Atlanta North Dermatology & Skin Care

Patient Information	**Date:**
Name: Date of Birth: Age:	
Address	
City State Zip	Mailing Address (if different)
* Primary Language: *Ethnicity (Circle): Hispanic or Latino Not Hispanic or Latino	
*Race (Circle): American Indian/Alaska Native Asian Black/African American Native Hawaiian/Pacific Islander White Other Race	
Sex: Male Female Marital Status: S M D W	**MUST HAVE 2 CONTACT PHONE NUMBERS**
Home Phone ( )	Cell Phone ( )
Work Phone: Exten. Or Dept	Employer
Email Address	**Pharmacy** Name, Street, City & Phone
If Minor Child: Parent Information that brought child to office Name: ________________________ Relationship: ____________________ Cell # Other means of contact:	
Person to Notify in case of an Emergency:______________________________ Relationship: Home Phone: Cell Phone:	
Primary Insurance Information (Please present cards)	
Primary Insurance Company: Specialist Copay:	
Name of Insured	Insurer's Date of Birth / /
Relationship to Patient:	Employer
Insured Cell Phone:	Work Phone: Ext
Secondary Insurance Coverage ____ Yes ____ No	
Spouse or Other Parent Information	
Name	Employer
Address (if different from patient)	
City State Zip	Work Phone ( ) Ext.
Home Phone ( )	Cell Phone ( )
I have read and understand the Patient Care Policy Letter AND Notice of Privacy Practices.	Patient Signature or Parent if Minor Child: Date:

- *** This information is required as part of the governments "Meaningful Use" mandate.**
- **PLEASE COMPLETE ENTIRE FORM**

Medical History

Name: ____ **Date:** ____/____/____

ALLERGIES: ____

MEDICATIONS (Including Over the Counter Medications and vitamin/herbal supplements)

_______________ _______________ _______________

_______________ _______________ _______________

Pharmacy Name , Address, City & Phone# ______________________________

Referring Physician: ____________________**PCP**:____________________

DO YOU CURRENTLY HAVE OR HAVE YOU HAD A HISTORY OF THE FOLLOWING CONDITIONS:
(Please answer all the questions by filling in the appropriate circles)

Heart:
- High Blood Pressure O Yes
- Heart Attack O Yes
- Irregular Heartbeat O Yes
- Heart Murmur O Yes
- Valve Replacement O Yes
- Blood Clots O Yes
- Pacemaker O Yes

Lungs:
- Asthma O Yes
- Emphysema O Yes

Endocrine:
- Diabetes Mellitus O Yes
- Thyroid Disorder O Yes

Kidney/Bladder:
- Kidney Stones O Yes
- Kidney Failure O Yes

Neurological:
- Stroke O Yes
- Seizures O Yes

Psychiatric:
- Depression O Yes

Abdomen:
- Liver Disease O Yes
- Hepatitis O Yes

Muscle/Join:
- Arthritis O Yes
- Muscle Weakness O Yes
- Artificial Joints O Yes

Malignancy:
- Leukemia O Yes
- Internal Cancer O Yes

HIV O Yes

Skin:
- Melanoma O Yes
- Non - Melanoma Skin Cancer(s) O Yes
- Keloids (scars) O Yes

Pregnant:
- Currently Pregnant O Yes
- Trying to Get Pregnant O Yes

Family History:
- Family History of Melanoma O Yes
- Family History of Psoriasis O Yes
- Family History of Eczema O Yes

<u>Social History</u>
- Alcohol O Yes
- Recreational Drug Use O Yes
- Smoking O Yes

Other Past Medical History?

____

____

What is your occupation?

____

Completed by: Patient ____ MA (Initials) ______

____
Signed by patient /Legal Guardian

Date: ____/____/____

Atlanta North Dermatology & Skin Care

Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Please list the manner(s) in which you would like to be contacted regarding any appointments, test results, etc.
By Phone: ____ 1st Number (Best)
____ 2nd Number (Alt)
** **Is it okay to leave a detailed message at any of the above numbers?** _________

Also, with the HIPAA privacy rules we will require written permission to release/discuss any of your medical records with any family members and/or friends. If you are at least 18 years of age, please list anyone we can release information to.

Name	Contact Number	Relationship to Patient
Name	Contact Number	Relationship to Patient
Name	Contact Number	Relationship to Patient

Patient/Guardian Signature:__________________________________ Date: ______________________

AGREEMENT AND AUTHORIZATION

I have read, understand, agree to and been given a copy of Atlanta North Dermatology's Patient Care, Appointment and Payment Policies and had the opportunity to review the Notice of Privacy Practices Policy, if I so desired.

I understand that all charges not covered by my insurance company, as well as payments and deductibles, are my financial responsibility.

I authorize my insurance benefits for assignment and/or payment directly to Atlanta North Dermatology and Skin Care. I further authorize Atlanta North Dermatology and Skin Care to release any medical or other information to my insurance company, Medicare and physicians participating in the continuity of my care.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Atlanta North Dermatology & Skin Care to release all medical information requested by my health insurance carrier, Medicare or any other third-party payers. I also authorize the release all medical information to my referring physician and or primary care physician. I authorize Atlanta North Dermatology to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Atlanta North Dermatology.

______________________________	______________________________	______________________
Patient/Legal Guardian Signature	Patient Name/Legal Guardian Printed	Date

Welcome to the Atlanta North Dermatology & Skin Care

PATIENT CARE POLICY LETTER

This letter will better acquaint you with our office policies for patient care.

Patient Medical Information Form. To help us provide you with better medical care, we ask that all new patients, and patients we have not seen in the past three years, fill out a medical information form.

Medications. We ask that whenever you come in for an appointment that you bring a current list of all the medications you are currently taking. You should keep this list in your wallet or purse and share it with other doctors you may visit. Whenever you are prescribed a new medication read any information that might come with it and check with your pharmacist to make sure it doesn't interfere with any of your other medications.

Prescription renewals. If you call for a prescription renewal, please be prepared to give the details of the medication needed (i.e. name, strength, quantity, where and how often using, etc.). Please make your request during regular clinic hours and allow up to 48 hours for them to be called in, longer if you call in the day before the weekend. If Atlanta North Dermatology & Skin Care hasn't seen you within the past 12 months, you should make an appointment for reevaluation before requesting additional prescriptions, with a few exceptions.

Skin Biopsy and Other Lab Tests. Sometimes it is necessary to take a skin biopsy and (or) order lab tests to help us figure out what is causing a skin condition. You or your insurance company will get a **separate bill from the laboratory**. It is very important that you get the results of any tests we order (i.e. skin biopsies, blood work). After we receive the results, we will notify you of the results. However, if you don't hear from us within three weeks from the time the test was done, it is important that you call us for the results.

Referring Physicians: If another doctor referred you to the Atlanta North Dermatology & Skin Care, please let us know and our center will send the referring doctor a letter that will provide the details of your evaluation.
Referrals. Some insurance companies require that we have a "referral authorization" from your primary care doctor before we are allowed to see you on the initial or subsequent appointments. If we have not received it by your appointment time, you will have to reschedule, so please make sure that your primary care doctor sends it to us in time. IT IS VERY IMPORTANT! PLEASE DO NOT FORGET.

Insurance and Billing Questions. Our current health care system is very complex and it is difficult to keep tract of the always-changing insurance company rules and regulations. We will work with you to help resolve problems that may arise form your insurance company (i.e. Refusal to pay for certain treatments, lab tests or follow- up visits). As a courtesy to our patients, we file the bills with most insurance companies. However, the involvement of the insurance companies makes the billing process extra complicated. If you have any questions regarding your billing statements, please let us know so we can help you figure them out.

Emergent Dermatological Needs. If you have a skin-related problem that you don't think can wait until the next available slot, let us know and we will make arrangements to see you sooner. If you have a question or problem that can't wait until our clinic is open again, please call (770) 516-5199 and listen to the recording to learn how to reach Atlanta North Dermatology & Skin Care after hours. If you think you have a more serious problem that needs more immediate medical attention and (or) might be life threatening, please go to your local emergency room without delay.

Appointment Policy

We have reserved an appointment time especially for you or your family member. As you may also be aware, however, a missed appointment does not allow us to see other patients who would also like to be seen. By providing us with advance notice of your need to cancel or reschedule, you enable us to see and treat other patients who wish to have an earlier appointment. Accordingly, we ask that you review the following guidelines for the cancellation or rescheduling of appointments.

We certainly understand that there may be emergency circumstances that make it difficult for you to keep your appointment or provide notification of your cancellation or need to reschedule. Absent such circumstances, however, we would request that you provide us with at least 48 hours telephone notice of your need to cancel or reschedule an appointment. In the event that such timely notice is not provided, it is our policy to request a $25 deposit at the time of scheduling the new (or rescheduled) appointment. Upon being seen at that future appointment, the $25 deposit will be applied to your co-pay amount or, if a co-pay is not required, will be refunded. Deposit will be forfeited if proper notice is not given to change/cancel appointment.

PAYMENT POLICY AND AUTHORIZATION

Patients who do not carry any form of medical or surgical insurance should know that all services furnished are charged directly to the patient, and that he or she is responsible for payment at the time of service unless otherwise handled. We will submit claims for patients with Medicare or private insurance in which we are a preferred provider. In these cases, you are responsible for any co-payments or deductibles at the time of service. For patients on any other insurance plans, payment is required at the time of visit. We will prepare all necessary forms and assist you in filing claims with your carrier so that you may be reimbursed. For elective, non-covered or cosmetic services, the total amount charged is due at the time of services.

In addition to the charge for the visit and/or procedure, if you have a biopsy, surgical specimen or culture swab taken at any visit, you (or your insurance carrier) will be billed separately by the pathologist or lab for their analysis of the specimen. We will provide your billing and insurance information to the lab or pathologist.

All insurance forms processed by this office, prior to payment in full, are assigned to this practice. It is your responsibility to bring any required referrals for treatment at, or prior to, the time of your visit. If you do not have a referral that is required, we will regrettably be required to reschedule your visit or you may be financially responsible.

If it becomes necessary to refer your account to an outside collections agency, a 33% service fee will be added to your account.

Print Patient name:______________________

TOBACCO: (if 18 years and older)

Are you a smoker/tobacco user? **YES** or **NO**

If **yes, please consider stop smoking/using tobacco as it will benefit in increasing skin healing and lowering the risk for premature aging.

FLU VACCINE: (if 6 months and older) ONLY 10/1 to 3/31

Have you had flu vaccine? **YES** or **NO**

If **yes**, when was it administered? ______________

**Please consider seeing your PCP for getting Flu Vaccination.

Continue ONLY if 65 years and older

PNEUMONIA VACCINE:

Have you had Pneumonia vaccine? **YES** or **NO**

If yes, when was it administered? ______________

**Please consider seeing your PCP for getting Pneumonia Vaccination.

Advance Care Directive: Do you have a Living Will or Power of Attorney for your healthcare?

- **Yes→ Name:_________________________**
  Relationship:___________________
- **No**

Atlanta North Dermatology & Skin Care
100 Stoneforest Dr., Suite 320
Woodstock, GA 30189
Tel.: (770) 516-5199

Travel Directions

Coming from Atlanta or Marietta

Take Interstate 75 North, to

Interstate 575 North

Take **Exit 8, Towne Lake Parkway**

Make **LEFT** onto Towne Lake Parkway

Turn **RIGHT** at the 4th traffic light, onto Stoneforest Drive. You will see a sign that reads "Parkview".

Take the first **RIGHT** into the Towne Lake Overlook Bldg parking lot.

Take the elevator to the third floor, and we are suite 320.

Coming from Canton/Holly Springs

Take Interstate 575 South

Take **Exit 8, Towne Lake Parkway**

Make a **RIGHT** onto Towne Lake Parkway

Turn **RIGHT** at the 3rd traffic light, onto Stoneforest Drive. You will see a sign that reads "Parkview".

Take the first **RIGHT** into the Towne Lake Overlook Bldg parking lot.

Take the elevator to the third floor, and we are suite 320.

Please call us (770) 516-5199, if you have any questions.