For Dependent Children:

Patient _____ Parent Name _____

Address _____ Parent Address: _____

Home Phone _____ Parent Phone Number _____

Birth Date: _____ Age: _____

At what age did acne become a problem? _____

Any member of family bothered with severe acne? _____

Any seasonal variation? _____

Sun (improves, aggravates, has no effect) on my complexion. (circle one)

Are you convinced that certain foods aggravate your acne? Yes [ ] No [ ] If so, list the foods: _____

_____

Tension (is, is not) an aggravating factor. (circle one)

Has a trip to another type of climate helped your acne? Yes [ ] No [ ]

Do you use cosmetics (daily, occasionally, rarely, never)? (circle one)

List type of cosmetic: (liquid, stick, pancake, gel, powder) (waterbase, oil base) (circle one)

List brand name of cosmetic if possible: _____

_____

Do you use creams or moisturizers? Yes [ ] No [ ] If so, please list: _____

_____

What type of soap or cleanser are you currently using to wash face? _____

How frequently do you wash face? _____ Would you describe your skin as oily? Yes [ ] No [ ]

Have you ever sought medical attention for acne before? Yes [ ] No [ ] If yes, from whom and when? _____

_____

What medications were prescribed? _____

Were any of these medications of any value ? Yes [ ] No [ ] If yes, name product(s): _____

_____

If you have not sought medical attention previously, have you attempted to treat yourself with any product(s)? Yes [ ] No[ ]

If yes, please list: _____

Were any of these products effective? Yes [ ] No [ ] If yes, please list: _____

_____

Are you currently taking medications for any other medical problem? Yes[ ] No[ ] If yes, please list: _____

_____

Do you have any significant medical problems? _____

_____

Are you allergic to any medications? Yes [ ] No [ ] If yes, please list: _____

_____

Do you have any hobbies or a job that causes you to be exposed to oil or grease? (cook, gas station attendant, repair cars, etc.) _____

_____

Do you feel your dietary habits differ significantly from the average? Yes [ ] No [ ] If so, in what way? (vegetarian, eat only health foods, etc.) _____

How much milk do you drink per day? _____

(Female patients — Please complete reverse side)

For Female Patients:

Complexion becomes worse (before, during, after) periods? (circle one)

Have you ever had a yeast infection? Yes [ ] no [ ] If so, how long ago? _____

Are you currently taking any type of hormone medication (include birth control pills)? Yes [ ] No [ ] If so, what brand name and dosage? _____

Have you ever taken any type of hormone medication? Yes [ ] No [ ] If yes, what medication? _____

_____ What dose? _____ When stopped? _____

Are you pregnant or planning on starting a family soon? yes [ ] no [ ] _____

_____

Have you recently had a baby? Yes [ ] No [ ] When? _____

Are you nursing? Yes [ ] No [ ]

Date: _____

SCARS - ~

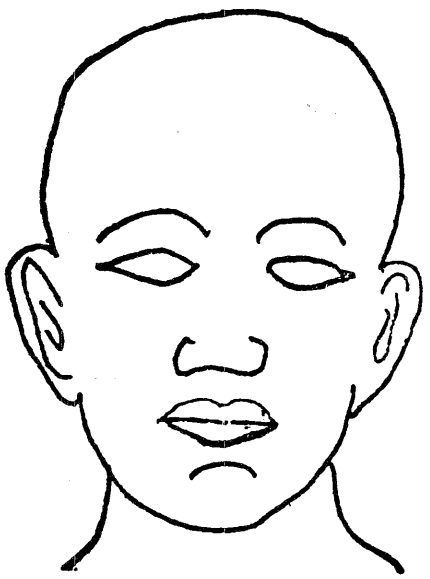
CYSTS - ☆

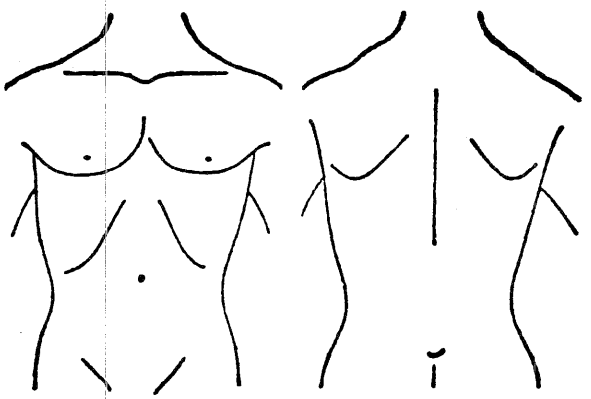
PUSTULES - o

PAPULES -

COMEDONES - X

OILINESS _____





Rock Hill Dermatology Center, P.A.

Patient's Name	Employer's Name
Patient's Address	Employer's Address
City, State, Zip Code	City, State. Zip Code
Home Telephone	Business Telephone
Birth Date Age S.S. No.	O Sngl. OMar. O Div. O Wid O Child
Spouse or Responsible Party S.S. No.	Employer's Name
Address	Employer's Address
City, State. Zip Code	City, State. Zip Code
Home Telephone Date of Birth	Business Telephone
Medical Insurance (Patient)	Medical Insurance (Spouse or Responsible Party)
Policy No.	Policy No.
Policy Holder's Name	Policy Holder's Name
Referred By (If Dr Give Address)	Letter Sent
Treating Any Other Member of Family	

Please Read the Following Information

- The patient is responsible for the bill- not the insurance company. Any failure of reimbursement on the part of the insurance company will result in the patient becoming responsible for the bill.
- We will file your visit if we participate with your insurance company. If we do not participate with your insurance company, payment is expected at the time of the visit.
- It is the patient's responsibility to determine whether or not we are participating in the patient's insurance program.
- It is the patient's responsibility to obtain any necessary referrals and authorizations needed as required by their insurance company. If failure to produce this paperwork results in non-coverage, the patient will be responsible for the bill.
- If the patient's insurance company has a requirement that only certain labs be used for blood work or examining pathology specimens, it is the patient's responsibility to bring this to our attention. Otherwise, we will use our normal facilities. If this results in non-coverage, the bill will be the responsibility of the patient.
- Patients are responsible for notifying the business office of any changes in insurance coverage and changes of address.
- Plan co-payments are due at the time of service.
- Patients are responsible for balances due to deductibles, co-payments, or insurance non-payment.

I have read and accept the above conditions _____

Patient or Guardian Signature

Please see other side

Authorization To Pay Benefits To Physicians:

I hereby authorize payment directly to Rock Hill Dermatology Center, P.A. of the surgical/medical benefits, if any, otherwise payable to me for services rendered to me in this office.

_____ _____

Signature Date

Authorization to Release/Request Medical Information:

I hereby authorize all treating physicians, hospitals, insurance companies, and other medical institutions to release/request any and all information regarding my physical condition and treatment which may be requested by them to aid in medical treatment or processing claims.

_____ _____

Signature Date

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Rock Hill Dermatology Center

Practice Name

I am a patient of Rock Hill Dermatology Center. I hereby acknowledge receipt of Rock Hill Dermatology Center's Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of Rock Hill Dermatology Center 's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

I authorize you to give messages regarding my treatment, appointments, lab results, etc. to an individual other than me. The name(s) of the designated individual(s) will be listed below:

_____

Name of Person and Relationship Telephone Number

I understand that these authorizations are in effect until revoked by me in writing.

_____ _____

Signature Date

_____ _____

Witness Date

ROCK HILL DERMATOLOGY CENTER

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Rock Hill Dermatology Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

(Rock Hill Dermatology Center's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)
I have the right to review the Notice of Privacy Practices prior to signing this consent.

Rock Hill Dermatology Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:Rock Hill Dermatology Center Privacy Officer at 1533 Ebenezer Road, Rock Hill, SC 29732.

With this consent,Rock Hill Dermatology Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Rock Hill Dermatology Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Rock Hill Dermatology Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Rock Hill Dermatology Center's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Rock Hill Dermatology Center has the option of declining to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Print Name of Patient or Legal Guardian

_____ _____

Patient's Name Date