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| **GEORGIA DERMATOLOGY PARTNERS**PATIENT REGISTRATION |
| **PATIENT INFORMATION (PLEASE PRINT LEGIBLY)** |
| LAST NAME | FIRST NAME, MI  | PREFERRED NAME | DATE OF BIRTH | GENDER |
| STREET ADDRESS | CITY, STATE, ZIP CODE |
| HOME PHONE #  | MOBILE PHONE # | EMAIL ADDRESS |
| MARITAL STATUS**Married Single Widowed Divorced Separated Partner**  | RACE/ETHNICITY  **Asian Black Caucasian Hispanic or Latino Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Declined** |
| PATIENT’S EMPLOYER | OCCUPATION Employed Not Employed Self-Employed Retired Active Military Student  |
| EMPLOYER’S STREET ADDRESS | CITY, STATE, ZIP CODE | WORK # | HOW DID YOU HEAR ABOUT US |
| IN CASE OF EMERGENCY | EMERGENCY CONTACT # | REFERRING PROVIDER | PRIMARY CARE PROVIDER |
| PREFERRED PHARMACY NAME | PHARMACY PHONE # | PHARMACY, CITY, STATE |
| **PHI COMMUNICATIONS TO PATIENT.** Please provide your consent to use your PHI for the following |
| Home Phone: Number on file.  OK to leave message with detail  Leave message with call back only |
| Cell Phone: Number on file.  OK to leave message with detail  Leave message with call back only |
| Email Marketing Consent:  OK to receive newsletters to inform you of special offers or promotions. We will not sell or distribute your email address to any third party at any time. Provide Your Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **PLEASE LIST PEOPLE TO WHOM OUR STAFF MAY DISCUSS AND/OR DISCLOSE YOUR HEALTH INFORMATION** ***(PLEASE PRINT LEGIBLY)*** |
| **NAME** | **RELATIONSHIP** | **CONTACT #** |
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| **RESPONSIBLE PARTY, IF OTHER THAN PATIENT (*PLEASE PRINT LEGIBLY)*** |
| LAST NAME | FIRST NAME, MI | RELATIONSHIP TO RESPONSIBLE PARTY Minor Child Dependent Adult Other0 |
| STREET ADDRESS  | CITY, STATE, ZIP CODE | PRIMARY # |
| **PATIENT INSURANCE INFORMATION *(PLEASE PRINT LEGIBLY)*** |
| PRIMARY INSURANCE COMPANY | MEMBER # (or ID #) | GROUP # |
| POLICY HOLDER’S NAME | DATE OF BIRTH | SOCIAL SECURITY # |
| POLICY HOLDER’S ADDRESS | CITY, STATE, ZIP CODE | RELATIONSHIP TO PATIENT  Self Spouse Parent Other  |
| SECONDARY INSURANCE COMPANY | MEMBER # (or ID #) | GROUP # |
| POLICY HOLDER’S NAME | DATE OF BIRTH | SOCIAL SECURITY # |
| POLICY HOLDER’S ADDRESS | CITY, STATE, ZIP CODE | RELATIONSHIP TO PATIENT  Self Spouse Parent Other  |

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| **ACKNOWLEDGEMENT.**  I acknowledge all information above is accurate. (Please ONLY sign the next available). |
| **Signature of Patient or Parent/Guardian (if a minor) or Power of Attorney** | **Date** | **Employee Initials** |
| Sign at Annual Update, if no changes | Date | **Employee Initials** |
| **GEORGIA DERMATOLOGY PARTNERS**PATIENT MEDICAL INFORMATION |
| **LAST NAME** | **FIRST NAME** | **DATE OF BIRTH** |
| Are you allergic to any medications? Yes No If yes, list: |
| Do you have a healthcare proxy in the event that you are unable to make your own medical decisions?  Yes No  |
| Designee’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designee’s Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have a living will? Yes No  |
| Have you had the Pneumonia vaccine within the last 3 years?  Yes  No  |
| Have you had the flu vaccine this flu season? Yes No Are you allergic to latex? Yes No |
| If female, are you pregnant, planning a pregnancy, or breastfeeding? Yes No  |

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| In an effort to accurately prescribe medications during your visit, please list the current medications that you are taking. Please include herbals, vitamins, over-the-counter and prescriptions. **If none, please mark n/a.** |
| Medication | Dosage | Frequency | Medication | Dosage | Frequency |
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| Please check below if you have, or have had any of the following medical conditions/treatment**: Check here if none**  |
| Anxiety |  | Depression |  | Hypothyroidism |  |
| Arthritis |  | Diabetes |  | Kidney/Bladder Disease |  |
| Asthma |  | Hay Fever/Allergies |  | Leukemia |  |
| Alzheimer’s/Dementia |  | Hearing Loss |  | Lung Disease |  |
| Bleeding Disorder or Bruise Easily |  | Heart Disease |  | Seizures |  |
| Bone Marrow Transplant |  | Hepatitis: Type: A B or C |  | Stroke |  |
| Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | High Blood Pressure/Hypertension |  | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Chest Pain |  | HIV/AIDS |  |  |  |
| Irregular Heartbeat |  | Hyperthyroidism |  |  |  |

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| List any surgical procedure(s) you have had in the last 12 months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Please check below if you have, or have had any of the following skin conditions: **Check here if none**  |
| Acne |  | Flaking or Itchy Scalp |  | Staph |  |
| Actinic Keratosis |  | Melanoma |  | Suspicious Growth or Mole |  |
| Basal Cell Skin Cancer |  | MRSA |  | Rosacea |  |
| Blistering Sunburns |  | Psoriasis |  | Warts |  |
| Eczema |  | Squamous Cell Skin Cancer |  | Other:­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

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| Please check YES or NO: |
|  | YES | NO |  |
| Do you wear sunscreen? |  |  | If yes, what SPF? |
| Do you tan in a tanning salon? |  |  |  |
| Do you have a family history of melanoma? |  |  | If yes, which relative?  |
| Do you drink alcohol? |  |  | If yes: Less than 1 drink/day 2-3 drinks/day 3+ drinks/day |
| Do you use recreational drugs? |  |  |  |
| Do you smoke currently? |  |  | If no: Never Former |

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| **Signature of Patient or Parent/Guardian (if a minor) or Power of Attorney** | **Date** | **Employee Initials** |
| **Printed Name of Parent/Guardian or Power of Attorney, if applicable** | **RELATIONSHIP TO PATIENT, if other than self** PARENT/GUARDIAN POWER OF ATTORNEY OTHER |
| **Patient Acknowledgement and Consents** |
| **CONSENT FOR TREATMENT.** I consent to all diagnostic and treatment procedures/examinations provided at all offices of Georgia Dermatology Partners. This will include, but not limited to injections, biopsies, administration of medications, treatments, and procedures considered medically necessary for the care of my dermatologic condition. I understand that the procedures will be explained to me and that I will have the opportunity to ask questions concerning the associated risks, alternatives and prognosis before allowing the procedures to be performed. I consent to treatment and care provided by a team of healthcare providers, which may include dermatologists, mid-level providers such as physician assistants or advanced care practice nurse practitioners.  |
| **CONSENT FOR DISPOSAL OF HUMAN TISSUE.** I agree that any tissues or specimens that are removed from my body in the course of performing my Procedures or providing my care and treatment will be examined and disposed of by Georgia Dermatology Partners. |
| **TELPHONE CONSUMER PROTECTION ACT CONSENT.** I expressly consent to receive telephone calls and text messages from Georgia Dermatology Partners, its affiliates, agents, vendors or third parties calling or texting on its or their behalf at any number that I provide or that they may obtain for me. Such calls or texts may be made using an automatic telephone dialing system and/or prerecorded or artificial voice and may be made for any non-marketing purpose. , including but not limited to: communications about my treatment, medication assistance, insurance benefits or account; appointment reminders; balance due and payment reminders; and debt collection attempts.  |
| **MEDICATION CONSENT.** I provide consent to access and obtain a history of my medications purchased at pharmacies.   |
| **PHOTOGRAPHS, VIDEOTAPES, AND RECORDINGS: I agree to turn off all recording devices prior to entering the exam room.** I understand that physicians and Georgia Dermatology Partners staff may request to take photographs, videotapes, or other recordings of me for purposes of ensuring proper patient identification or for medical documentation, care, or treatment purposes. I understand the photograph(s) or videotape(s), will be used for documentation of my medical condition.   For example, my clinical team will take pictures of my skin condition, biopsy site, or surgical site.  They will also take before and after pictures to monitor the progression of my condition.   I consent to being photographed, videotaped, or recorded for these purposes. I further acknowledge that such photographs, videotapes, recordings and related information may be used for internal operations including, but not limited to quality improvement activities and training programs that do not include treatment.   |
| **PRIVACY PRACTICES**. I acknowledge that I have been provided a copy of the Notice of Privacy Practices from Georgia Dermatology Partners and that I have read (or had the opportunity to read if I so chose) the Notice. *(Please Initial)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENTS** |
| **ASSIGNMENT OF BENEFITS.** If I am entitled to benefits under the Medicare program or any insurance policy or other health benefit plan, in consideration for services provided to me by Gwinnett Dermatology, dba as Georgia Dermatology Partners, I assign, transfer and convey the benefits payable under such program, policy, or plan for services rendered to Georgia Dermatology Partners. I authorize payment of benefits directly to Gwinnett Dermatology dba Georgia Dermatology Partners, with such benefits applied to my bill.  |
| **PATIENT RESPONSIBILITY.** I understand and acknowledge that the assignment of benefits does not relieve me of my financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts and deductibles and any charges for services deemed to be non-covered, or not preauthorized by my insurance plan. I agree to provide all known insurance information at the time that services are rendered. In the event that I overpay on my account, I authorize the application of such overpayment to satisfy any outstanding charges I owe for services rendered by any facility of Georgia Dermatology Partners.  |
| **INFORMATION RELEASE.** I authorize Georgia Dermatology Partners to release all protected health information to my insurance, (including Medicare, if appropriate) and third-party collection agencies in order to secure payment for services rendered. I also authorize Georgia Dermatology Partners to release my medical information to my Primary Care Provider or Referring Provider for continuity of my care.  |
| **REFERRALS.** I understand that it is my responsibility to obtain any referrals required by my insurance company from my primary care physician or insurance carrier. It is my responsibility to make sure that my referral is accurate and denial of payment because of my failure to do this will result in my being personally responsible for the charges incurred. |
| **CANCELLATION POLICY.** We will reserve your appointment time specifically for you. Therefore, we respectfully request that you give us a minimum of 24-hour notice if you need to cancel or reschedule. We do understand that an emergency or unforeseen event may result in you needing to cancel your appointment at the last minute. However, appointments missed or cancelled without notice will be assessed a no show/late cancellation fee. We charge $25 for each medical appointment and $100 for each surgical or cosmetic procedure if the appointment is missed or the appointment is cancelled with less than 24-hour notice. |
| **DEPOSIT POLICY.** I understand that a $100 non-refundable deposit may be required when scheduling first appointments for fillers. Appointments for Fraxel and Bellafill require a $500 non-refundable deposit at the time of scheduling.Appointments scheduled for Coolsculpting and Ultherapy must be paid in full at the time of scheduling. Patients who miss or cancel without notice on more than two occasions will be required to pay a deposit when scheduling all appointments.  |
| **RETURN POLICY.** I understand that we cannot accept returns of skin care products and prescription pharmaceutical preparations. These products are non-refundable. |
| **TREATMENT GUARANTEE.** Although good results are anticipated, I understand that there can be no guarantee or warranty, expressed or implied, by anyone as to the actual results I may get. I also understand that additional charges, for which I will be responsible, will be applied for the management of problems and/or complications. |

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| **Signature of Patient or Parent/Guardian (if a minor) or Power of Attorney** | Date | Employee Initials |
| **Printed Name of Parent/Guardian or Power of Attorney, if applicable** | **RELATIONSHIP TO PATIENT, if other than self** PARENT/GUARDIAN POWER OF ATTORNEY OTHER |



***We value our relationship with you and we consider it a privilege that you have chosen us for your dermatologic, surgical or cosmetic needs. We want to assure its ongoing success through a mutual understanding of our cancellation policies.***

**Cosmetic Consultations**

Consultations for non-surgical facial rejuvenation, all aesthetic services, including skin care, are complimentary. Please note there will be a $25 fee charged to your account if you are a No Show to your appointment or cancellation of your appointment is made with less than a 24-hour notice. This fee will not be billable to your insurance and must be paid prior to scheduling another consultation.

**Surgery and Cosmetic Procedures**

We understand that a situation may arise that could force you to cancel or postpone your surgery. Please understand that such changes affect not only your surgeon, but other patients as well. Gwinnett Dermatology will reschedule a surgery/procedure one time at no charge when notice is provided 24 hours prior to the procedure. Beyond that, there will be a $100 charge each time a surgery/procedure is rescheduled. This fee will not be applied toward your surgery/procedure and will be added as a charge to your account. This will not be billable to your insurance.

Fees for in-office treatments such as dermal fillers, neurotoxins (such as Botox®, Dysport®), chemical peels, laser hair removal, vascular lasers, laser resurfacing and other similar procedures are priced either on a per treatment basis or as a treatment package, and are payable in full at the time of your appointment. Treatments and series of treatments are non-refundable.

If any touch ups are needed there will be a modest fee for set-up, sedation, materials and medications used. The procedure itself is performed without doctor’s charges. In case of Botox we always apply a determined number of units per area that in some patients might not be enough. In the event that extra doses of neurotoxins (Botox, Dyport, etc.) are needed, a charge per extra units will be assessed.

**Treatment of Complications**

The practice of medicine and surgery is not an exact science. Although good results are anticipated, there can be **no guarantee or warranty, expressed or implied, by anyone as to the actual results that you may get.**The results of certain procedures may not last as long as expected or meet the degree of your expected improvement. It is important that you understand that all services are non-refundable.

Surgical revisions and/or other medical treatment or management of problems and/or complications may be required. These will result in additional charges **for which you will be responsible**.