PATIENT INFORMATION

Dermatology & Skin Surgery Center

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

Name _____ Date _____
Last *First* *M.I.*

Date of Birth ____/____/____ SS# _____ Gender _____

Mailing Address _____
Street *City* *State* *Zip*

Cell _____ Home _____ Work _____

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

Race/Ethnicity *(Optional)* ☐ White/Caucasion ☐ Black/African American ☐ Hispanic/Latino ☐ Other _____

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

Primary

Insurance Name _____
Name of Insured _____
Date of Birth _____
Insurance ID# _____
Group # _____
Relationship to Patient _____

Secondary

Insurance Name _____
Name of Insured _____
Date of Birth _____
Insurance ID# _____
Group # _____
Relationship to Patient _____

Pharmacy _____ Phone _____

Pharmacy Address _____

In case of Emergency, please notify _____ Phone _____

Who may we thank for referring you? _____

Primary Care Physician _____

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MEDICAL HISTORY

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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.)

PATIENT FINANCIAL AGREEMENT

Dermatology & Skin Surgery Center

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Welcome to Dermatology & Skin Surgery Center, PC. We are dedicated to making sure that our patients are provided with exceptional medical care. **We strongly encourage each patient to contact their insurance company to confirm their doctor is a participating provider in their plan.**

As a service to our patients, we are currently enrolled in numerous Managed Care plans. However, it is impossible for the practice to know all the requirements of each individual plan. **It is the patient's responsibility to be aware of the parameters of your individual plan and to notify the office of any changes or restrictions.** Any charges which are accrued because of failure of notification will be the responsibility of the patient. If insurance cannot be verified prior to each appointment, payment will be due at the time of service.

At Dermatology & Skin Surgery Center, PC we provide diagnostic procedures, examinations and medical treatment including laboratory work. As a courtesy, we file charges directly to your insurance. At times, it is required that we send medical records to assist with payment of these charges.

Please be aware some of the services billed to your insurance may result in charges to you depending on your individual insurance plan coverage. Please take the time to acquaint yourself with your insurance policy.

Please note Dermatology & Skin Surgery Center, PC follows all Federal laws. We are not able to rebill due to services not being covered by your insurance policy. If you receive a bill from an outside facility such as LabCorp, Quest, etc., you will need to contact them directly.

Self-pay patients are required to pay at the time services are rendered. An initial deposit of $144.00 will be required at Check In for new patients and $94 for established patients. Upon check out charges will be reconciled. As a courtesy, Dermatology & Skin Surgery Center, PC offers a self-pay rate on same date services provided, including most laboratory services, only if charges are paid the day of services.

In the event you must cancel a surgical or cosmetic appointment, we must be notified at least 48 business hours prior to your appointment time. If not, you will be charged a $50 fee for a surgical appointment and for cosmetic appointments you will forfeit your $75 deposit. Patient balances 120 days+ overdue will be forwarded to an outside collection agency.

Any **returned check** will incur a $35.00 charge to cover bank charges associated with the returned check in addition to the amount of the check. NSF checks must be redeemed with certified funds and check will no longer be accepted as payment.

An upfront fee of $25.00 will be collected for administrative tasks such as completing disability forms, FMLA and some medical records request. These tasks may require up to ten days to complete.

If any bills are acquired, it must be paid within 30 days of receipt. If you are unable to pay your balance, please contact the billing office to make payment arrangements. Any balance left unpaid not under arrangements may be sent to a collection agency. If your account is sent to collections, there will be a $30.00 collection fee added to the total outstanding balances.

I acknowledge I have read and understand the policies above. I accept the rights and responsibilities outlined within them.

Patient/Guardian Signature: _____ Date: _____

Patient/Guardian Printed Name: _____

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CONSENTS & RELEASES

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Consent for Treatment

I, _____, hereby voluntarily consent to patient care at Dermatology & Skin Surgery Center, PC (DSSC) encompassing routine examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine, and other studies), and administration of medications prescribe by the medical provider. I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physicians, physician assistants and/or medical assistants as is necessary.

(Please initial all sections below)

Notice of Patient Privacy Consent (HIPAA)

____ I have been provided with a copy (electronic and/or printed copy) of the practice's Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information. (The Notice of Patient Privacy Consent is posted on our website at www.dermandskin.com for your convenience.)

Authorized Release of Medical Information

There are times where the physicians and employees of DSSC need to contact you. Our primary method is through your patient portal, however, circumstances may require us to contact you via mail, email, telephone, voice mail, and/or text messaging.

I authorize the release of medical information to the following: _____,
Name and Relationship

_____,_____
Name and Relationship *Name and Relationship*

Consent for Use, Disclosure of Patient Information for the purposes of Treatment, Payment, and Healthcare Operations

____ I hereby consent to DSSC using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to DSSC using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information for another provider or health care entity to conduct health care operations.

Lifetime Medicare Authorization & Consent for Medicare Patients Only

____ I certify that the information given by me in applying for payment under Title SVIII and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. Please note Federal Law requires us to collect your yearly deductible and co-insurance amounts. If you have a secondary insurance, we will bill your secondary insurance after Medicare pays the requested amount. I understand that I am responsible for my health insurance deductible and coinsurance.

Terminating Services

____ All the providers at DSSC value a meaningful and productive relationship with our patients. Unfortunately, there are occasions when this is no longer feasible. Please be advised that the Practice reserves the right to terminate the provider/patient relationship for the following reasons:

1. Multiple cancellations or missed appointments.
2. Medical Non-Compliance, including violation of Therapeutic Drug Agreement.
3. Failure to comply with practice policies.
4. Rude, abusive behavior, use of obscene language, mistreatment of staff in person or on the phone.
5. Failure to pay a debt/account sent to collections.

If the relationship is terminated, you will be notified in writing. Your provider will provide emergency medical care for 30 days following the date of the written notice and will send medical records to a new provider with a written release.

_____ _____

Patient/Guardian Signature *Date*

_____

Patient/Guardian Printed Name

PATIENT PRIVACY NOTICE

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This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

SUMMARY – NOTICE OF PATIENT PRIVACY

Your Rights

You have the right to:
• Get a copy of your paper or electronic medical record
• Correct your paper or electronic medical record
• Request confidential communication
• Ask us to limit the information we share
• Get a list of those with whom we've shared your information
• Get a copy of this privacy notice
• Choose someone to act for you
• File a complaint if you believe your privacy rights have been violated

Our Uses and Disclosures

We may use and share your information as we:
• Treat you
• Run our organization
• Bill for your services
• Help with public health and safety issues
• Comply with the law
• Respond to lawsuits and legal actions

DETAILED EXPLANATION – NOTICE OF PATIENT PRIVACY

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
• We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address law enforcement and other government requests

We can use or share health information about you:

- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- If you have a concern regarding your patient privacy, please contact our Privacy Officer, Dean Height at:

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- For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site at: www.dermandskin.com