Dermatology & Skin Surgery Center, PC - 210 Village Center Pkwy - Stockbridge, GA 30281

Dr. Maria Pico - Dr. Neville Pereyo - Dr. Brenda Morales - Dr. Nicole Rochet - Dr. David Pharis

Matthew Brunner, PA-C - Christopher Golden, PA-C - Vanessa Winokur, PA-C - Lisa Weiss, PA-C

HIPAA PATIENT CONSENT

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

1. With my consent, **DERMATOLOGY & SKIN SURGERY CENTER, PC** may use the following methods to communicate with me:
   - **Call** to my home or other designated location and leave a message on voicemail or in person,
   - **Mail** to my home or other designated location, and/or
   - **E-mail** to my home or other designated location.
2. I also understand and consent that my personal health information may be disclosed to other appropriate entities, such as (but not limited to) my insurance company(ies), other physicians or health care providers and others as indicated in the Notice of Privacy Practices.
3. I have the right to request that **DERMATOLOGY & SKIN SURGERY CENTER, PC** restricts how it uses or discloses my personal health information. I request the following restriction(s):

____

The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. The above restrictions **ARE, ARE NOT** agreed to by DERMATOLOGY & SKIN SURGERY CENTER, PC.

Signed: ______________________ Position/Title: ________________ Date: ____________

4. If I do not sign this consent, DERMATOLOGY & SKIN SURGERY CENTER, PC may decline to provide treatment to me. I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent.

By signing this form I am consenting to DERMATOLOGY & SKIN SURGERY CENTER, PC's use and disclosure of my personal health information (PHI) to carry out treatment, payment, and operation (TPO).

____
Signature of Patient or Legal Guardian

____
Patient or Guardian's Printed Name

I also authorize assignment of insurance benefits to DERMATOLOGY & SKIN SURGERY CENTER, PC

____
Signature of Patient or Legal Guardian

____
Date

DERMATOLOGY & SKIN SURGERY CENTER, LLP 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 Ms. Dean Height, Privacy Office at 210 Village Center Pkwy, Stockbridge, GA 30281

Patient Information

(Please Print)

Dermatology & Skin Surgery Center

210 Village Center Pkwy - Stockbridge, GA 30281

Name ______________________________
Last *First* *M.I.*

Mailing Address ______________________________
City *State* *Zip*

Home Phone ____________ Cell ____________ SS# ____________

Date of Birth ____________ Sex ____________

Relationship of patient to the Insured ____________

INSURANCE INFORMATION (Please present Insurance card at time of check in)

Primary		**Secondary**	
Insurance Name		Insurance Name	
Name of Insured		Name of Insured	
Date of Birth		Date of Birth	
Insured's ID#		Insured's ID#	
Group #		Group #	

E-mail ____________ Would you like to receive email notifications? *YES or NO*

In case of Emergency, please notify: ____________ Phone ____________

Referred by: ____________ Primary Care Physician: ____________

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature ____________ Date ____________

In order to establish optimal relations with our patients and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. 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. We accept payment in the form of cash, check or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be preverified and you will be asked to pay any unmet deductibles, non-covered services and copayments.

In the event you must cancel a surgical or cosmetic appointment, we must be notified at least 48 hours prior to your appointment time. If not, you will be charged a $50 cancellation fee for a surgical appointment and your cosmetic deposit will be forfeited. All unpaid balances over 90 days will be charged a $2.00 per month finance charge. After 120 days of non-payment, an additional $10.00 charge will be added and your account will be forwarded to an outside collection agency.

Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature ____________ Date ____________

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NON-COVERED SERVIES

I understand that the following procedures / services are usually considered as **non-coverd services.**
If I request medical or surgical treatment for these diagnosis, I will be responsible for the fees.

Acrochordons (Skin Tags)
Alopecia (Hair Loss)
Benign Nevi (Moles)
Laser Hair Removal
Lentigo (Liver Spots, Age Spots)
Keloid (Injections/Surgery)
Dermabrasion
Seborrheic Keratosis
Sebaceous Hyperplasia
Dilated Blood Vessels
Botox and Fillers
Laser Surgery/Consult
Injections (Cortisone)
Chemical Peels
Milia (Cysts)
Scar Revision/Acne Scarring
Male Pattern Baldness
Wrinkles

PLEASE READ - OUR FINANCIAL POLICY

- All cosmetic surgeries/procedures are to be paid for in full, prior to procedure being done.
- All co-payments will be collected upon completion of the Patient Information sheet or at sign-in prior to seeing the physician
- If we are not a provider for your insurance, or if you have not met your deductible, or are ineligible for benefits, FULL PAYMENT WILL BE COLLECTED TODAY.
- **Deposits for procedures are non-refundable.**
- All billed balances must be paid within 30 days of 1st billed date, after which they are subject to collection efforts
- **All returned checks are subject to a $30.00 returned check fee.**
- **TISSUE SPECIMEN WILL BE SENT TO A BOARD CERTIFIED DERMATOPATHOLOGIST, WHO WILL BILL A SEPARATE FEE.**

______________________________ ______________

Parent or Legal Guardian's Signature ***Date***

Dermatology & Skin Surgery Center, PC - 210 Village Center Pkwy - Stockbridge, GA 30281

HIPAA RELEASE

I, ________________________________, hereby do give permission to Dermatology & Skin Surgery Center, PC to discuss my medical/financial case with the following person(s):

Name:____________________ Phone Number:________________ Relationship:________________

Name:____________________ Phone Number:________________ Relationship:________________

Name:____________________ Phone Number:________________ Relationship:________________

Name:____________________ Phone Number:________________ Relationship:________________

The following are persons whom I specifically **DO NOT** wish my case to be discussed with:

Name:____________________ Phone Number:________________ Relationship:________________

Name:____________________ Phone Number:________________ Relationship:________________

Name:____________________ Phone Number:________________ Relationship:________________

Name:____________________ Phone Number:________________ Relationship:________________

____ ______________________

Parent or Legal Guardian's Signature ***Date***

Dermatology & Skin Surgery Center, PC - 210 Village Center Pkwy - Stockbridge, GA 30281

PERMISSION TO TREAT A MINOR

I, ____________________________, parent or legal guardian of ____________________________, born the ______ day of __________________, 20______ do hereby consent my child to attend his/her appointment alone without my presence and authorize treatment in accordance with the office policy of **Dermatology & Skin Surgery Center, PC**. This includes providing a history of present illness, disclosure of protected health information, and responsibility for relaying any diagnosis, treatment plan, or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all copays and coinsurance. This authorization is effective on: ___________________________________ and expires on: _____________________________________.

Child's Health Information:

Current prescribed or over the counter medications and dosages:

Medication: ________________________________ Dosage: _______________________________

Medication: ________________________________ Dosage: _______________________________

Medication: ________________________________ Dosage: _______________________________

Allergies, illnesses or other comments: ____

____

____

Emergency Contact Information for Parents/Guardians:

Where/how can you be reached in case of emergency? Phone _______________________________

Comments ____

Temporary Guardian Information Name: ____

Phone: _________________________ Address: ____

____ _________________________

Parent or Legal Guardian's Signature ***Date***

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PERMISSION TO ACCOMPANY A MINOR

I, ______________________________ give permission to the adult(s) listed below to accompany my child (name and DOB) ____ and authorize treatment for my child in accordance with the office policy of **Dermatology & Skin Surgery Center, PC.** This includes bringing the child into the office of **Dermatology & Skin Surgery Center, PC,** providing a history of present illness, disclosure of protected health information, accompanying consented research study procedures, and witnessing any physical exam completed by the provider. This adult has the responsibility to relay and diagnosis, treatment plan and/or prescriptions(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all copays and coinsurance.

This authorization is effective on: ________________________ and expires _____________________.

Name: ____

Name: ____

Name: ____

Child's Health Information:

Current prescribed or over the counter medications and dosages:

Medication: ______________________________ Dosage: ______________________________

Medication: ______________________________ Dosage: ______________________________

Medication: ______________________________ Dosage: ______________________________

Allergies, illnesses or other comments: ____

____

Emergency Contact Information for Parents/Guardians:

Where/how can you be reached in case of emergency? Phone ______________________________

Comments ____

Temporary Guardian Information Name: ____

Phone: ________________________ Address: ____

____ ________________________

Parent or Legal Guardian's Signature ***Date***

210 Village Center Pkwy - Stockbridge, GA. 30281
(770) 474-5952

MEDICAL HISTORY FORM

NAME: ______________________________ **DATE OF BIRTH:** __________ **AGE:** _____

SEX: _____ **HEIGHT:** ______ **WEIGHT:** ______ **EMAIL:** ______________________________

PHARMACY: ____________________________ **REFERRED BY:** ___________________

REASON FOR TODAY'S VISIT: ____

Skin areas involved: ____

How long has the problem been present? _________________________________

Has a skin biopsy been done? ☐ No ☐ Yes - Result?____________________________

Was there any previous treatment? ☐ No ☐ Yes - What? ______________________

LIST ALL MEDICATIONS (including vitamins, herbs, supplements) **OR BRING SEPARATE LIST:**

____

____

DRUG ALLERGIES: ____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING? (Circle all that apply.)

Anxiety

Arthritis

Asthma

Atrial fibrillation (irregular heartbeat/arrhythmia)

Benign prostatic hyperplasia (enlarged prostate)

Cataracts

Cerebrovascular accident (stroke)

Chronic obstructive lung disease (COPD)

Coronary artery disease

Depression

Diabetes ☐ Type I ☐ Type II

End-stage kidney disease (ESRD)

Gastroesophageal reflux disease (GERD)

Glaucoma

Hypertension (high blood pressure)

Other ________________________________

Hearing loss

Human immunodeficiency virus (HIV/AIDS)

High cholesterol

Hyperthyroidism (high thyroid function)

Hypothyroidism (low thyroid function)

Inflammatory disease of liver (hepatitis)

Leukemia

Lymphoma

Lung cancer

Breast cancer

Colon cancer

Prostate cancer

Radiation therapy

Seasonal allergies

Transplantation of bone marrow

None _____

(PLEASE TURN PAGE OVER TO COMPLETE)

Name: ______________________

PAST SURGICAL HISTORY (CIRCLE ALL THAT APPLY):

Appendectomy (appendix removed)
Bilateral tubal ligation
Cholecystectomy (gallbladder removed)
Colectomy (part of colon removed)
Coronary angioplasty (balloon angioplasty)
Coronary artery bypass graft
Coronary artery stent
Hysterectomy
Joint replacement - joint & year: ____________
Lumpectomy - circle: left / right / both
Mastectomy - circle: left / right / both
Mechanical heart valve replacement
Prosthetic heart valve replacement
Solid organ transplant - organ: ____________
Splenectomy (spleen removed)
None _____
Other ____

CIRCLE ANY SKIN OR SKIN-RELATED CONDITIONS YOU HAVE HAD:

Acne
Actinic keratosis (precancer)
Basal cell carcinoma (BCC)
Biopsy of skin – result: ___________
Contact dermatitis (rash) due to poison ivy
Dry skin
Dysplastic nevus (precancerous mole by biopsy)
Eczema
Melanoma - location & year: __________
Psoriasis
Squamous cell carcinoma (SCC)
Sunburns (blistering)
Other ____

Do you wear sunscreen? ☐ No ☐ Yes – SPF: _____

Have you tanned at a tanning salon or in a tanning bed? ☐ Past ☐ Present ☐ Never

Do you have a **family history of melanoma**? ☐ No ☐ Yes: Which relative(s)? ____________

Do you have a **family history of any other skin cancers**? ☐ No ☐ Yes

SOCIAL HISTORY

Occupation: _________________________

Smoking: ☐ Daily
☐ Occasionally
☐ In the past
☐ Never

Alcohol (Drinks per Day): ___________________

IV Drug Use: ☐ Past ☐ Present ☐ Never

Other Drug Use: ___________________________

Sexual Partners: ☐ None ☐ One ☐ Multiple

(For Women) Date of Last Period: _____________

Name: ______________________

ARE YOU *CURRENTLY* EXPERIENCING ANY OF THESE SYMPTOMS? (Circle all that apply.)

Changing mole
Rash
Abdominal pain
Bloody stool
Bloody urine
Blurry vision
Cough
Depression
Fevers or chills
Headaches
Joint aches
Muscle weakness
Drenching night sweats
Seizures
Shortness of breath
Unintentional weight loss
Wheezing
Unwanted hair growth
Itch
Diarrhea
Irregular menstrual periods
Mouth sores

DO YOU HAVE ANY OF THE FOLLOWING? (Circle all that apply.)

Problems with bleeding
Problems with healing
Problems with scarring (keloid or hypertrophy)
Pacemaker
Defibrillator
Artificial joint(s) within the last 2 years
Artificial heart valve
Need premedication prior to procedures – which meds? ________________________
Allergy to adhesive
Allergy to antibiotic ointments or creams
Taking blood thinners (including aspirin)
Pregnant currently, trying to conceive/planning a pregnancy, or breastfeeding currently
Allergy to lidocaine
Rapid heartbeat with epinephrine
Yeast infection with antibiotics
Immunosuppression (due to marrow or organ transplantation, chemotherapy, biologics, etc.)