PATIENT INFORMATION *Georgia Skin Specialists, P.C.*

PATIENT NAME: _____ PREFERRED NAME: _____

DATE OF BIRTH: _____ /_____ / _____ SEX: ☐ MALE ☐ FEMALE ☐ OTHER

SSN: _____ MARITAL STATUS: _____ PREFERRED PRONOUNS: _____

PATIENT ADDRESS: _____ UNIT NUMBER:_____

CITY/STATE/ZIP: _____

Please check the box to indicate your **primary** phone number:

☐ HOME PHONE: _____ ☐ WORK PHONE: _____

☐ CELL PHONE: _____

EMAIL ADDRESS: _____@_____._____

RACE: ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN
☐ HAWAIIAN/PACIFIC ISLANDER ☐ WHITE/CAUCASIAN ☐ OTHER
☐ UNKNOWN ☐ DECLINED

ETHNICITY: ☐ NOT HISPANIC OR LATINO ☐ HISPANIC OR LATINO ☐ DECLINED ☐ UNKNOWN

LANGUAGE: _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP TO PATIENT: _____

EMERGENCY CONTACT HOME PHONE: _____ CELL PHONE: _____

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____

PRIMARY PHARMACY: _____ PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE PLAN NAME: _____ EFFECTIVE DATE: _____

POLICY HOLDER: _____ **POLICY HOLDER** DATE OF BIRTH: _____

INSURANCE ID#: _____ GROUP #:_____

SECONDARY INSURANCE PLAN NAME: : _____ EFFECTIVE DATE: _____

POLICY HOLDER: _____ **POLICY HOLDER** DATE OF BIRTH: _____

INSURANCE ID#: _____ GROUP #:_____

ASSIGNMENT AND RELEASE OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include Major Medical Benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: **Georgia Skin Specialists, P.C.**

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release medical information to secure payment.**

SIGNED: _____ DATE: _____

Thank you for choosing Georgia Skin Specialists, P.C. for your dermatology needs. We are committed to providing you with the best possible medical care. Your assistance in complying with our policies will help us serve you.

Consent of Treatment

_____ (initials) I hereby authorize the certified providers of Georgia Skin Specialists to provide dermatologic care for me. I give the providers permission to perform any necessary procedures (including the administration of local anesthetic), and I understand that I will be advised of any associated risks.

Labs

_____ (initials) I understand that all pathology specimens and lab work are sent to an outside laboratory for testing. These facilities are a separate entity from Georgia Skin Specialists and therefore will file a separate claim with your insurance and send a separate bill. I understand that Georgia Skin Specialists will forward my insurance information to the lab, and if my insurance does not pay for these services, I will be responsible for the balance. I also understand that if my insurance company requires me to use a certain lab, it is my responsibility to inform a member of Georgia Skin Specialists staff **prior** to the specimen being sent.

Proof and Change of Insurance

_____ (initials) I authorize the release of medical information to my primary care or referring physician and as necessary to process insurance claims, insurance applications, prior authorizations, and prescriptions. I also authorize payment of medical benefits to the physician.

Patients are required to show both proof of insurance and a Government issued photo ID at their initial and subsequent visits. The patient (parent/legal guardian) is responsible for informing our office of any changes in their insurance coverage since their last visit. We will file claims to your insurance carrier and accept payment directly from them. If you are billed for denial of coverage, it is your responsibility to contact your insurance company regarding the denial. Patients are fully responsible for all costs denied by their insurance. If your plan requires a referral or prior authorization, it is your responsibility to obtain this **prior** to your visit.

It is important that you educate yourself about your individual insurance benefits. Some policies have deductibles for surgical procedures. Insurance companies consider procedures like cryosurgery (freezing with liquid nitrogen), removal of moles, or other small procedures to be "surgery." If you have a surgical deductible that has not been met and have one of these procedures, you will be responsible for the payment. We can never guarantee insurance coverage for any service provided. **We cannot submit or resubmit claims with preventative codes.** There are a number of services we provide that are typically considered "cosmetic" by your insurance company. Please note that we do not file insurance claims for cosmetic services, and these services must be paid **in full** at the time these services are rendered. We are unable to offer payment plans on cosmetic services.

Patients Under 18 Years Old

_____ (initials) The patient registration form must be signed and guaranteed by the parent or legal guardian accompanying the minor at the first appointment. The guarantor is legally responsible for payment. We are unable to know the financial arrangements and responsibilities of divorced parents. The adult accompanying the minor is responsible for payment of the patient portion due at the time of service. If the guarantor believes the former spouse is responsible for a balance, the guarantor must forward the statement to him or her.

CONTINUED ON NEXT PAGE/REVERSE – PLEASE REVIEW AND SIGN

Payment, Fees, and Collections

_____ (initials) For your convenience, we accept cash, personal checks, debit cards, Visa, MasterCard and American Express. If you do not have insurance, **or it cannot be verified at the time of your visit**, total payment for your visit is due at the time of service. If you do not have insurance, we offer a self-pay discount of 30% on medical (non-cosmetic, non-product) charges. Payment for self-pay charges is due at the time of service. **Co-payments and outstanding account balances are due at the time of service.** Once insurance has processed a claim, bills are sent for outstanding patient balances. Payment is due within 15 days of statement date.

_____ (initials) I agree that I am personally responsible for payment of all charges for medical and/or surgical services whether not covered, part of my deductible, co-insurance, co-payment or otherwise not paid or payable by my insurance or medical plan. I understand and agree that in the event my account is turned over to a collection agency for non-payment, I will be responsible for collection agency fees in the amount of 10% of the account balance. I further understand and agree that if my account is turned over to an attorney for non-payment, I will be responsible for all court costs and costs of collection including reasonable attorney's fees in the amount of 15% of the account balance.

Collections balances must be paid **in full** before a future appointment can be made. Patients who are sent to collections more than one (1) time will be dismissed from the practice and notified by certified letter.

Returned check fee: A $25 fee will be due for any check returned from the bank for non-payment.

No-Shows or Late Cancellations: We request that appointments be cancelled at least 24 hours prior to appointment time. No-Shows and Late Cancellations will be charged a fee of $25. Patients who No-Show or give Late Cancellation notice more than three (3) times in a calendar year may be dismissed from the practice and notified via certified letter.

Acknowledgement

- I hereby authorize Georgia Skin Specialists, P.C. to release any information requested by the insurance company or companies or respective representatives and act as my agent to secure payment from any and all services rendered.
- I understand that I am financially responsible to Georgia Skin Specialists, P.C. for any and all charges incurred by myself and/or dependents.
- I further acknowledge and understand that I accept the terms outlined in the above policies.
- I understand that no warranty or guarantee has been made to me relative to result in care or medical outcome.

Patient Name (PRINT): _____ DATE OF BIRTH: _____

Patient or Responsible Party Signature: _____ TODAY'S DATE: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES ***Georgia Skin Specialists, P.C.***

We are committed to ensuring your Protected Health Information (PHI) remains confidential. Your paper and electronic medical records are safeguarded and released only with your consent, or to your insurance carrier, other medical professionals involved directly with your care, or as required by law. Our Notice of Privacy Practices policy manual, which explains how your medical information may be used and disclosed, is available for your review or you are welcome to have a copy. If you would like to release your PHI to another doctor or facility, you will be required to fill out a separate form to request your records.

PATIENT NAME (please print): _____ DATE OF BIRTH: _____

I hereby acknowledge the receipt of a copy of the Notice of Privacy Practices of Georgia Skin Specialists.

PATIENT SIGNATURE: _____ TODAY'S DATE: _____

OR

PATIENT REPRESENTATIVE'S NAME (please print): _____

RELATIONSHIP TO PATIENT: ☐ PARENT ☐ LEGAL GUARDIAN ☐ PERSON WITH POWER OF ATTORNEY

SIGNATURE: _____ TODAY'S DATE: _____

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

This form summarizes the anticipated use of information about you for which this authorization is required. Georgia Skin Specialists, P.C. provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). By signing this authorization, I permit Georgia Skin Specialists, P.C. to use and/or disclose my protected health information (PHI) as outlined below.
Please check all that apply:

☐ Do not share my medical/account information with anyone but myself.

☐ You may leave a message at my primary phone number: _____

☐ You may share my medical/account information with: _____

_____

(Please list the full name and relationship of any and all individuals authorized, ex: spouse, parent (if over 18), sibling, friend, etc.)

Expiration date of this authorization: _____
(If "none" is selected as the expiration date of this authorization, it will be valid until it is revoked or changed in writing.)

TELEPHONE CONSUMER PROTECTION ACT (TCPA)

I agree that the facility, Georgia Skin Specialists or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message to any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or otherwise associated with my account.

SIGNATURE: _____ TODAY'S DATE: _____

Patient History Questionnaire

Patient Name: _____ Date of Birth: _____ / _____ / _____

Specific Area of Concern: _____

Minors only: Weight: _____ Height: _____

Allergies:

Medication or Substance	Reaction or Symptom
_____	_____
_____	_____

Current Medications (including Supplements):

Name and dosage	Name and dosage	Name and dosage
_____	_____	_____
_____	_____	_____

Past Medical History:

Please check all that apply

_____ Blood Clots
_____ Cancer: _____
_____ Diabetes
_____ Heart Problems: _____
_____ Hepatitis/Liver Disease
_____ High Blood Pressure
_____ High Cholesterol
_____ HIV/AIDS
_____ Lung Disease
_____ Seizure Disorder
_____ Skin Cancer/Disease
_____ Stroke
_____ Thyroid Problems
Other: _____

Please list any surgeries/hospitalizations with dates

_____
_____
_____
_____
_____

Family Medical History: *Please list any direct relatives with a history of **skin cancer** or **skin disease***

_____

Social History:

Occupation: _____ Where did you grow up? _____

Alcohol Use: ___ Yes ___ No Number of drinks per week? _____

Tobacco Use: ___ Current ___ Former ___ Never Tanning Bed Use: ___ Current ___ Former ___ Never

Females Only:

Are you currently pregnant or trying to get pregnant? ___ Yes ___ No Are you currently nursing? ___ Yes ___ No

Date of last menstrual period: _____/_____/_____ Current contraception/birth control method: _____

	YES	NO		YES	NO
Skin	---	---	**Gastrointestinal**	---	---
Itching			Nausea/Vomiting		
Rashes			Diarrhea		
Non-healing sore(s)			**Cardiovascular**	---	---
Dry skin/lips			Pacemaker		
Acne			Currently taking blood thinners/Aspirin		
Mole Changes			**Respiratory**	---	---
New Growth			History of Asthma/Wheezing/Shortness of Breath ***(If yes, circle appropriate answer)***		
Constitutional	---	---	**Ear/Nose/Throat**	---	---
Weight Loss			Nose Bleeds		
Fatigue			Hay Fever		
Fever			**Musculoskeletal**	---	---
Psych	---	---	Joint Pain		
Depression			**Eyes**	---	---
Neurological	---	---	Dry Eyes		
Headaches			Blurred Vision		
Vasovagal Reaction/Fainting with Blood Draws			**Lymph Nodes**	---	---
			Painful/Swollen Lymph Nodes		