LOW COUNTRY DERMATOLOGY
Patient Information Form

Date_____ Appt. Date_____ New Patient ☐ Former Patient ☐ Doctor _____

How did you hear about us… ☐ Physician Referral ☐ Internet ☐ Television ☐ Radio ☐ Newspaper ☐ Friend/Family ☐ Other _____

Referring Physician_____ Phone Number_____ Primary Care Physician _____

Reason for Visit/Referral_____ Date of Onset _____

Patient's Personal Information

Male _____ Female _____

Name_____ DOB _____ SSN_____ Marital Status M S W D
(Last First MI)

Street Address_____ City_____ State_____ ZIP_____

Mailing Address_____ City_____ State_____ ZIP_____
(If different from above)

Home Phone_____ Work Phone_____

Employer's Name_____ Address _____

Occupation_____ Phone Number_____ ext. _____

Guarantor's Personal Information

(Person responsible for bill) Male _____ Female _____

Name_____ DOB _____ SSN_____ Marital Status M S W D
(Last First MI)

Street Address_____ City_____ State_____ ZIP_____

Mailing Address_____ City_____ State_____ ZIP_____
(If different from above)

Home Phone_____ Work Phone_____

Employer's Name_____ Address _____

Occupation_____ Phone Number_____ ext. _____

Spouse Information

Name_____Address (If different from patient) _____

DOB_____ SSN_____ Home Phone_____ Work Phone_____

Employer's Name_____ Address_____ Occupation _____

Insurance Information

Primary Insurance _____ Group Number_____ Policy Number _____

Claims Address_____
(City State ZIP)

Insured_____ Patient Relationship to Insured _____

Insured SSN_____ Insured DOB_____ Co-pay $ _____

Secondary Insurance _____ Group Number_____ Policy Number_____

Claims Address_____
(City State ZIP)

Insured_____ Patient Relationship to Insured _____

Insured SSN_____ Insured DOB_____ Co-pay $ _____

Emergency Contact (Not living in same household) Name_____

Address_____ Phone No._____Relationship_____

Authorization to Treat and Release

In connection with my care and treatment I authorize Low Country Dermatology to release to, and receive from, any Doctor, Hospital, Clinic, other Healthcare Provider, or Insurance Carrier any medical records or information relating to my health, including without limitation, any information relating to illness or disease cause, treatment, diagnoses, prognoses, laboratory and/or radiology test and/or procedures, and prescriptions. The forgoing shall include records, and information relating to HIV infection, any disorder of the immune system including Acquired Immune Deficiency Syndrome (AIDS), Mental Illness, and/or use of alcohol or drugs. **Your signature below fully authorizes our staff and doctors to perform examinations, diagnostic test and/or treatment, as we may consider it necessary.**

I agree to notify Low Country Dermatology of any changes pertaining to my address and/or insurance information.

Signature:_____ (If minor, signature of parent or guardian) Date _____

Assignment

I authorize direct payment form my Insurance Company to my provider. At any time should I decide that I want to file my own claims, I understand that payment in full will be required at the time of service. I also understand that I will be financially responsible for all charges incurred.
We will file non-contracted insurance as a courtesy; however, if we have no response from your insurance company within 60 days, the charge(s) will be transferred to your responsibility to pay.

Signature:_____ (If minor, signature of parent or guardian) Date _____

Low Country Dermatology

Dermatology Medical History

Patient: _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? ☐ YES ☐ NO If yes, please list:_____

Have you ever had a reaction to dental anesthesia (Novocaine) or local anesthesia (Lidocaine)? ☐ YES ☐ NO

Explain, If yes _____

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

_____

_____

Primary Physician _____

General Health: _____ Poor _____ Fair _____ Good _____ Excellent

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

Lungs:	**YES**	**NO**
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Tuberculosis	☐	☐
Shortness of Breath	☐	☐
Cardiovascular:	**YES**	**NO**
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Pacemaker	☐	☐
Varicose Veins	☐	☐
Blood Clots	☐	☐
Bleeding Disorders	☐	☐
Prolonged Bleeding	☐	☐
Anemia	☐	☐
Stroke	☐	☐
Skin:	**YES**	**NO**
History of Skin cancer	☐	☐
If yes, type _____		
Family history of skin Cancer	☐	☐
If yes, type _____		
History of specific skin Diseases	☐	☐
Problems with healing	☐	☐
Excessive scarring/Keloids	☐	☐
Easy Bleeding	☐	☐
Skin Rashes	☐	☐
Reaction to Medication	☐	☐
Reaction to Food	☐	☐
Reaction to Environment	☐	☐
Sensitivity to Sunlight	☐	☐

Other Systemic:	**YES**	**NO**
Diabetes	☐	☐
Lupus	☐	☐
Thyroid Disease	☐	☐
Kidney Disease	☐	☐
Bladder Infections	☐	☐
Connective Tissue	☐	☐
Stomach Ulcers	☐	☐
Nausea, Vomiting, Diarrhea when taking antibiotics	☐	☐
Yeast infection when taking antibiotics	☐	☐
Arthritis/Joint Deformity	☐	☐
Epilepsy	☐	☐
Seizures	☐	☐
Fainting	☐	☐
Anxiety/Depression	☐	☐
Mental Disorder	☐	☐
Glasses/Contacts	☐	☐
Liver Disease	☐	☐
Cancer	☐	☐
Type _____		
Polycystic Ovarian Disease	☐	☐
Hirsutism/Hypertrichosis	☐	☐
Cushing's disease	☐	☐

Social History:	**YES**	**NO**
Do you smoke?	☐	☐
Do you drink alcohol?	☐	☐
If yes, _____ per day		
Do you use IV drugs?	☐	☐
If yes, what? _____		
How often? _____		

Infectious Disease:	**YES**	**NO**
HIV/AIDS	☐	☐
Hepatitis: A B or C	☐	☐
Syphilis/other STD's	☐	☐
Herpes Simplex	☐	☐
Antiviral Therapy	☐	☐
Stomach Disorder	☐	☐
Females:	**YES**	**NO**
Are you pregnant?	☐	☐
Could you be pregnant?	☐	☐

Date of last menstrual cycle_____

Type of birth control

_____

Previous pregnancies

_____

_____

_____

Past Medical History:

_____

_____

_____

Past Surgical History:

_____

_____

_____

I hereby declare that I have honestly and completely answered the above questions to the best of my knowledge. I understand that it is my obligation and responsibility to notify Dr. Howington of any changes in my medical condition or medications during the course of my medical treatments or at follow up visits.

_____	_____	_____	_____
Patient Signature	Date Signed	Reviewed By	Date

LOW COUNTRY
DERMATOLOGY

NOTICE OF PRIVACY POLICIES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Low Country Dermatology, LLC, we are committed to treating and using protected health information about your responsibility. This Notice of Health information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective 10-1-02, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Low Country Dermatology, LLC, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, an a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Record/Information

Although your health record is the physical property of Low Country Dermatology, LLC, the following information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health records provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528, Obtain an accounting of disclosures of your health information as provided in 45 CFR 164,528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164,522, and,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Low Country Dermatology, LLC, is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use of disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practices Privacy Officer, Practice Manager 912-354-1018 or 310 Eisenhower Dr. Suite 12A Savannah, GA 31406

If you believe your privacy rights have been violated, you can file a complaint with the practices Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filling a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For Example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. in that way, the physician will know how you are responding to treatment.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in a effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ. procurement organizations: Consistent with applicable law, we may disclose health information to organ procure¬ment organizations or other entities engaged in the procure¬ment, banking, or transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law we may your health information to public health or legal authorities charge with pre¬venting or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct of have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

LOW COUNTRY
DERMATOLOGY

PATIENT FINANCIAL POLICY

Welcome, and thank you for choosing Low Country Dermatology for your skin care. Your clear understanding of your Patient Financial Policy is important to our professional relationship. Carefully review the following information and return this form with your signature and today's date. Please ask if you have any questions about our fees, our policies, and/or your responsibilities.

Insurance – When making an appointment with Low Country Dermatology, it is your responsibility to confirm with your insurance company that Dr. Howington is currently under contract with the plan. If your plan requires that you have a referral prior to seeing a specialist, please contact your primary care physician so that you have the referral at the time of your appointment. If you do not have your referral at the time of your appointment, you will need to reschedule our appointment, or choose to be seen without the insurance benefits and pay for your visit in full.

You are responsible for knowing your insurance benefit coverage. We will gladly file your insurance claim on your behalf. We allow 45 days from the date the claim is filed for the insurance company to pay. If the insurance company does NOT pay within this time, you will be responsible for the entire balance. We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria, i.e. deductibles, non-covered service, co-insurance, coordination of benefits, or pre-existing conditions. You are responsible for all co-payments and deductibles at time of service.

Check-in: Please bring your current insurance card with you to EACH visit. Without the insurance card, we will be unable to file your insurance, and you will be responsible for all charges for that visit. On follow-up visits you will be asked to verify all demographic and insurance information so that our records remain up-to-date.

Check-out: Please be prepared to pay for the current visit as well as any past balances on your account. Payment and copayments, deductibles, or fees for non-covered services will be required at the time of service. For your convenience we take cash, check, and all major credit cards.

Non-Covered Services: An Insurance Waiver may be required to acknowledge understanding of your responsibility for paying for non-covered services. In dermatology, there are many procedures that are considered by Medicare and private insurers as non-covered, including removal of skin tags, cosmetic treatment of spider veins, removal of whiteheads, as well as others. If you are coming in for a non-covered service, please be prepared to pay for the service in full.

Return Check Fees: Any returned check from the bank for non-payment shall result in the patient's or Guarantor's account being assessed $25.00 fee per check.

Pathology Fees and Lab Tests: If your visit includes biopsies or lab tests these specimens are sent out for processing. You will receive separate billings from the laboratory performing the service. You are responsible to notify us if your insurance company requires particular labs for coverage of the processing.

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Privacy Statement

You have the right to review our privacy notice, request restrictions and revoke consent in writing after you have reviewed our privacy notice. Signing below signifies that you have had the opportunity to view the privacy notice by requesting a copy or reading a copy located in the waiting room and you agree to the privacy policy of our office.

By signing below you acknowledge you have read, understand and agree to the Low Country Dermatology Financial Policy and our Notice of Privacy Practices.

Printed Patient Name: _____

Signature of Patient/Insured/Guardian: _____ Date: _____

Printed Name of Patient/Insured/Guardian: _____ Date: _____

Signature of Office Representative: _____ Date: _____

Please list the names of the persons to whom we may disclose the patient's private health information and state how the individual is related to the patient:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____