Savannah Dermatology Clinic, P.C.

Adam S. Pritzker, M.D.
Courtney Williams, FNP-BC
712 E. 70th Street
Savannah, GA 31405
Telephone: (912) 352-8974 Fax: (912) 355-8329

Patient Information

Patient's Name: ________________________________ SS#: _______________ Date of Birth: __________

Marital Status: _______________ Spouse's Name: _______________________

Address: ________________________________ City: _______________ State: ______ Zip: _________

Telephone Number: (preferred) _________________ (cell) _________________

Referred by: ____________________Primary Care Physician: ____________________

Employer Name: ______________________ Tel#: _________________ Occupation: _______________

Emergency Contact: ____________________ Tel#: _________________ Relationship: ______________

Personal Email address: ____

** Please provide to access your own personal patient web portal. This will give you the opportunity to view your medical records via the internet as well as be reminded for any future appointments.

How did you hear about us? Referred__ Internet__ Friend__ Phone Book__ Insurance Company__ Other___

Insured Person (if not patient)

Name: _____________________ Tel#: _________________ Relationship to Patient: ______________

Address: ________________________________ City: _______________ State: ______ Zip: _________

Insurance(s)

Primary Insurance Company Name: ________________________________

ID#: _________________ Group#: _________________

Secondary Insurance Company Name: ________________________________

ID#: _________________ Group#: _________________

Pharmacy Information

Name_______________________________________ Phone Number_________________________________

Address/Location:____

REASON FOR TODAY'S VISIT: ______________________________

REASON FOR TODAYS VISIT ON THIS LINE

- **Have you had or do you currently have any of the following medical conditions**:

____ Anxiety	____Kidney Disease	____Lung Cancer
____ Arthritis	____Hearing Loss	____Lymphoma
____ Asthma	____Hepatitis	____MRSA
____ Atrial Fibrillation	____High Blood Pressure	____Pacemaker
____ Bone Marrow Transplant	____HIV/AIDS	____Prostate Cancer
____ Breast Cancer	____High Cholesterol	____Radiation Treatment
____ Colon Cancer	____Thyroid Disorder	____Seizures
____ COPD	____Heart attack	____Stroke
____ Heart Disease	____Immunosuppression	_____Heart Valve Replaced
____ Depression	____Diabetes	Other: _______________

Are you currently: Pregnant: Yes / No Planning Pregnancy: Yes / No Breast Feeding: Yes / No

Have you had any surgeries? (including joint replacement and heart valve surgeries)

____

____

Medications: (including over the counter)

____

____

____

Drug Allergies: (including reaction)

____

____

Do you have or have had any of the following skin conditions?

_____Acne	_____Eczema	_____Precancerous Moles
_____Actinic Keratosis	_____Flaking or Itchy Scalp	_____Psoriasis
_____Basal Cell Carcinoma	_____Hay Fever/Allergies	_____Squamous Cell Carcinoma
_____History of Blistering Sunburns	_____Melanoma Skin Cancer	______Dry Skin

Do you have a family history of melanoma or other skin cancers?___Yes___No
If yes, which relative? What type of skin cancer? ____

Smoking Status:
- ____Current Every Day Smoker
- ____Current Some Day Smoker
- ____Former Smoker
- ____Never Smoked

Alcohol Consumption:
- ____None
- ____Socially
- ____Moderate
- ____Daily

Information and Assignment of Benefits

As a courtesy to you, we will file your insurance claims on your behalf. We encourage everyone to understand the coverage your insurance provides for professional services. We will do our best to estimate what your insurance company will pay based on information provided by you and your insurance company. Estimates are NOT GUARANTEED. Payments for services rendered are expected upon checking out today.

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize Dr. Adam S. Pritzker to apply for benefits on my behalf for covered services rendered by him or by his order. I request that payment from my insurance company be made directly to Dr. Pritzker. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Signature: ________________________ **Date:** ______________________

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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____
Signature of Patient or Personal Representative

____
Date

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority.

** I authorize Savannah Dermatology Clinic, P.C. to disclose my health care and diagnostic information to the **person** (relative, caregiver or friend) listed below:

My medical records (e.g. biopsy results) may be released to: ______________________________

Signature of Patient: ________________________________ **Date**: _________________________

Patient Financial Policy

Pritzker Dermatology Clinic, PC
Adam S. Pritzker, M.D.
Courtney Williams, FNP-BC

We regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. Please review and carefully read the policies outlined below. Initial each line, agreeing that you have read and understand the following. If you have any questions, please discuss them with a member of our staff.

______ 1. Unless other arrangements have been made in advance, full payments of co-pays, coinsurance, and deductibles are **due at the time of service**. This includes, but not limited to, your office visit and any additional procedures that were done at the time of service (e.g. biopsies, removal/treatment of benign lesions, surgeries and cosmetic procedures, etc.). In the event we over collect, we will voluntarily refund your overpayment.

______ 2. This office participates with a number of health insurance providers. To see if your plan is listed among these, please contact our office staff. If we are out of network with your particular plan, **you will be responsible for payment in full** and we can provide you with a form so that you may file a claim with your insurance carrier.

______ 3. All insurance plans are not the same and do not cover the same services. In the event your insurance plan determines the service to be "not covered," **you will be responsible in full for the remaining balance**. Any disallowed charges are due upon receipt of a statement from our office. If you are unsure of your plan benefits, please contact your insurance company.

______ 4. If your insurance company requires a **referral**, you must obtain this from your primary physician prior to your appointment. This is a requirement of your insurance carrier and we must follow these rules to ensure that you get the full benefits to which you are entitled. If you have any questions regarding the regulations your carrier has, contact your employer's human resources department or your insurance carrier directly.

______ 5. **Collections**: Failure to pay balance in full or arrange payment on your account for a period of 90 (ninety) days will result in your account being turned over to an outside collection agency. Additional collection costs/fees will be added to your account in this instance and you will be financially responsible for additional collection fees.

______ 6. If your insurance company sends you a check for services provided by Pritzker Dermatology, P.C., you must turn over the check to our office or pay us immediately. If there is no receipt of payment, your account will go to an outside collection agency.

By signing below, I agree that I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended periodically by this practice.

______________________________ ____________________

Signature of Patient **Date**
(or responsible party if a Minor)