Fort Mill Dermatology, LLC
1700 First Baxter Crossing, Suite 101
Fort Mill, South Carolina 29708-8950

Rebecca L. Smith, MD
Julie P. Iannini, MD

Board Certified Dermatologists

Welcome to Fort Mill Dermatology!

Attached is our Patient Registration Package. Please complete these so we can maintain accurate contact and medical records. If you printed these forms from our website, you may fax them to us at 803-802-3329 prior to your appointment. Please bring the completed original forms with you to your appointment along with the other items listed at the bottom of this letter.

We realize that you have a choice of where to be treated. We also realize that you place a great deal of trust in your physician to provide you with the most up to date information and treatment options regarding your skin care health. We do appreciate and value the trust you have placed in us.

Fort Mill Dermatology specializes in the diagnosis and treatment of skin, hair and nail disease. We provide our patients and their families with comprehensive dermatologic care. We want to help you get the best of what today's medicine has to offer. We are highly committed to quality patient care with an emphasis on individual attention for each patient. Our focus is to provide quality time for each patient. Providing the best service, in a comfortable, private atmosphere is extremely important to us. We will do our best to give you total satisfaction.

We place a high value on our relationship with our patients. We especially value patient feedback. Therefore, we will ask you to communicate to us your experiences with us. Be assured your feedback matters. It helps us continue to serve you and our other patients with the highest level of care possible. If you have any questions or concerns, please do not hesitate to ask any member of our team.

Warmest Regards,

Rebecca L. Smith, M.D.
Julie P. Iannini, M.D.

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REMINDERS OF REQUIRED ITEMS FOR YOUR VISIT

- **Insurance Card**
  If you have health insurance, we can't see you without making a copy of your insurance card.
- **Written Referral** from your Primary Care Physician if required by your insurance plan or verify that it has already been faxed to us by your primary care physician.
- **Co-pay** or **Deductible** is collected at check in
- **Cosmetic procedure fees** are due at time of visit
- **Completed Patient Registration Package**
- **Parent or Legal Guardian must accompany patients who are minors**

Patients MUST sign and date below before medical care can be rendered.

PATIENTS WHO ARE MINORS: Parents or legal guardians must sign for patients who are younger than eighteen. A parent or legal guardian must be present at all visits for any patient younger than sixteen.

Privacy Practices (HIPAA)

We use the contact information that you provide for appointment reminders and to contact you regarding your appointments and care. By signing below, I acknowledge that I have read and understand Fort Mill Dermatology's Notice of Privacy Practices, which is posted on the Fort Mill Dermatology website and is also available at the check-in desk.

Release of Medical Information

By signing below, I authorize the release of medical information to my primary care and/or referring physician, to medical consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions.

Financial Policy

Payment is required for all services at the time they are rendered unless the patient is in an insurance plan with which we participate. We accept payment in the form of cash, check, and most credit cards. In the event that your account must be turned over to collections or becomes delinquent, a $25.00 fee will be added to your account. Accounts that are delinquent after 45 days of being sent to collections may accrue additional collection agency fees and legal fees. For appointments which are missed or canceled with less than 24 hour notification, there may be a $25.00 missed appointment fee added to your account. Please understand that missed appointments with little or no notice prevent other patients who are on a waiting list from being seen by the doctor. A $25.00 fee is assessed for all returned checks. Your signature below signifies your understanding and willingness to comply with this policy.

I have read and understand the financial policy statement. I agree to make in-full prompt payment to Fort Mill Dermatology when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered. Further, I authorize payment directly to Fort Mill Dermatology for medical insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed for my treatments.

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.

Patient Name: _____

Patient Signature: _____ Date:_____/_____/_____

Guardian Name (if patient is younger than 18): _____

Guardian Signature: _____ Date:_____/_____/_____

Fort Mill Dermatology LLC

How did you find us?
❑ Family/Friend - Name:_____
❑ Insurance Provider List
❑ Internet Search
❑ Newspaper Ad
❑ Physician - Name:_____
❑ Yellow Pages
❑ Other_____

PATIENT INFORMATION

Last Name: _____

First Name: _____ MI: _____

Preferred Name: _____
("John", "Mr. Jones", etc.)

Mailing Address:_____
(if PO Box, complete Street Address below)

City:_____ State: _____ Zip:_____

Street Address:_____
(complete only if Mailing Address provided above is a PO Box)

City:_____ State: _____ Zip:_____

Email _____

PCP/Family Doctor: _____

Patient Date of Birth: _____ ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Partner

Patient Social Security Number: _____

SEND PATIENT STATEMENTS TO:
❑Patient ❑Primary Ins Policy Holder ❑Secondary Ins Policy Holder
❑Other:
Name_____ Relation _____

Address:_____
(if different from patient's)

City:_____ State: _____ Zip:_____

Preferred Phone: (_____)_____ ❑Cell ❑Home ❑Work ❑Other: _____

Alternate Phone: (_____)_____ ❑Cell ❑Home ❑Work ❑Other: _____

Alternate Phone: (_____)_____ ❑Cell ❑Home ❑Work ❑Other: _____

INSURANCE INFORMATION ❑ Self Pay *(no insurance or Blue Cross/Blue Shield PPO)*

Primary
Insurance:_____ ID#:_____

Policy Holder:
❑ Patient (if not patient, complete information below)
❑ Name:_____ DOB:_____

SS# _____ Relation _____

Address:_____
(if different from patient's)

City:_____ State: _____ Zip:_____

Secondary
Insurance:_____ ID#:_____

Policy Holder:
❑ Patient (if not patient, complete information below)
❑ Name:_____ DOB:_____

SS# _____ Relation _____

Address:_____
(if different from patient's)

City:_____ State: _____ Zip:_____

Does your insurance plan require you to have a referral to see a specialist? ❑ No ❑ Yes ❑ I don't know
NOTE: It is the patient's responsibility to get any required referrals. Failure to do so may result in denied claims and the patient will be responsible for all services rendered.

IMPORTANT – WE ARE NOT CONTRACTED WITH ANY WORKERS COMP OR MEDICAID PLANS.

CMS QUALITY REPORTING INFORMATION: My preferred language is: ❑ English ❑ Spanish ❑ Other
Race (optional): ❑ White ❑ Black/African American ❑ Asian ❑ Hispanic ❑ American Indian/Alaska Native ❑ Native Hawaiian ❑ Other

PHARMACY INFORMATION (WHERE YOU MOST OFTEN GET PRESCRIPTIONS FILLED):

Pharmacy 1: _____ Location: _____ Phone: (_____)_____

Pharmacy 2: _____ Location: _____ Phone: (_____)_____

Mail Order: _____ Location: _____ Phone: (_____)_____

CONTACT IN CASE OF EMERGENCY: ❑ Check only if this person is **NOT** to be included in MEDICAL RELEASE section below.

Name: _____ Phone #(s):_____ Relationship:_____

MEDICAL RELEASE: Please list any persons to whom your protected health information can be disclosed (e.g., spouse, parent, etc):

Name: _____ Phone #(s):_____ Relationship:_____

Name: _____ Phone #(s):_____ Relationship:_____

Signature (Patient or Guardian) _____ **Date** _____

Fort Mill Dermatology LLC

OFFICE USE:

Exam Room:_____

❑ SP/BCBS ❑ Smith ❑ Iannini

MEDICAL HISTORY

Patient_____ **Reason for visit:**_____ **Appointment Date:**_____

Did a doctor's office send you to us for a specific problem? ❑ Yes ❑ No If YES, name of referring provider: _____

List any medications, herbal supplements and/or vitamins you are currently taking: ❑ Not taking any medications

_____ _____ _____

_____ _____ _____

Do you have or have you had any of the following? *(if yes, please check)* ❑ None

- ❑ Acne
- ❑ Artificial heart valve
- ❑ Artificial joints or metal implant
- ❑ Atopic Dermatitis
- ❑ Atypical moles
- ❑ Autoimmune disease (lupus, rheumatoid arthritis)
- ❑ Bleeding disorder
- ❑ Blood clots
- ❑ Cold sores/herpes
- ❑ Depression
- ❑ Diabetes
- ❑ Heartburn/Reflux
- ❑ HIV
- ❑ High blood pressure/Hypertension
- ❑ Keloids or scarring problems
- ❑ Kidney disease
- ❑ Liver disease or hepatitis
- ❑ Lung disease
- ❑ Psoriasis
- ❑ Seasonal allergies/asthma
- ❑ Skin Cancer
- ❑ Skin Pre-Cancers (actinic keratoses)
- ❑ Thyroid trouble
- ❑ Ulcers (stomach)
- ❑ Other conditions
  Please list:_____

Female patients (check all that apply): I am ❑ pregnant ❑ nursing ❑ planning to become pregnant in the near future

Are you allergic to any medications/anesthetics? ❑ Yes ❑ No
(if yes, please list)

_____ _____ _____

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-Other: _____
- ❑ Other Cancers: _____
- ❑ Psoriasis: _____
- ❑ Eczema: _____
- ❑ Other: _____

Your Occupation (please specify):_____

Smoking Status:
❑ Never ❑ Former ❑ Current Daily ❑ Current Occasional

Do you use smokeless tobacco? ❑ Yes ❑ No
Drink alcoholic beverages? ❑ Yes ❑ No
Do you use recreational drugs? ❑ Yes ❑ No

Do you use sunscreen on a daily basis? ❑ Yes ❑ No
Have you traveled outside the U.S. in past 3 months? ❑ 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

Have you RECENTLY had any of the following? (*Please check all that apply)* ❑ None

- ❑ Other skin complaints
- ❑ Other systemic complaints
- ❑ Fever/chills/wt. change
- ❑ Sun sensitivity
- ❑ Itching
- ❑ Muscle Aches
- ❑ Joint Aches
- ❑ Ringing in ears

Thank you for taking the time to help us give you the highest quality care.

Fort Mill Dermatology LLC

To Our Patients:

In our efforts to continuously improve our patient service and office efficiency, you will be asked for a credit card number at the time you check in. That information will be held securely (as are your medical records) until your insurances have paid their portion and notified both you and us how much, if any, is your portion. At that time, any remaining balance owed by you may be charged to your credit card and it will be presented on your credit card statement. It is our company policy to call you prior to applying any charge over $15.00 to your credit card and we always mail a receipt unless you otherwise specify.

This will be an advantage to you, because it will save writing and mailing another check. It will be an advantage to us as well, because it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down. **If you have a credit card that is designated for health care expenses, such as an HSA, FSA, or flex spend card, then this is the card you should put on file for any medical expense balances.**

You can think of this as much like when you check into a hotel or rent a car; you are asked for a credit card which is imprinted and later used to pay your bill.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

If you have any questions about this payment method, please do not hesitate to ask.

Sincerely yours,

Fort Mill Dermatology, LLC

I authorize Fort Mill Dermatology, LLC to charge outstanding patient portion balances for me and my dependents to the following credit card:

Card Type: ❑ Visa ❑ Mastercard ❑ Discover ❑ American Express

Category: ❑ Debit ❑ Credit ❑ Healthcare Credit/Debit Card (HSA, FSA, health flex spend, etc.)

Account Number _____

Expiration Date _____ Zip Code where statement is mailed: _____

Signature _____ Date _____

Full name on card (please print) _____

Frequently Asked Questions about our Credit Card Policy:

Why is Fort Mill Dermatology, LLC requiring a credit card agreement from patients?
This practice will improve efficiency for everyone, and lower total costs of providing service to our patients. It will also allow us to focus our energies on providing dermatologic care, rather than patient billing.

When will my credit card be charged?
As a courtesy to our patients, we submit claims to their insurance within a few days of providing the patient service. Claims are typically settled by insurance companies within 2 – 8 weeks after service was provided. Once a claim is adjudicated, your card will be charged for your portion. It is our company policy to call you prior to applying these charges to your credit card when the amount exceeds $15.00. This saves time, paper, and postage for both you and our practice.

How will I know how much the charge will be?
Insurance typically sends an Explanation of Benefits (EOB) to both the patient and the provider after claims have been settled that explains the contracted fees agreed between our office and the insurance. The EOB also shows whether any of the agreed upon fee must be paid by patient in the form of co-pay, co-insurance, or deductible. At that time, any patient balance is due in full.

What if I do not agree with the patient portion as specified by my insurance?
As the customer of the insurance company, patients can exercise procedures with their insurance for handling disputes as to whether insurance or patient is responsible for a particular fee. These procedures are typically regulated by state governments. Our office's position is that the patient is ultimately responsible for the cost of the service provided, up to the amount allowed by an insurance plan that our office accepts. We are not a party to disputes involving what portion of payment is the patient's versus the insurance's. Nonetheless, we will provide our expertise to our patients as a resource to help facilitate understanding of what their insurance company communicates to them about their contract.

What if I still do not agree with the charge applied to my card?
Our office's billing staff will review each patient's situation before applying a charge. In the event of any question or issue, please do not hesitate to contact our billing staff or office manager and we will work to resolve it as quickly as possible. As a last resort, our patients should rest assured that credit card issuers typically have procedures for a cardholder to dispute a charge applied by any merchant. Credit card companies can typically suspend or reverse charges if they determine it was not appropriate.

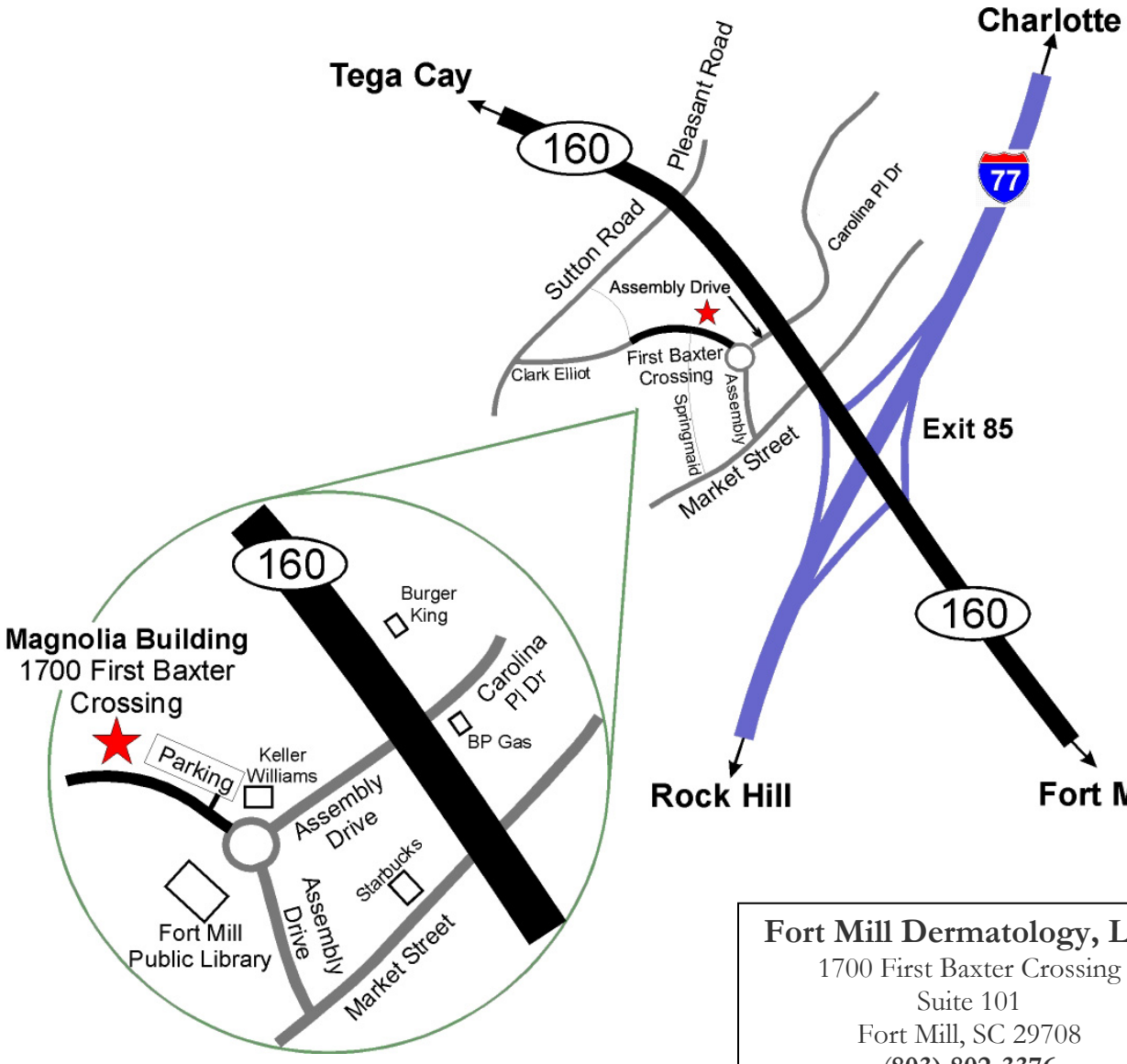
What if I don't have a credit card, or do not want to participate? Is this mandatory?
This is offered as a payment option for the convenience of our patients. It becomes mandatory for patients who do not abide by the Fort Mill Dermatology's financial policy.

Sincerely yours,
Fort Mill Dermatology, LLC

Fort Mill Dermatology is located in the Magnolia Building in Baxter Village near the intersection of SR-160 and I-77 (two exits south of Carowinds amusement park).

Directions from I-77:

- Take SC **Exit 85** and turn **west toward Tega Cay** at the top of the ramp onto SR-160
  - (RIGHT onto SR-160 if coming from Charlotte)
  - (LEFT onto SR-160 if coming from Rock Hill/Columbia)
- From the I-77 ramp take the **Second Left** at the **traffic light** onto Assembly Drive into Baxter
- Enter the round-about and you will see the Fort Mill Library straight ahead
- **First right** onto First Baxter Crossing
- **First right** into our parking lot
- We are located in the red brick Magnolia Building at the far end of the parking lot.



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