Last Name_________________________ First____________________M_______
Address____
City___________________ State___________ Zip_________________
Nickname_________________________
Email____________________________
Would you like to receive occasional newsletters and promotions from us? Y☐ N☐
Home #___________________________ Cell # ____________________________
Social Security #____________________
Date of Birth________________________
Sex: M☐ F☐
Marital Status: ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed

Employment

Employer Name_________________________________
Address______________________________________
City___________________ State___________ Zip_________________
Active Military☐
Employed☐
Self-Employed☐
Part-Time Student☐
Full-Time Student☐
Not Employed☐
Retired☐

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Language ☐ English ☐ Other______________________
Race
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Hawaiian or Pacific Islander
☐ White Other_____________________________

Smoking Status
☐ Current Everyday Smoker
☐ Current Occasional Smoker
☐ Former Smoker
☐ Never Smoker
☐ Other____________________________

Patient's Height ___________________
Patient's Weight ___________________

Primary Insurance Holder Name & Address

Last Name__________________________________ First__________________________M_________
Address____
City__________________________ State______________ Zip_______________________
Social Security #__________________________
Date of Birth ______________________________
Sex: M ☐ F ☐

Carrier Name_____________________________
Subscriber #______________________________
Group #___________________________________

Secondary Insurance

Carrier Name_____________________________
Subscriber #______________________________
Group #___________________________________

Medications & Allergies

List Current Medications

List All Allergies

Do we have permission to: Leave a message on your voicemail ☐
Leave a message at your place of employment ☐
Discuss your medical condition with a family member ☐
Leave a message with Pathology & Lab results ☐

Pharmacy Name_____________________________ #____
In Case of Emergency Contact______________________________#_________________________

Please make sure to fill out all information. Payment is accepted at time of service. If you have any questions, please speak with our receptionist. Thank you.

Electronic Signature
Electronic Signature: *
Please type your First and Last Name **Date**
☐ **I understand that checking this box constitutes a legal signature confirming that I acknowledge and warrant the truthfulness of the information provided in this document.**

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with the office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services at www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your case are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health Insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or Information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. Mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and reviews of documents (which may include PHI) by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your PHI, and to request changes in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

Electronic Signature
Electronic Signature: *
Please type your First and Last Name   Date
☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and warrant the truthfulness of the information provided in this document.

PAYMENT POLICY

Thank you for choosing Sheperd Integrative Dermatology for your skin care needs. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding financial responsibility for services rendered, we have developed this payment policy. Please read it, 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 in most insurance plans, including Medicare and Medicaid. If you are not insured or not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business 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. Knowing your insurance benefits 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 without exception. 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 at each visit. You may require a biopsy or removal of a lesion. If so, you may receive an additional separate bill for these services unless we collect for the pathology service at the time of your office visit.

3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. Cosmetic services are not covered by insurance providers.

4. **Proof of insurance.** All patients must complete our patient information form before seeing our providers. We must obtain a copy of your driver's license 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 will be responsible for the balance of a claim.

5. **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 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 a party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis.

8. **Missed appointments.** Our policy is to charge $25.00 for missed appointments not canceled within 24 hours. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

9. **Laser and Cosmetic appointments.** We require $100.00 to hold your appointment time. This is fully refundable provided that you cancel your appointment with at least 24 hours notice.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. If you have a question about a charge on your bill, please call our billing staff at (843) 513-6395.

Thank you for taking the time to read and understand 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.

Electronic Signature

Electronic Signature: *

Please type your First and Last Name Date

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and warrant the truthfulness of the information provided in this document.