W.R. McWilliams, M.D.
Jim C. Chow, M.D.
Alfonso Gonzalez, M.D., Ph.D.
Greta C. Zimmerman, D.O.
Asha P. James, M.D

Columbia Skin Clinic, LLC
Three Richland Medical Park Drive
Suite 500
Columbia, SC 29203-6886

Richard A. Laws, M.D.
Allison L. Cashman, M.D.
Melissa M. Munoz, M.D.
John A. Mouzakis M.D.
April M. McNeill, PA-C
Anna F. McKie, PA-C

803-779-7316
FAX – 803-343-2538
www.columbiaskinclinic.com

The Midlands premier dermatology specialists

Welcome to our Practice. The physicians and staff of Columbia Skin Clinic are pleased that you have chosen us to participate in your dermatological healthcare needs. To make your first visit to our office as convenient for you as possible, we have enclosed the following forms (Patient Registration, Medical History Summary, Notice of Privacy Practices, Acknowledgement of Receipt of Notice of Privacy Practices, and Patient Financial Policy) for you to complete prior to your appointment. Please bring the completed forms, current insurance card, and any required insurance authorization to your appointment.

Payment is expected at the time of service. Applicable copayments and deductibles will be collected. We accept payment in the form of cash, check, or credit cards (Visa, MasterCard, and Discover).

If you have any questions or need further clarification, please feel free to call the office. We will be happy to assist you.

Again, thank you for choosing Columbia Skin Clinic, LLC. We look forward to meeting you.

Sincerely,

The Staff Members of
Columbia Skin Clinic, LLC

Camden Office
1205 Lyttleton Street
Camden, SC 29020

Irmo Office
1 Wellness Blvd., Suite 104
Irmo, SC 29063

COLUMBIA SKIN CLINIC, LLC
Acknowledgement / Consent

_____(initial) HIPAA Notice of Privacy Practices

I, **(print patient name)** _____, have read a copy of Columbia Skin Clinic, LLC's Notice of Privacy Practices. (This document is available at our front desk or columbiaskinclinic.com)

_____(initial) Release of Medical Information

I do/do not **(circle one)** authorize Columbia Skin Clinic, LLC and its designated representatives to release medical information to my spouse, parent or guardian. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information that does not pertain to assisting with my health care and any copies of medical records will require a signed HIPAA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

_____(initial) Consent to Treatment

I consent to the performance of those diagnostic procedures, examinations, and rendering of treatment by the medical provider and their designated medical office staff as is deemed necessary in the medical provider's judgment.

_____(initial) Authorization/Assignment/Financial Responsibility

I authorize the release of any medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges and that I am responsible for obtaining any referrals required by my insurance carrier. I request that my medical insurance carrier make any payment directly to Columbia Skin Clinic, LLC for services rendered to me. As a courtesy, my charges will be filed with my insurance carrier; however, I will be billed if the claim is denied or is not paid in a timely manner. Should my account become a collection problem, additional charges may be incurred.

I acknowledge that this form and the Practice Financial Policy have been read in full and explained as necessary.

The Physician/Staff has my permission to: (Please check all boxes that apply)

□ Leave message at home with my spouse or: Name:_____
Relationship:_____DOB:_____

□ Leave message on cell phone. Cell phone number:_____

□ Leave message at work. Work phone number:_____

□ Leave message on voicemail/
answering machine Phone number:_____

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Printed Name of Patient or Legal Guardian Relationship *(if not self)*

COLUMBIA SKIN CLINIC, LLC

Patient Name: _____DOB: _____

Patient Financial Policy

Thank you for choosing Columbia Skin Clinic, LLC for your dermatologic care. We are committed to providing you with the highest quality medical care possible in a cost effective manner. Our professional fees have been determined through careful consideration in addition to being reasonable and customary within our geographical area.

We accept cash, check, MasterCard, Visa, and Discover. There will be a $30 charge for returned checks. If payment is not received from your insurance carrier within our contract limits, any balance will be your responsibility. Our billing/insurance department is available to discuss any questions you may have regarding your insurance or your account at Columbia Skin Clinic, LLC.

Items to bring with you to each appointment:

- Health Insurance Card(s)
- Obtain Referral(s) (if applicable)
- Driver's License
- Method of Payment

Appointments: We do our best to run on schedule, as we realize that your time is also valuable. There are many ways you can assist us in staying on time. Please arrive for your appointment 15 minutes early to allow for registration. If more than 15 minutes for your appointment, you may be marked as a No Show and may be asked to reschedule your appointment. Please inform the receptionist of any demographic changes (phone numbers, address, insurance information, etc.) Failure to notify us immediately of changes in demographic information, financial status and/or insurance coverage may result in you being responsible for any services not covered by your insurance carrier. Patients scheduled for appointments are asked to give 24 hour notice of cancellation.

Medicare: We accept Medicare assignment. As a Medicare patient you are responsible for your deductible and for the difference between the approved charge and the amount Medicare pays. If you have supplemental insurance we will bill it for you. Any remaining balance will be your responsibility and billed to you.

HMO/PPO/Commercial: All co-pays are due at the time of service, we are members of most, but not all plans. You are responsible for verifying what your insurance plan will cover and that we are providers for your plan. You are responsible for referrals, payment of all deductibles and co-payment/co-insurance, procedures without authorization, non-covered charges as determined by your contract with your insurance carrier. All payments are due at time of service. If there is no referral, you will be asked to sign a waiver and responsible for the charges in full at time of service.

Self-Pay: If you do not have health insurance or we do not participate with your insurance company, you will be responsible for all medical services rendered at Columbia Skin Clinic, LLC. Payment in full is due at the time of service. If you are unable to make full payments, suitable payment arrangements will be discussed between you and our financial counselors.

Minor Patients: The parent(s) or guardian(s) accompanying a minor are responsible for providing current insurance information for the minor as well as the payment in full for services provided. Parent(s) or guardian(s) must have an Authorization for Medical Treatment form signed each time a minor arrives unaccompanied for an appointment. Both parents/legal guardian(s) are responsible for payment for services rendered to the minor patient.

Delinquent Accounts: If your account becomes delinquent, Columbia Skin Clinic, LLC, will take the necessary steps to collect the debt, including but not limited to collection agency,

lawyers, and reporting to a Credit Bureau where you agree to pay all of the collection costs incurred.

Payment Plans: Our office will be happy to work with you in order to pay any balance due to our practice. Please contact our billing department to arrange a payment plan.

Medical Records: Your medical records will be held in the strictest confidence. If you request a copy of your medical records to be sent to another provider or to yourself, a written authorization will be required. A processing fee and additional costs may apply. Only the records requested will be forwarded.

Cosmetic/Elective/Esthetician Procedures: By definition, these procedures are not covered by insurance companies; and our office does not submit claims on their behalf. Payment in full is required on the day of the scheduled procedure. Deposits are required for these procedures. Patients scheduled for these procedures are required to give at least 48 hours' notice of cancellation to avoid forfeiture of deposit.

I have read, understand, and agree to abide by its guidelines the payment policy regarding my financial responsibility to Columbia Skin Clinic, LLC, for providing medical services to me or the above named patient. I certify that the information I provide to Columbia Skin Clinic, LLC, is, to the best of my knowledge, current, true, and accurate.

Patient Signature _____Date _____

Guarantor Signature _____Date _____
(If guarantor is not the patient)

COLUMBIA SKIN CLINIC MEDICAL HISTORY FORM

Patient:_____ Date: _____

Are you allergic to any medications? Yes No If yes, please specify:_____

_____

List all medications you are currently taking:_____

_____

History of Diseases

Do you have now, or have you ever had, diseases, or conditions of (please check yes or no):

Lungs:	**Yes**	**No**	**Systemic:**	**Yes**	**No**
Bronchitis	❑	❑	HIV exposure	❑	❑
Emphysema	❑	❑	Hepatitis or yellow skin	❑	❑
Asthma	❑	❑	Diabetes	❑	❑
Chronic cough	❑	❑	Thyroid	❑	❑
Morning cough	❑	❑	Kidney	❑	❑
Vascular:			Bladder	❑	❑
High blood pressure	❑	❑	Stomach	❑	❑
Chest pain	❑	❑	Bowel	❑	❑
Heart attack	❑	❑	Convulsions, epilepsy		
Heart murmur	❑	❑	or seizures	❑	❑
Irregular or			Fainting	❑	❑
fast heartbeat	❑	❑	Phlebitis	❑	❑
Pacemaker	❑	❑	Joint deformity	❑	❑

Skin:

When you are exposed to sun, do you: tan only ❑ burn ❑ tan and burn ❑

Have you ever had skin cancer? Yes ❑ No ❑ Don't know ❑

Has anyone in your family had skin cancer? Yes ❑ No ❑ Don't know ❑

Do you have history of any specific skin diseases? Yes❑ No ❑ Don't know ❑

If yes, please list: _____

List any other diseases or condition: _____

Surgeries in the last six months:_____

Please answer the following questions:

A. Do you smoke? Yes ❑ No ❑ If yes, how much? _____

B. Do you bleed easily? Yes ❑ No ❑

C. **(Female patients only)**
Are you pregnant? Yes ❑ No ❑ Due date? _____

D. Do you have artificial joints? Yes ❑ No ❑

I hereby authorize treatment by the physicians of Columbia Skin Clinic. I further authorize the release of my medical information to:

_____
(i.e., spouse, parent/caretaker)

_____
Patient Signature (if over 18 years of age)

_____
Responsible Party Signature (for minors)

Physician Signature:_____

COLUMBIA SKIN CLINIC, LLC

AUTHORIZATION TO TREAT A MINOR

This consent shall remain effective until _____, 201___. (*Please define the period as one day, one week, one month, or a year. This form cannot exceed one year.)*

I (We) the undersigned parent(s) or legal guardian of _____, a minor, do hereby authorize and consent to medical treatment rendered under the general or special supervision of any member of the medical staff. It is understood that this authorization is given only after a specific diagnosis has been made and is granted to provide authority and power to render care, which the aforementioned provider in the exercise of his best judgment may deem advisable. A minor, by law, must be accompanied by a parent/guardian on the first scheduled appointment.

Please remember that co-payments and any additional fees incurred must be paid at time of service.

List any Restrictions:_____

Address:_____ City:_____ State:____ Zip:_____

Patient Date of Birth:_____Allergies:_____Medications:_____

Health Problems:_____

Telephone Number s where parents/guardian may be reached

Mother:_____Home:_____ Work:_____

Father:_____Home:_____ Work:_____

Legal Guardian:_____ Home:_____ Work:_____

Primary Care Physician:_____

Address:_____City:_____State:_____ Phone: _____

Insurance Provider *(Please bring your insurance card(s) & photo id)*

Primary Insurance Company:_____Policy #_____

Secondary Insurance company:_____ Policy#_____

_____ _____

Signature of Parent/Legal Guardian Date

COLUMBIA SKIN CLINIC, LLC

New Patient Registration Form (Please Print)

Date____/____/____

Name_____

Address_____

City State Zip Code

Home Phone _____ Work Phone_____ Cell Phone_____ DL#_____

Marital Status □S □M □D □W □Male □Female Date of Birth_____ Social Security#_____

Age____ Employer/School _____ Address _____

Occupation_____ Email Address:_____

Responsible Party (if different from patient)
Name_____

Address_____

City State Zip Code

Home Phone _____Work Phone_____ Employer _____

Date of Birth _____Age_____ □Male □Female SS#_____

Insurance Information (Please present insurance card at time of check in)

Primary _____ID# _____Group# _____

Relationship to patient_____Policyholder _____Address_____ Date of Birth_____

Secondary _____ID#_____Group# _____Relationship to patient_____

Policyholder _____Address _____ Date of Birth _____

In case of Emergency, who should be notified?
_____ Relationship_____Phone _____

REFERRED BY: _____

NATURE OF PROBLEM: _____ ALLERGIES:_____

I authorize treatment by the Columbia Skin Clinic physician. Until revoked in writing, my signature below authorizes the release of medical information to: (1) my primary care and/or referring physician, to consultants if needed, and any physician involved in my medical care; (2) any insurance company through which I claim benefits, to include SSA, CMS, or its intermediaries; (3) for processing insurance applications, and prescriptions. I further authorize the assignment of all medical benefits to which I am entitled, including Medicare, MediGap, private insurance, group policy benefits, and other health plans to the Columbia Skin Clinic, LLC.

We wish to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies. Payment is required for all services at the time they are rendered, unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected. Any amount that your insurance company does not pay is due from you, unless we have agreed to accept the carrier's charge determination, in which case, you are responsible for the copayments, deductibles and any non-covered services. We accept payment in the form of cash, check, or credit card. Your signature below signifies your understanding and willingness to comply with this policy.

Patient/Responsible Party Signature [x] _____ Date _____/_____/____
(If under 18 years of age, a responsible party must sign. **We must have your signature in order to file your insurance claims).**

COLUMBIA SKIN CLINIC, LLC

Referral Waiver Form

As a member of a Managed Care Plan, we want you to be aware that such plans usually require your Primary Care Provider to provide prior referral authorization for specialist visits. As of today, our office has not received a referral from your Primary Care Provider.

I understand that if I receive services today from the Columbia Skin Clinic, LLC without obtaining a referral from my Primary Care Provider, I will be financially responsible for all charges resulting from this visit.

Patient or Responsible Party Name:_____Date of Birth:_____

Signature:_____Date:_____

Chart Number:_____

As required by the Privacy Regulations Created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI) also referred to as protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law we must follow the terms of the notice that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information: How we may use and disclose your PHI, Your privacy rights in your PHI, Our obligations concerning the use and disclosure of you PHI.

The terms of this notice apply to all records containing you PHI that are created and retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

Our practice may use and disclose your PHI in the following ways: The following categories describe the different ways in which we may use and disclose your PHI:

Treatment. Our practice may use or disclose your PHI to physicians, nurses and all other health care personnel who provide you with your health care services or are involved in your care. For example, we may ask you to have a laboratory test (such as blood or urine tests), and we may use the results to help us reach a diagnosis and treat you accordingly.

Payment. Our practice may use and disclose your PHI to obtain payment for your health care services. For example, we may contact your health insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your treatment to determine if your insurer will cover your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. In addition, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

Health Care Operations. Our practice may use and disclose your PHI to operate our practice. As an example of the way in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

Treatment Options: Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

Health-Related Benefits and Services: Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

Release of Information to Family/Friends: Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking in care of you. Fore example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

Emergencies: Our practice may use or disclose your PHI in an emergency treatment situation.

Other Permitted and Required Uses and Disclosures that may be made without your authorization or opportunity to object: Our practice may use or disclose your PHI in the following situations without your authorization, these situations include:

Required by law, legal proceedings, or law enforcement: Our practice makes disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with crime; or when ordered by a judicial or administrative proceeding.

Public Health. Our practice reports information about births, deaths, and various diseases, to government officials in charge of collecting that information, and we provide coroners, medical examiners, organ procurement entities, and funeral directors, necessary information relating to an individual's death.

Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example investigations, inspections, audits, surveys, licensure and disciplinary actions; civil administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

Organ and Tissue Donation: Our practice may release your PHI to organizations that handle organ, ever or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

Research: Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when Internal or Review Board or Privacy Board as determined that the waiver of your authorization satisfies the following: (i) the use of the disclosure involves no more than a minimal risk to your privacy based on the following (A) an adequate plan to protect the identifiers from improper use and disclosure, (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (c) adequate written assurance that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver, and (iii) the research could not practicably be conducted without access to and use of the PHI.

Military/ National Security/ Serious Threats to Health or Safety: Our practice may use and disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. Our practice may use and disclose

your PHI to federal official for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials, or foreign heads of state, or to conduct investigations. Our practice may use and disclose your PHI to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the public.

Inmates: Our practice may use and disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary; (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

Worker's Compensation. Our practice may use and disclose your PHI for Workers' Compensation and similar programs.

Appointment Reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

Your Health Information Rights: Confidential Communications: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Privacy Officer at our main office address specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

Requesting Restrictions: You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for you care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Privacy Officer at our main office address. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure or both; and (c) to whom you want the limits to apply.

Inspection and Copies/ Amendments: You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Privacy Officer at our main address in order to inspect and/or obtain a copy of you PHI. Our practice may charge a fee for the cost of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at our main office address. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual entity that created the information is not available to amend the information.

Accounting of Disclosures: All of our patients have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an "accounting of disclosures", you must submit your request in writing to the Privacy Officer at our main office address. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not included dates before April 14, 2003. The first list you request within a 12- month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact our Privacy Officer at (803)779-7316.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice contact the Privacy Officer at our main office address. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to Provide Authorization for Other Uses and Disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to use regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Questions: If you have any questions about any part of this notice, or if you want more information about our privacy practices, please contact the Privacy Officer, Columbia Skin Clinic, LLC at 803-779-7316 or in writing to Columbia Skin Clinic, LLC Three Richland Medical Park Drive, Suite 500 Columbia, SC 29203. We reserve the right to change this notice at any time in the future. We will post a current copy of this Notice of Privacy Practices in our waiting room as well as on our web site at www.columbiaskinclinic.com.

The Centers for Medicare and Medicaid Services has created a Clinical Laboratory Improvement Amendment (CLIA) Complaint Brochure. A complaint is any concern that you may have about a laboratory's operation. Examples include the following: quality of testing, unlabeled specimens, unethical practices; e.g., record falsification, proficiency testing cheating, confidentiality of patient information and laboratory personnel qualifications or responsibility issues. You may contact the Centers for Medicare and Medicaid Services to file a complaint at 1-877-267-2323 (toll free) extension 63531.