PATIENT INTAKE FORM

Primary Care Physician:		Specialist Physician:	
Referred? :	Referred By:		

PATIENT INFORMATION

(Please give your I.D. to the receptionist.)

Patient's FIRST Name:	LAST Name:	MI:	Preferred Name:
Patients D.O.B.:	SSN:		
Address:	Apt/Unit:		Zip Code:
Cell Phone no.:	Home phone no.:	Work phone no.:	
Email Address:		**Email List?: Y / N**	

UNDER 18 years old?:

Guardian Name:	*Guardian D.O.B.:*	*Relation to Patient:*

If child is 15 or older: Would you like to grant permission for them to be seen alone? Y/N

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance Carrier:

Subscriber's Name:	Subscriber's D.O.B.:	Policy no.:	Group no.:

Patient's relationship to subscriber:

_____

Secondary Insurance Carrier:

Subscriber's Name:	Subscriber's D.O.B.:	Policy no.:	Group no.:

Patient's relationship to subscriber:

_____

Tertiary Insurance Carrier:

Subscriber's Name:	Subscriber's D.O.B.:	Policy no.:	Group no.:

Patient's relationship to subscriber:

ACCOUNT PRIVACY

Who can have access to your account information?

IN CASE OF EMERGENCY

Name of friend or relative:	**Relationship to patient:**	**Phone No.:**	**Secondary No.:**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Reason for your visit: _____

Past Medical History (please circle all that apply):

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood Pressure
HIV/AIDS
High Cholesterol
Thyroid Problems
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

NONE

OTHER: _____

Past Surgical History (please circle all that apply):

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement, within last 2years
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (prostate removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

NONE

OTHER: _____

Alerts (please circle all that apply):

Allergy to Adhesive
Allergy to Lidocaine
Allergy to Topical Antibiotics
Artificial Heart Valve
Artificial Joint Replacement
Blood Thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to surgical procedure
Rapid heartbeat with epinephrine
Are you pregnant or currently trying to get pregnant?

NONE

Skin Disease History (please circle all that apply):

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay 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

Family Medical History (immediate relatives ONLY):

_____
_____
_____

Do you have a Family History of Melanoma? Yes No
If so, which relative? _____

Medications (list current medication. if none, put N/A):

_____
_____
_____

Allergies (incl. food, & seasonal. if none, put N/A):

_____
_____
_____

Social History (please circle all that apply):

Cigarette Smoking:

Never Smoked
Currently Smokes
Has smoked in the past (socially)
Former Smoker

Alcohol Use:

NONE
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Race: _____ **Ethnic Group**: _____ **Preferred Language**: _____

Pharmacy Information

Pharmacy Name:
Pharmacy Phone#:
City or Zip Code:

Atlanta Dermatology & Aesthetics, PC

Notice of Privacy Policy

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.

As our patient, you have entrusted your medical information to our care. We know that your relationship with us is based on trust, and that you expect us to act in your best interest. As your personal medical history is your private information, we hold ourselves to the highest standards in its safekeeping.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. HIPAA provides penalties for covered entities that misuse personal health information. We are required by law to maintain the privacy of your protected healthcare information and to provide you with this notice of our legal duties and our privacy practices. HIPAA gives you, the patient the right to understand and control how your protected health information ("PHI") is used.

Under HIPAA regulations, we may use and disclose your Protected Health Information (PHI) without written consent for treatment, payment and health care operations (TPO).

• Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is communicating with your referring physician, pharmacy or laboratory.

• Payment means activities related to obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include verifying insurance coverage or sending you a billing statement.

• Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. Examples of this would be patient survey cards or contacting you by phone or in writing to remind you of an appointment.

• We may also be required or permitted to disclose your PHI for law enforcement, matters of public health and safety, and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We will not use your information for marketing or fundraising without your permission.

In compliance with federal and state privacy laws, **written authorization by the patient or legal guardian is required before we can release records for reasons other than treatment, payment and healthcare operations.** If you give authorization to release your records, you may revoke such authorization in writing, and we will honor your request from the date we receive your written request forward.

Protecting Your Privacy Online

Our concern for your privacy naturally extends to our online communication. We transfer your data over the Internet to submit health insurance claims and send electronic prescriptions to your pharmacy via a secure server. We will file an insurance claim to your private insurance, Medicare or Supplement if you authorize us to do so. If you request us not to give details about services to an insurance company, such as cosmetic services, we will make every effort to honor your request.

You may have the following rights with respect to your PHI:

You have the right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you.
• You can advise us of the best location to contact you to protect your private information.
• You can request a copy of medical record in writing.
• You can request an amendment of your PHI. This request must be done in writing and will be honored at our discretion.
• We keep a log of disclosures of your medical information for the past six years and you can request a copy
• We will notify you if a breach of your protected health information if it occurs.

Please let us know if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with our practice and with the Department of Health and Human Services, Office of Civil Rights.

Atlanta Dermatology & Aesthetics, PC

Atlantic Station
232 19TH Street, NW
Suite 7230
(404)873-1795

Patient Acknowledgement Receipt of Privacy Notice

I, _____ (Patient's name) hereby affirm that I have received a copy of the *Notice of Privacy Practices* from **Atlanta Dermatology & Aesthetics, P.C.** Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the *Notice*, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

Patient Name: _____

_____
Signature of Patient or Representative

_____
Date

_____
Representatives Relationship to Patient (if applicable)

ATLANTA DERMATOLOGY & AESTHETICS, P.C.
232 19TH Street, NW, Suite 7230, Atlanta, GA 30363
Phone: 404-873-1795 Fax: 404-891-7800

FINANCIAL POLICY

Welcome and thank you for choosing our practice. Our goal is to provide excellent care and superior patient service. Our policies are printed below. Your agreement to follow these policies will help us serve you.

Payment

- Our office accepts cash, personal checks, debit cards, Visa, MasterCard, American Express, and Discover.
- If your insurance cannot be verified at the time of your visit, you may reschedule or be a Self-Pay patient.
- Co-payments and account balances are due at the time of service.
- **Co-insurance (deductible) Plans:** If your insurance plan does not require copayment and your deductible or out-of-pocket has not been met, you may receive a bill for your office visit.
- Partial payment may be required when scheduling cosmetic procedures
- **Self-Pay Office Visit:** New patients - $175 Established patients - $100. Procedures are an additional cost quoted by the Doctor.
- **Refunds:** Our office does not issue refunds for services rendered or products (incl. in-office prescriptions) purchased. You can return the product to the office, and the amount may/will be credited to your account.

Insurance

- To protect against fraud you MUST present your insurance card at each visit, and we REQUIRE a **government-issued** ID on file.
- We will file claims to your insurance carrier and accept payment directly from them. It is the patient's responsibility to keep us informed with up to date insurance coverage and contact information. **Patients are fully responsible for all costs denied by their insurance.**
- It is your responsibility to know your insurance benefits. We can never **guarantee** insurance coverage for any service provided.
- If your plan requires a referral or prior authorization to see the Doctor, it is your responsibility to obtain this prior to your visit.
- **MEDICARE PATIENTS:** If you are currently covered under Medicare, please present ALL insurance cards at the time of your visit. Medicare offers a *Medicare Advantage* plan in lieu of traditional Medicare. If you have chosen an Advantage plan and do not present the correct card, you will be responsible for any denied charges. **ALL INS Cards Given? Y/N *INITIAL HERE: _____**

Labs

- Lab tests ordered through our office are billed separately to your insurance from the laboratory. Patients are responsible for any lab charges.
- If your insurance requires that tests be sent to a specific lab, **it is your responsibility to tell the Nurse**, not the front desk, at the time the test is ordered.

Collections

- Balances are due within 30 days of statement date.
- **Past due balances:** Outstanding balances are sent to a collections agency and your account with our practice may be closed.
- **BILLING COMPANY: West Coast Derm Billing (WCDB), 1-888-541-9232. Please call for any questions or concerns you may have.**

Patients Under 18 Years Old

- The patient registration form must be signed and guaranteed by the legal guardian accompanying the minor at the first appointment. The "Responsible Party" is legally responsible for payment.

FEES

- **Confirmation calls** (made within 2 days of appointment) are considered a courtesy. We cannot be responsible for voicemails that are full and phone numbers that are disconnected. Patients are responsible for maintaining their appointment dates. To protect the practice, we must charge a "no show" fee for missed appointments. The fee is $50 for any **missed appointments and appointments cancelled or rescheduled** without a 24 hour notice. ***INITIAL HERE: _____**
- Returned check fee: You will be responsible for the full amount of any check returned from the bank for non-payment, in addition to a $35 check return fee.
- A fee of $25 is assessed for printed medical records, medical letters for work, school, legal proceedings, health insurance, and paperwork for life insurance and disability applications.

By signing this form, I am stating that I have read the information above and understand my financial responsibility for my account.

Patient/Guardian signature _____ Date _____

