Advanced Dermatology, P.C.
4904 Timber Ridge Drive, Suite 101
Douglasville, GA 30135
www.skinangel.com

Today's Date ___/___/____ Date of Birth __/__/____

Patient Name_____
Last First M.I. Race/Nationality

_____
Street Address City State Zip Code

Home Phone_____ Cell_____ Email_____

SSN#_____ Gender___ Marital Status_____ Pharmacy_____

Emergency Contact_____ Relationsip_____ Phone_____

Patient Insurance Information

Primary Insurance: _____
Policy Holder (if different from patient): _____
Policy Holder's DOB: ___/___/_____
Member ID: _____

Secondary Insurance: _____
Policy Holder (if different from patient): _____
Policy Holder's DOB: ___/___/_____
Member ID: _____

How did you hear about our Practice? □ *Phone Book* □ *Insurance* □ *Friend* □ *Social Media*
□ *Referred by Dr.* _____ □ *Ad in* _____

What type of skin issue are you having? _____
How long have you had this problem?_____
Do you feel this is work related?_____
Have you been treated for this problem?_____ Who & when?_____
Are you allergic to any medications?_____ If yes, what? _____
Are you allergic to any food or drinks? ____ If yes, what?_____
Do you smoke? _____ Do you drink alcohol?_____
Are you pregnant?_____ Are you trying to become pregnant?_____

Current Medications:

_____ _____
_____ _____
_____ _____

Skin Disease History
(Circle Any That Apply)

- Acne
- Actinic Keratosis
- Basal or Squamous Cell Skin Cancer
- Blistering Sunburns
- Dry Skin
- Eczema
- Flaking or Itchy Scalp
- Hay Fever/Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Other: _____

Past Medical History
(Circle Any That Apply)

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation
- Bone Marrow Transplant
- Depression
- Other_____
- Diabetes
- Hepatitis
- Hypertension
- HIV/AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Seizures
- Strokes
- Psoriasis
- Cancer (Please specify) _____

Past Surgical History

_____ _____
_____ _____
_____ _____

General Consent to Treat

I voluntarily consent to medical care of a routine/emergency nature from the authorized professional staff of Advanced Dermatology, PC for myself or the above-mentioned minor for whom I am the parent/ guardian. I authorize the release of any and all medical records and information obtained through my medical evaluation to those individuals that my doctor feels appropriate for my continued medical care. I understand that I have the right to a full disclosure of the nature of any medical treatment received or proposed to be rendered and the risks, if any, involved and alternative means available. It is understood that I may withdraw this consent at any time by contacting any member of the professional staff in writing.

Patient Signature _____ Date _____

Guarantor Signature/ Relationship _____

HIPAA Compliance Patient Consent Form

Advanced Dermatology, P.C.

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- •Protected health information may be disclosed or used for treatment, payment, or healthcare operation
- •The practice reserves the right to change the privacy policy as allowed by law
- •The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions
- •The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
- •The practice may condition receipt of treatment upon execution of this consent

May we phone you to confirm appointments? YES NO
May we leave a message on your answering machine at home or on your cell? YES NO
May we leave a message at your employment? YES NO
May we email to your specified email address personal private health information including but not limited to laboratory reports, treatment recommendations, relevant scientific articles and medical forms? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature:_____Date:_____

Witness:_____ Date:_____

Patient Responsibility Form

Advanced Dermatology, P.C.

Individual's Financial Responsibility

I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service. Co-payments are due at the time of service. If my plan requires a referral, I must obtain it prior to my visit. In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at the time of service. Patients may incur, and are responsible for the payment of additional charges. These charges may include (but are not limited to): -charge for returned checks - charge for copying and distribution of medical records -any costs associated with collection of patient balances.

Insurance Authorization For Assignment Of Benefits

I hereby authorize and direct payment of my medical benefits to Advanced Dermatology, P.C. on my behalf for any services furnished to me by the providers.

Authorization To Release Records

I hereby authorize Advanced Dermatology, P.C. to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical providers.

Medicare Request For Payment

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Advanced Dermatology, P.C. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Patient, Guarantor or Responsible Party | Date

_____ _____

Print Name of Patient, Guarantor or Responsible Party | Relationship to Patient

No Show / Missed Appointment Policy

Advanced Dermatology, P.C.

We, at Advanced Dermatology, P.C., understand 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 24 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 care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call or text to you is made/attempted one (1) 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 with at least 24 hours notice
2) If less than a 24 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 a "No-Show" appointment. A $40 fee 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 $40 fee to your account.

I have read and understand Advanced Dermatology, P.C.'s No Show/Missed Policy and understand my responsibility to plan appointments accordingly and notify Advanced Dermatology, P.C. appropriately if I have difficulty fulfilling my scheduled appointments.

By my signature below, I acknowledge and understand that missed appointment without 24-hours advance notice will incur a $40 fee which must be paid in full before future appointments will be scheduled.

_____ _____

Last Name First Name (Please Print) **Date of Birth**

_____ _____

Signature of Patient or Guarantor **Today's Date**