Asha ADVANCED DERMATOLOGY, PC

4904 Timber Ridge Dr Suite 101 Douglasville GA 30135
3459 Acworth Due West Rd Suite 305 Acworth GA 30101
Ph: 770-739-7546 Fax: 770-739-7920
www.skinangel.com

PATIENT REGISTRATION **(Please Print)** **Today's Date ____/____/____**

Name _____
Last First M.I.

Mailing Address _____
City State Zip Code

Home Phone (____)_____ Cell # (____)_____ Email _____

Date of Birth ____/____/____ Age____ Sex____ Marital Status _____ SSN _____

Employer _____ Occupation _____

Ethnicity-Race _____ Language _____

Emergency Contact _____ Relationship _____ Phone #_____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name _____
Last First M.I.

Mailing Address _____
City State Zip Code

Home Phone (____)_____ Cell # (____)_____ Email _____

Date of Birth ____/____/____ Age____ Sex____ Relationship _____

INSURANCE INFORMATION (Please present insurance card at time of check in.)

Primary Insurance Name _____
Ins. Address_____
Name of Insured_____
Insured's ID#_____
Insured's SSN _____
Group # _____
Insured's Date of Birth _____
Employer Name _____
Employer Address _____
Employer Phone (_____)_____
Relationship of patient to the Insured _____

Secondary Insurance Name _____
Ins. Address_____
Name of Insured_____
Insured's ID#_____
Insured's SSN _____
Group # _____
Insured's Date of Birth _____
Employer Name _____
Employer Address _____
Employer Phone (_____)_____
Relationship of patient to the Insured _____

HOW DID YOU HEAR ABOUT US?

☐ Phone Book ☐ Insurance ☐ Social Media ☐ Friend/Family
☐ Google Search ☐ Other: _____
☐ Referred by Dr. _____ ☐ Ad in _____

Patient Name: _____ D.O.B: _____ Today's Date: _____

□ What is your current and/or former occupation? _____
□ What type of outdoor activities, if any, do you participate in? _____
□ Do you have any other hobbies or activities you would like us to know about? _____
□ Do you have any children or pets? _____
□ With whom, if anyone, do you live? _____
□ Where do you live (generally speaking: what town or city or county, assisted living facility)? _____

PAST MEDICAL HISTORY:
Personal history of cancer other than skin?_____

__Anxiety	__COPD	__High Blood Pressure	__Thyroid Issues (hypothyroid/hyperthyroid)
__Arthritis	__ Depression	__High Cholesterol	__Organ Transplant, Type:_____
__Asthma	__ Diabetes	__Inflammatory Bowel Disease	__Stroke
__Atrial Fib	__Psoriasis	__Hay Fever	__Heart Disease
__Eczema	__ Hepatitis	__HIV/AIDS	__Kidney Disease

Other Medical History not listed:_____

PAST SURGICAL HISTORY (List all past surgeries)**:** _____
_____

HISTORY OF SKIN DISEASE:
Are there any pertinent or major skin problems that run in your family?
_____

Personal History of Skin Cancer?
__Basal Cell Carcinoma __Squamous Cell Carcinoma __Melanoma
DO YOU HAVE A FAMILY HISTORY OF MELANOMA? Relative(s):_____

MEDICATION: Check here if you have an attached list ☐ (Please include dosage and strength if known)

_____ _____
_____ _____
_____ _____
_____ _____

Patient Height: _____ **Patient Weight:** _____ (Required for prescriptions)

ALLERGIES:
_____

SOCIAL HISTORY: Do you smoke? __Yes __No Do you drink alcohol? __Yes __No
Number of packs per day ____ Number of drinks per week? _____

ALERTS:

__ Allergy to lidocaine	__ Artificial heart valve	__ Defibrillator
__ Rapid heartbeat with epinephrine	__ Allergy to adhesive	__ Pacemaker
__ Premedication prior to procedures	__ Allergy to topical antibiotics	__ Pregnant, planning or nursing
__ Artificial joints within last 2 years	__ Blood thinners	__ Other_____

PREFERRED PHARMACY:
Pharmacy Name:_____ Pharmacy Number:_____
Pharmacy Address:_____
PCP:_____ Referring Provider:_____

I AUTHORIZE ADVANCED DERMATOLOGY, PC TO RETRIEVE MY MEDICATION HISTORY THROUGH THEIR PRESCRIBING SYSTEM AND IMPORT IT INTO MY ELECTRONIC MEDICAL

PATIENT/GUARDIAN SIGNATURE:_____ DATE:_____

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GENERAL CONSENT/AGREEMENT

This form applies to all Advanced Dermatology, PC practice sites. This form must be completed by all new patients and then, at least annually or when the patient's insurance changes.

1) **CONSENT TO TREATMENT**: I consent to receive medical and/or cosmetic health care services provided by Advanced Dermatology, PC entities. I understand that such services may include but are not limited to examination and treatment of skin disorders, performing cryosurgery, shave biopsies, punch biopsies or other minimally invasive testing on lesions, and sending specimens to a pathology or other lab for diagnosis. I acknowledge that no warranty or guarantee has been made to me as to result or cure. I understand that I could be tested for HIV, and have the right to opt out. I understand that my consent will be requested for HIV and other testing in case of an unintended exposure of a healthcare worker.

2) **PAYMENT FOR SERVICES**: I understand that Advanced Dermatology, PC may bill my health plan for the care I receive. I agree that payments from my health plan may go directly to Advanced Dermatology, PC. If I should receive the payments, I understand that I will be responsible for paying Advanced Dermatology, PC. I understand that I must pay any co-payment or other part of the bill that my health plan says I must pay. I know that I may need to pay this before I am treated. I understand and agree that if my plan does not pay the hospital or doctor, I will have to do so. I understand that Advanced Dermatology, PC will hold me responsible in any one of the following situations:

a. When I choose to have a service that my health plan covers but I do not obtain the required referral or authorization from my health plan.
b. When I choose not to use my health plan and agree to pay for services myself. (Use Do Not Bill Insurance Form).
c. When my health plan does not participate with Advanced Dermatology, PC for the services I want or need and I agree to pay for my care myself.
d. When I receive services that are not covered under my health plan including cosmetic services.

3) **CONSENT TO PHOTOGRAPH**: I understand photographs, videotapes, digital and/or other images may be made/recorded for identification, treatment and payment purposes. I will specifically authorize in writing any other use or disclosure of my image or recording.

4) **ELECTRONIC PRESCRIBING**: I authorize SureScripts, an electronic prescribing network, to release my medication refill history to Advanced Dermatology, PC for the purpose of continued treatment.

5) **MY PERSONAL BELONGINGS**: I understand that I am responsible for my personal belongings and valuables.

6) **RELEASE OF INFORMATION**: I authorize Advanced Dermatology, PC practice site(s) to release healthcare information for purposes of treatment, payment, or healthcare operations. Healthcare information from or regarding prior encounter(s) at other Advanced Dermatology, PC practice locations may be made available to subsequent Advanced Dermatology, PC - affiliated sites to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, laboratory reports, operative reports, physician progress notes, nurse's notes, and consultations.

Name (Print): _____ **Signature:** _____

Relationship to Patient (Self/Parent/Personal Representative): _____

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Consent to Treat a Minor without a Parent/Guardian Present

By law any child under the age of 18 years old cannot be seen by a provider without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Minor's name: _____ DOB: _____

For the occasions when a parent or legal guardian can not be with their minor child, please list those individual(s) whom you **authorize to bring your minor child** to Advanced Dermatology, PC for diagnostic evaluation and treatment (other than parents):
Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____

LIMITATIONS:
☐ Check here if you wish to give consent for the minor to receive medical care without an accompanying adult present.

This consent to see my minor child without an adult present shall be in effect for:
☐ Date _____(only) OR
☐ Indefinitely, until revoked by written consent.

AUTHORIZATION:
I (parent/legal guardian name) _____ request and authorize Advanced Dermatology, PC to deliver dermatologic care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I have read, understand, and give my consent as stipulated above. My signature means that I have read and understand this form.

_____

Parent or Legal Guardian (please print) **Relationship**

_____

Parent or Legal Guardian Signature **Date**

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HIPAA Notice of Privacy Practices Authorization

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices which provides a more complete description of such uses and disclosures. I also understand that this practice has the right to change its Notice of Privacy Practices at any time.

●May we call your home or other alternative location and leave a message in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations (TPO), such as appointment reminders, insurance items and any calls pertaining to your clinical care including lab results, among other.
If yes, please provide phone number:_____ □YES □NO

●May we phone you at work and leave a message to call our office? □YES □NO
If yes, please provide phone number:_____

●May we mail appointment reminders/patient statements to your home or alternate address? □YES □NO
*Our office will mail benign lab results to the patient. These results are in the form of a postcard, addressed to the patient. Unless told otherwise, these results will be mailed to your home address. Please notify our office if you want these results mailed to an alternate address:_____

●Do we have your permission to talk to family members or other individuals regarding your PHI? □YES □NO
If yes, please provide their name, phone number, and relationship to you.

Name:_____Phone:_____Relation:_____
Name:_____Phone:_____Relation:_____
Name:_____Phone:_____Relation:_____

Patient Information: I understand that I have the right to revoke this authorization at any time in writing. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned by signing.

Authorization Signature of patient:_____, or Signature of Legal Guardian:_____(if patient is under 18 years of age)

Note: This form does not authorize the release of actual medical records to you or your representative(s). An authorization for the release of medical records is available upon request. This authorization shall be in effect until revoked by the patient

Consent I hereby give my consent for Advanced Dermatology, PC to use and disclose my protected health information (PHI) to carry out treatment, payment, and healthcare operations.

_____
Print patient name

_____

Signature of patient or Legal Guardian (if patient is under 18 years of age) Date

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FINANCIAL POLICIES

Insurance
For each visit to our office, we will ask you to provide the information needed to verify your insurance coverage and file your insurance claim. It is your responsibility to understand your insurance plan coverage. You may wish to contact the number on the back of your card to review and verify your benefits. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services or diagnosis codes which they will not cover. Our office never guarantees that your insurance will pay for all services. If, for any reason your claim is denied, or the payment from them is less than anticipated, you are responsible for the balance due on your account. _____
Initial

Co-payments, Deductibles and Coinsurance
A **copayment** is a dollar amount set by your insurance company which you are responsible for at each visit. A **deductible** is the amount you are obligated to pay before your insurance company starts paying for your healthcare costs. Some insurance plans may also have a **coinsurance**, in which you may be responsible for a percentage of healthcare costs in addition to your copay or deductible. Payment will be due at time of service if your deductible has not been met or if your plan requires a coinsurance payment. Should your insurance company notify us that additional payment over and above copayments, deductibles, or coinsurance is due from you, you will be billed for this amount.

- We may require a deposit to schedule certain procedures with the balance due in full at the time the procedure is performed. You will be notified of this prior to scheduling your procedure.
- All past due balances are required to be paid in full before new services are rendered. Prior balances and copayments may be collected at check-in.

_____
Initial

Medicaid
Medicaid patients must present a current Medicaid card and be prepared to pay any applicable co-payments. If you do not bring your current Medicaid card and applicable co-payment, your appointment will be rescheduled.

Self-pay
Patients who do not have insurance coverage are considered self-pay. Payment in full for services provided are due at the time of service for self-pay patients.

Laboratory and Pathology Fees
It may be necessary to obtain a tissue sample (biopsy) or perform lab tests to confirm a diagnosis or determine a course of treatment. Depending on specific factors, your provider may send the specimen to an outside lab for slide processing and interpretation. In those instances, patients or their insurance will receive a bill from the outside lab. _____
Initial

Cosmetic Services (services that are not medically necessary)
Patients are responsible for all cosmetic procedure fees at the time of service. We do not bill insurance companies for cosmetic procedures. The cost of any procedure will be a separate fee from an office visit or consultation fee.

Methods of Payment
For your convenience, we accept cash, MasterCard, Discover, American Express, Visa and CareCredit.

Medical Records
A signed authorization is required. Please allow us 72 hours to process your request.

_____ _____
Signature of patient or Legal Guardian (if patient is under 18 years of age) Date

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No Show/ Missed Appointment Policy

We, at Advanced Dermatology, PC, understands that sometimes you need to cancel or reschedule your appointment and there are emergencies. If you are unable to keep your appointment, please notify us within **48 hours** of your scheduled appointment time.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality of care, it is very important for each scheduled patient to attend their visit on time. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. As a courtesy, an appointment reminder call or text is made/attempted three (3) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

Please review the following policy:

1) Please cancel or reschedule your appointment at least 48 hour's notice
2) If less than a 48 hour cancellation is given, this will be documented as a "No-Show" appointment.
3) If you do not present to the office for your appointment, this will be documented as "No-Show" appointment. A $75 fee ($150 for surgery) will be incurred which must be paid in full before future appointments will be scheduled.
4) We allow a 15-minute grace period from your scheduled appointment time until you will be considered late. Failure to arrive within the allotted time frame will be documented as a "No Show" and may incur a $75 fee ($150 for surgery) to your account.

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____
Printed Name Date

_____
Signature

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Telemedicine Patient Consent Form

Patient Name: _____ Date of Birth: _____

ESTIMATED PATIENT FINANICAL RESPONSIBILITY

Telemedicine visit charges are billed and collected in the same manner as regular office visits and any co-pay will be due prior to start of Telemedicine encounter. Final patient responsibility will be determined after charges are filed and processed by your insurance carrier(s).

Purpose: The purpose of this form is to obtain your consent for a Telemedicine visit with a provider at Advanced Dermatology, PC.

Medical Information and Records: All federal and state laws covering access to your medical records (and copies of medical records) also apply to Telemedicine. No one other than the healthcare team described above can view your photos or information unless you agree to give them access.

Privacy: All information given at your Telemedicine visit will be maintained by the doctors, other health care providers, and health care facilities involved in your care and will be protected by federal and state privacy laws.

Your Rights: You may opt out of the Telemedicine visit at any time. This will not change your right to future care or health benefits.

Waiver/Release: By signing below, you understand and agree that you solely assume the risk of any errors or deficiencies in the electronic transmission of information during your Telemedicine visit or in the electronic submission of your images to your dermatologist and further understand that no warranty or guarantee has been made to you concerning any particular result related to your condition or diagnosis. To the extent permitted by law, you also agree to waive and release your dermatologist and his or her institution or practice from any claims you may have about this advice or telehealth visit generally. The consent provided in this document will expire in one year from the date you sign it, but your waiver and release shall apply indefinitely for any Telemedicine visits that occur during the one-year period after your signature date.

_____
Name of Patient (or Parent/Legal Guardian)

_____
Signature of Patient (or Parent/Legal Guardian)

_____
Date

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PLEASE DETAIL THE REASON FOR TODAY'S VISIT

	Problem 1	Problem 2
Problem (e.g. growth(s) or rash or follow-up for a skin condition?)		
Location (site on body?)		
Quality (stable, asymptomatic, itch, bleed, tender, scaly, rough, darker, enlarging?)		
Severity (mild, moderate, or severe?)		
Duration (how long?)		
Previous treatments (OTC, prescriptions or other?) Who was it treated by?		
What makes it better or worse?		

Do you have any other rashes? YES or NO
Do you have any problems with allergy or your immune system? YES or NO
Are you under significant stress? YES or NO
Do you have problems with scarring? YES or NO
Do you have problems with healing? YES or NO
Do you have problems with bleeding? YES or NO