Dermatology
Specialists of Atlanta

Last Name, First Name: _____ Middle Initial:_____

Street Address: _____ **City / State:** _____

Zip Code: _____ **Date of Birth:** _____/_____/_____ **Gender:** _____

Home Number: _____ **Cell Phone Number:** _____

Preferred Phone Number: _____ SSN: _____

Email Address: _____ Emergency Contact: _____

Preferred Language: _____ Race: _____ Ethnic Group:_____

Today's Date: _____

Preferred Pharmacy

Pharmacy Name: _____

Pharmacy Number: _____

Pharmacy Address: _____

Employer: _____ Occupation: _____

Guardian /Parent Name (if patient is under 18):_____

Guardian/Parent SSN#: _____ Guardian/Parent Date of Birth: _____

Spouse's Employer: _____ Spouse's Work Phone #: _____

Emergency Contact: _____Phone Number: _____

Do you have a Primary Care Physician? ☐ Yes ☐ No

If so, who? _____ Phone Number: _____

Referred by Physician? ☐ Yes ☐ No If so, who? _____

Phone Number: _____

How did you hear about us? □ Internet □ Facebook □ Best Self Magazine □ Family/Friend
□ Other _____

Primary Insurance: _____ Policy Holder's Name: _____
ID#: _____ Group/Account#: _____
Policy Holder's SSN# (required): _____ Policy Holder's DOB (required):_____
Secondary Insurance: _____ Policy Holder's Name: _____
ID#: _____ Group/Account#: _____
Policy Holder's SSN# (required): _____ Policy Holder's DOB (required): _____

PLEASE PRESENT ALL INSURANCE CARDS AND IDENTIFICATION TO THE RECEPTIONIST

I hereby authorize the physician to provide information to insurance carriers concerning my medical care and I hereby irrevocably assign to the doctor all payments for all the medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as the original.

Signature of Patient or Parent/Guardian: _____Date: _____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

_____

_____

Past Surgical History

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Live: Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Postate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy: Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ NONE
- ☐ Other _____

Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Have Fever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ NONE
- ☐ Other

_____
_____

Do you wear Sunscreen?

○ Yes ○ No

If yes, what SPF? _____

Do you tan in a tanning salon?

○ Yes ○ No

What is your reason for being seen today?

_____
_____
_____
_____
_____
_____
_____

Do you have a family history of Melanoma?

○ Yes ○ No

If yes, which relative?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter
- ☐ Other

_____
_____

Medications

List all current medications:

_____
_____
_____

Allergies

List all allergies and reactions if known:

_____
_____
_____

Social History

Smoking Status (please choose one):

- ☐ Current everyday smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy _____

Quit Smoking:

- mm/dd/yyyy _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Check Review of Systems

Driving Status:

- ☐ Drives in the Daytime
- ☐ Drives at Night

How often do you exercise?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

What is your caffeine use?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

Family History

Please include only first-degree relatives:

_____
_____
_____
_____

Dermatology Specialists of Atlanta

NOTICE OF FINANCIAL POLICY

Dermatology Specialists of Atlanta is dedicated to you and your well-being. We promise to do our best to provide you with the highest possible care available. As a private practice, we are not subsidized by any government or private programs. We offer our service to you at a competitive price that is comparable to any other Dermatology practice in the area.

We accept all major credit cards, cash, or checks (Returned Checks for non-sufficient funds may be charged a fee of $35).

Insured Patients
Insurance coverage will normally cover payment for some of the healthcare services we provide. Most insurance plans have co-pays, deductibles, or co-insurances that are paid by the patient. For the plans that Dermatology Specialists of Atlanta participates with, we will honor the amount allowed by your insurance company. We will file your claim with them for reimbursement of the charges associated with the services we provided, and we will write off the amount we have agreed to discount. ***Please be advised the costs of lab services, biopsies and any in-office procedures are not included in the office visit fee.***

If your plan has a copay/deductible/co-insurance, we are required by the agreement, to collect it at the time of service.

We cannot pre-determine what your insurance carrier will/will not define as necessary care. We believe that should be determined by your physician. If, for whatever reason, the company does not pay for the services, please understand you will be responsible for the unpaid balance. You will receive a detailed statement including your insurance companies' response. Due to the delay in receiving payment for the services, and the cost of communicating with them and you, we would appreciate your timely response to any balance.

Self-Pay Patients
For patients that are presently without insurance coverage, we want you to know that both your physical and financial interests are considered as we treat your illness; however, we are primarily dedicated to treating that illness as effectively as we can. For us to remain efficient and viable, we ask that you pay for treatment at the time of service. Unfortunately, it is impossible to determine what the cost of the care will be prior to the date of service. We will do our best to inform you of what to expect along the way, but please understand that we do not have control over the cost of many of the elements involved in that care.

I understand that if I do not have health insurance, FULL payment of $125 is due at the time of service. Please be advised the costs of lab services, biopsies and any in-office procedures are not included in the office visit fee of $125 and these lab fees may vary. Any follow up office visit will be $100 plus the cost of any lab services and any in-office procedures.

It is your responsibility prior to any lab services, biopsies and procedures to indicate and opt out of those services prior to them being done.

Past Due Accounts
I understand that all outstanding accounts will be turned over to a collection agency after 3 statements and one pre-collection letter is mailed. Please contact us before this if you would like to set up a payment arrangement.

We are contracted with an outside collection agency to help collect outstanding, past due balances. If you are sent to collections, or if you have a returned check, you will be charged a $35.00 billing fee.

By signing this Notice of Financial Policy you acknowledge that you have read, understand and accept the above policies.

Patient/ Guardian Signature _____ **Date** _____

ACKNOWLEDGEMENT OF LABORATORY SERVICES

I, _____, acknowledge that:

- I am financially responsible for any in-house labs or pathology studies and/or office procedures conducted by Dermatology Specialists of Atlanta if not covered by my insurance company.
- Lab and Pathology studies conducted by an outside lab or pathology facility (such as Lab Corp, Quest, and Pathology Lab of Georgia) that is not covered by my insurance company will be my responsibility.
- Dermatology Specialists of Atlanta has informed me of the cost associated with my labs and pathology studies. Ambetter is not in Network with Pathology Lab of GA
- I have been informed that I may be responsible for any deductibles or co-insurance.
- **ALL REMOVALS WILL BE SENT TO PATHOLOGY LAB OF TO BE ANALYZED**

_____ _____/_____/_____
Print Full Name Date

_____
Patient Signature

□ Patient has accepted terms

ACKNOWLEDGEMENT OF OFFICE POLICIES

Cancellation Policy: If the patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel within 24hrs of the scheduled appointment. *Please note: Dermatology Specialists of Atlanta reserves the right to charge a $35 Cancellation Fee if the patient does not cancel their appointment (procedure cost is $50) within 24 hours.*

Unaccompanied Minors (Under 18 Years Old): I understand that Dermatology Specialists of Atlanta is UNABLE to treat unaccompanied minors unless prior consent is obtained from parent or legal guardian. Non-emergency treatment will be denied unless we have this consent. New patient minors must have a parent or legal guardian present for the New Patient Exam. Existing minor patients may provide signed minor consent form. *I understand that I must make arrangements for payment of copay or other fees as needed at the time of service.*

Proof of Identity: Dermatology Specialists of Atlanta requires proof of identity on file. I understand that I will be asked to provide a photo ID such as a State Issued Driver's, Non Driver's License or U. S. Passport at check-in. It will be scanned into your private medical record to document who we are treating. If you are reluctant to scan your ID, we may ask to view your photo ID at each visit.

Consent to Disclose Information to Family Member and/or Personal Representative
You may give Dermatology Specialists of Atlanta written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information (results of labs, prescription refills, etc.) on your home answering machine, voice mail at work, cell phone, or another party that you designate.

*At my request, I authorize Dermatology Specialists of Atlanta to disclose my protected health information to: ***if name is not listed, we CANNOT disclose any of your information to anyone other than yourself****

1. Family Member/Personal Representative: _____
   Relationship to Patient: _____ Phone Number: _____
2. Family Member/Personal Representative: _____
   Relationship to Patient: _____ Phone Number: _____

At my request, I also authorize Dermatology Specialists of Atlanta to communicate my protected health information to me via the following methods:

- □ Leave detailed message on my home answering machine (phone #: _____)
- □ Leave detailed message on my voice mail at work (phone #: _____)
- □ Leave detailed message on my cell phone voice mail (phone #: _____)
- □ Fax detailed medical information (fax #: _____)

By signing this Notice of Office Policies you acknowledge that you have read, understand, and accept.

Signature of Patient or Guardian: _____ Date: _____

ACKNOWLEDGEMENT: NOTICE OF PRIVACY PRACTICES

I am a patient of Dermatology Specialists of Atlanta. I hereby acknowledge receipt of Dermatology Specialists of Atlanta's Notice of Privacy Practices.

_____ _____
Patient's Name DOB

_____ _____
Signature Date

OR, **if you are not the patient:**

I am the parent or legal guardian of_____(print patient's name).
I hereby acknowledge receipt of Dermatology Specialists of Atlanta's Notice of Privacy Practices with respect to the patient.

_____ □ Parent □ Legal Guardian
Your Name

_____ _____

Signature Date

Records Release/Request

TO/From: Dermatology Specialists of Atlanta
1670 Scott Blvd, Ste 202, Decatur, GA 30033

(678) 904-4932 Office
(470) 428-2869 Fax

I hereby authorize the release of my medical records or copies of such and request that they be transferred to/from:

To/From:_____

(Doctor/Hospital)

Address_____

City_____State_____Zip Code:_____

Phone_____Fax_____

Print Name of Patient

Last Name:_____ First Name_____

DOB:_____/_____/_____

From:_____ To:_____

Entire Medical File: YES / NO (Date of Records)

_____ Date:_____
Patient's Signature