patient or Personal Representative: **_____*Date:*** **_____**

Physician Signature: **_____*Date:*_____**

CAROLINAS DERMATOLOGY GROUP, P.A. 1706 ST. JULIAN PLACE, COLUMBIA, SOUTH CAROLINA 29204 TELEPHONE: (803) 771-7506

Date: _____ **Name:_____**

Chart #_____

Authorization Regarding Payment and Release of Medical Information

I hereby authorize and request the payment of services from Medicare, Medicaid and/or other insurance plans or payers be made on my behalf to Carolinas Dermatology Group, PA. I hereby assign to Carolinas Dermatology Group, PA all payments for treatment services. I understand and agree that I am responsible for paying any amount not covered by Medicare, Medicaid and/or other insurance plans or payers.

I hereby authorize the release of medical information to Medicare, Medicaid and/or insurance plans or other payers. I also authorize the release of medical information to other healthcare providers including, but not limited to, my primary care or family physician, consulting physicians or healthcare providers, hospitals, pharmacies, rehabilitation centers or other healthcare providers or facilities. I permit a copy of this authorization to be used.

Printed Patient/Representative's Name: _____

Relationship to Patient: _____

Patient/Representative's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Authorization to Release Medical Information

I understand that my medical records are protected under State and Federal confidentiality regulations. If our staff calls to discuss your care or leave a test result, are there members of your household that we can discuss your medical information with? □ Yes □ No
If yes, please specify:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This authorization expires in: □ 6 months □ 1 year □ other (must specify): _____

_____ _____
Patient/Responsible Party Signature Date:

CAROLINAS DERMATOLOGY GROUP, P.A. 1706 ST. JULIAN PLACE, COLUMBIA, SOUTH CAROLINA 29204 TELEPHONE: (803) 771-7506

Date: _____ **Name: _____**

Chart #_____

Revised October 2014

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCEESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.
www.carolinasdermatology.com

At Carolinas Dermatology Group, P.A., we are committed to protect the privacy of your personal health information (PHI). This Notice of Privacy Practices describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice. We may change our Notice, at any time. Any changes will apply to all PHI. **If you wish to have a copy of this notice, please notify the front desk.**

Uses and Disclosures of Protected Health Information

-Health professionals who contribute to your care
-Insurance companies, health plans
-Government agencies in order to assist with qualification of benefits
-Billing companies
-Collection agencies

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations. (Treatment, Payment and Operation)

Uses and Disclosures that require written authorizations

-Marketing
-Disclosure for any sales purposes
-Psychotherapy notes
-Physicians not related to TPO

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

We may use and disclose your PHI in other situations without your permission: **we DO NOT participate in without your consent*

-If required by law
-Public health activities*
-Health oversight agencies*
-Police or other law enforcement purposes
-Health Information Exchange*
-Legal Guardians/Representatives
-Coroners, funeral directors
-Special government purposes
-Correctional institutions
-Workers' Compensation*
-Fundraising Activities*
-Family members present with you at the time of service*
-Business Associates*
-Medical research*
-Treatment alternatives*
-Legal proceedings
-Appointment reminders

Your Privacy Rights

-Request an amendment of your health information
-Request for us to communicate in different way or location
-To receive notification of any breach of your PHI
-Obtain a list of people/organizations who have received your PHI from us.
-To see and obtain a copy of your PHI.
- Request a restriction of your PHI.

All requests to exercise your rights must be made in writing, please contact our Security and Privacy officer for details on how to complete that request, (803) 771-7506.

For More Information or to Report a Problem

If you think we have violated your rights, or you need more information about our privacy practices you can contact our Security and Privacy officer at (803) 771-7506 or you can contact the Office for Civil Rights, U.S. Department of Health and Human Services at the address listed below:
Office for Civil Rights, U.S. Department of Health and Human Services
200 Independence Ave, S.W. Room 509F, HHH Building Washington, D.C. 20201

Acknowledgement of Carolinas Dermatology Group, P.A. Notice of Privacy Practices

_____ _____
Patient/Responsible Party Signature Date