Welcome to Weimer Skin Clinic!

We are so happy that you've chosen us for your dermatological care.

Below is some important information that you need to know:

We are located at 1240 21st Ave. N., Suite 106, Myrtle Beach, SC 29577

www.weimersc.com

843-839-1414 – 843-839-1413 fax

(Option #1: Appointment; #3: Prescription refills; #4: Nurse; #6: Address)

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1. **Always bring your most recent legal photo ID.**
2. **Always bring your most recent insurance cards.** If your insurance is through your spouse or parent, we will need their date of birth for insurance purposes. Even if we do not accept your particular insurance, we need the information to send with any pathology and to be able to provide you with a completed claim form.
3. We will need your social security number (we do not need to see your social security card).
4. **Always bring all your medications or an updated list** (with the date you began taking them).
5. Please fill out the attached (5) forms and arrive **15 minutes before** your scheduled appointment time (if you did not receive or if you cannot fill out the forms prior to coming in, please arrive 30 minutes before appointment time).
6. All minors must be accompanied by a parent or **legal** guardian (if legal guardian, copies of legal documents must be presented). **Please let receptionist know if you have Medical Power of Attorney (only if you are unable to make your own medical decisions) and provide copy for your chart.**
7. If you are late to an appointment, you may be asked to reschedule that appointment for another day.
8. **All Insurance co-pays, deductibles and co-insurances are due at time of service.**

*** One week prior to your appointment you will receive a call from us to confirm your appointment. If you are unable to keep this appointment or no longer are in need of it please let us know at that time due to our extensive waiting list. We will also call 2 days before to confirm but if we do not receive a verbal confirmation at that time your appointment will be cancelled and given to someone else.**

Thank you and we look forward to serving you!

EIMER SKIN CLINIC, P.A.

Patient _____ _____
Last Name First Name Initial Social Security #

Responsible Party _____
Last Name First Name Initial

Street Address _____

Mailing Address (if different from above) _____

City _____ State _____ Zip Code _____

*Check next to Preferred number ☐ Home Phone # _____ ☐ Cell Phone # _____

Birth date ____/____/_____ Age_____ Sex: Male_____ Female_____

Single_____ Married_____ Widowed _____ Separated _____ Divorced _____

Employed __ Full-Time Student __ Part-Time Student __ Patient's School Name _____

Patient Employed By _____

Business Address _____

Occupation _____ Business Phone _____

Spouse/Parent Name _____ Birth date _____

Spouse's Social Security Number (For Insurance Purposes) _____

Business Name & Address _____

Occupation _____ Business Phone _____

In Case of Emergency, who should be notified? _____

Phone _____ Relationship _____

Please list Primary Care Physician: _____

Office Phone# _____ Fax# _____

Were you referred by a Doctor other than your Primary Care Physician: Yes No

If yes, please list referring Doctor _____ Office Phone# _____

Do we have permission to: Please circle

Leave a message on your answering machine at home? Yes No

Leave a message on your cell #? Yes No Leave a message at your place of employment? Yes No

Have you <u>enacted</u> a Medical Power of Attorney? (Does someone have to sign for you?) Yes No

If yes, Name: _____ Phone # _____

Please provide copy of Medical POA to be kept in your chart if someone needs to sign for you.

May we discuss your medical condition with any member of your household? Yes No

If yes, whom _____ Relationship _____

If yes, whom _____ Relationship _____

Patient Signature _____ **Date** _____

***Please present Insurance Cards and photo ID to the receptionist so copies may be made.**

Do you have Medical Insurance _____No _____Yes If yes:_____

Are you covered under any of these programs?

_____ Medicare; _____BC/BS State Employee; _____Cigna; _____Aetna;

_____Not covered by one of these categories

(Weimer Skin Clinic, P.A. only accepts the above insurances)

This office is required to keep a copy of your recent photo ID, Insurance cards as well as your signature on file authorizing us to file claims to Insurance companies for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or it intermediaries or carrier any information needed for this or a related Medicare/insurance 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 the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

Signature as it appears on Primary/Medicare Insurance Card Date

I request/authorized Supplemental/Secondary benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above Supplemental/Secondary carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature as it appears on Secondary, or Supplemental Card*** Date

***If you have a supplemental/Secondary policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I assign to Weimer Skin Clinic, P.A. all medical benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits authorized on all my insurance submissions whether manual or electronic.

I hereby authorize, C. Edward Weimer, Jr., MD, FAAD, to prescribe treatment, conduct necessary tests and prescribe medication as necessary.

_____ _____

Signature Date

Weimer Skin Clinic, P.A. accepts

Medicare Part B –
BCBS State Employees –
Aetna - Cigna

INSURANCE CO-PAYS, DEDUCTIBLES AND CO-INSURANCES ARE DUE AT TIME OF SERVICE

Patients with Medicare Part B as their primary insurance will be required to pay up to 20% depending on your secondary insurance plan, until a history is established.

If you do not carry an insurance that we accept– **Payment is required at the time of service** – we accept Cash, Check, Visa, and Mastercard and Discover.

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The following fees will be incurred for missed (no show) appointments and appointments that are not cancelled with the courtesy of a 24 – 72 hour notice. (Please understand that the 24 - 72 hour notice will give us the opportunity to offer your office visit or surgery time to someone else who may be waiting to be seen). Thank you for your understanding.

$50.00 for Missed Office Visits

(24 Hour Cancellation Notice Required for Office Visits!)

$200.00 for Missed Surgery

(72 Hour Cancellation Notice Required for Surgery!)

In the event of an emergency, please call as soon as possible.

*If you do not have a valid emergency, you WILL be billed the appropriate missed appointment charge!

****

I certify that I have read and understand the statements above:

_____ _____

Signature (Patient's/Guardian's/Parent's) Date

_____

Printed Name (Patient's/Guardian's/Parent's)

DATE _____ CHART# _____PATIENT'S NAME_____

NEW PATIENT BRIEF MEDICAL HISTORY

1. What is your skin problem today and when did it begin? (rash, growths, warts, acne, other):_____

_____

_____

PLEASE CIRCLE "YES" OR "NO" AND ANSWER THE FOLLOWING:

2. Have you had any other **past** skin problems or skin cancers? YES NO
   If yes, where on your body, and when:_____

_____

3. Do any of your blood relatives have skin problems, skin cancer, abnormal scarring lupus, asthma/hay fever or inheritable skin diseases? (Circle and list)_____ YES NO

_____

4. Has a doctor given you anything for today's skin problem? If so, what?_____ YES NO

_____

5. Have you put anything else on today's skin problem that you obtained yourself without a prescription? If so, what?_____ YES NO

6. Are you allergic to any medicine(s)? If so, what?_____ YES NO

7. Does anything touching your skin; such as jewelry, gloves, shoes, plants, etc; cause a rash, itch or allergy? (Circle and list)_____ YES NO

8. FOR WOMEN ONLY: Are you now pregnant, or **may** you be? YES NO

9. What else should I know about your general health: such as past surgery, easy bleeding, Asthma, diabetes, lupus, high blood pressure, heart disease, hepatitis, organ recipient, HIV/AIDS, or need or receiving antibiotics prior to dental work or invasive surgery? (Circle and list)_____

_____

10. List all your **current medications** prescriptions and any over the counter medications and supplements:

_____

Who is your primary care physician?_____Phone #_____

Patient's, Parent or Legal Guardian's (circle one) **Signature**_____

Dermatologist's **Signature** (signifying review)_____

C.Edward Weimer, Jr., MD, FAAD

DATE _____ CHART# _____PATIENT'S NAME_____

REVIEW OF SYSTEMS TODAY
(To Be Completed by the Patient/Parent/POA)

Please answer by checking or circling the box beside the body system that **is feeling abnormal or <u>not well today</u>; i.e., you are having these symptoms <u>today</u>.**

Constitutional Symptoms
- ❑ Don't Feel Good/Don't Know Why
- ❑ Fever, Chills
- ❑ Loss of Appetite
- ❑ Unplanned Weight change
- ❑ Weakness, Fatigue

Eye Symptoms
- ❑ Blurry or Double Vision
- ❑ Itchy or Red Eyes or Eyelids
- ❑ Glasses or Contacts

Ear,Nose,Mouth,Throat Symptoms
- ❑ Dental Work Needs Done
- ❑ Itching or Discomfort
- ❑ Nose or Mouth Bleeding or Sores
- ❑ Chewing or Swallowing Difficulty
- ❑ Taste or Smell Disturbance
- ❑ Hearing Loss or Ringing Sounds

Cardiovascular Symptoms
- ❑ **I have an artificial heart valve**
- ❑ **I must take antibiotics before dental work**
- ❑ **I Take Blood Thinners**
- ❑ **I Have a Pacemaker**
- ❑ Past Blood Clots
- ❑ Chronic Leg Swelling
- ❑ Shortness of Breath
- ❑ Chest Pain w or w/o Exertion
- ❑ High Blood Pressure
- ❑ Palpitations (Rapid Thumping)
- ❑ Fainting Spells

Respiratory Symptoms
- ❑ Cough / w Phlegm or Blood
- ❑ Hay Fever / Sneezing
- ❑ Asthma / Wheezing

Gastrointestinal Symptoms
- ❑ **Past Hepatitis A, B, or C**
- ❑ **High Liver Tests**
- ❑ Frequent Heartburn
- ❑ Nausea / Vomiting
- ❑ Diarrhea
- ❑ Bloody Bowel Movement
- ❑ Any Type of Chronic Colitis

Musculoskeletal Symptoms
- ❑ **I Have an Artificial Joint(s)**
- ❑ I Have a Prosthetic Limb
- ❑ Joint Swelling / Pain / Stiffness
- ❑ Unexplained Muscle Aches
- ❑ Difficulty Walking or Standing

Genitourinary Symptom
- ❑ Kidney Disease or Kidney Failure
- ❑ Genital Warts or STDs
- ❑ Burning on Urination
- ❑ Recurrent Sores on Genitals

Skin &/or Breast Symptoms
- ❑ **New or Changing Mole or Growth**
- ❑ **Nonhealing Sore or Wound**
- ❑ **MRSA or Other Skin Infection**
- ❑ Itchy Skin
- ❑ Red or Scaly / Flakey Skin
- ❑ Sunburn Easily or Photosensitivity
- ❑ Unexplained Skin or Mouth Blisters
- ❑ "Crawling" Skin Sensation
- ❑ "Burning" Skin Sensation

Neurological Symptoms
- ❑ Headaches / Migraines
- ❑ Dizziness / Balance Problems
- ❑ Numb Areas of Skin
- ❑ Seizure Disorder
- ❑ Partial Paralysis

Psychiatric Symptoms
- ❑ Depression
- ❑ Poor or Impaired Memory
- ❑ High Anxiety / Worry
- ❑ Excessive Alcohol Consumption
- ❑ Addictive Behaviors

Endocrine Symptoms
- ❑ High Blood Sugar / Diabetes
- ❑ High Cholesterol or High Lipids
- ❑ Thyroid Problem or Goiter

Hematologic/Lymphatic Symptoms
- ❑ **HIV positive**
- ❑ Abnormal Blood Count or Anemia
- ❑ Unexplained or Easy Bruising
- ❑ Swollen "Glands"
- ❑ Have Been Told You're Immunosuppressed

Allergic/Immunologic Symptoms
- ❑ **Drug Allergies**
- ❑ **Hives**
- ❑ I Take "Allergy Shots"

Patient's/Parent's/POA's Signature_____

Dermatologist's Signature (Signifying Review)_____

C. Edward Weimer, Jr., MD, FAAD

Excellence in Dermatology & Dermatologic Surgery

C. Edward Weimer, Jr., MD, FAAD
Certified by the American Board of Dermatology

Weimer Skin Clinic, P.A.
1240 21st Ave. N., Suite 106
Myrtle Beach, SC 29577
Appointments: 843-839-1414
Fax: 843-839-1413
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Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME _____ DATE _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Weimer Skin Clinic, PA may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Weimer Skin Clinic, PA has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Weimer Skin Clinic, PA will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Weimer Skin Clinic, PA to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Weimer Skin Clinic, PA has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) _____ DATE _____

Relationship to Patient if signed by another party _____ DATE _____

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: Weimer Skin Clinic, PA 1240 21st Ave. N., Suite 106 Myrtle Beach, SC 29577 843-839-1414 843-839-1413 Fax.

FORM Us