Dermatology Specialists of Augusta
Medical, Surgical & Cosmetic Dermatology

NEW/UPDATED PATIENT INFORMATION

Please fill out completely:

Date: _____

Patient Name: _____ **Preferred Name**:_____
First M.I. Last

Date of Birth: _____/_____/_____ **Age**:_____ **SSN**:_____/_____/_____ **Gender**: ☐ M ☐ F

Email: _____ **Marital Status**: ☐ Married ☐ Single ☐ Other

Mailing Address: _____
Address City State Zip Code

Phone (PRIMARY): _____ **Phone** (SECONDARY): _____

Employer Phone: _____ Ext. **Employer**: _____

GUARANTOR/RESPONSIBLE PARTY

Guarantor may be different than insurance policy holder. Guarantor must be over the age of 18, present at this appointment, provide picture ID & sign financial policy

☐ **Patient is Guarantor** *(✓box & skip to Insurance)*

Guarantor: _____ Date of Birth: _____/_____/_____
First M.I. Last

Address: _____ **SSN:** _____
Street Address City State Zip Code

Phone (PRIMARY): _____ **Phone** (SECONDARY): _____

Employer Phone: _____ **Employer**: _____

INSURANCE

Please FULLY complete this section and provide your insurance card to the receptionist.

Primary Ins.: _____ **Secondary Ins.**: _____

Member ID: _____ **Member ID:** _____

☐ **Patient** ☐ **Guarantor is policy holder**
If Patient or Guarantor is Policy Holder skip to 2nd Ins.

Policy Holder Name: _____
Relationship to Patient: _____
DOB: _____/_____/_____ SSN: _____

☐ **Patient** ☐ **Guarantor is policy holder**
If Patient or Guarantor is Policy Holder skip to Emergency Contact

Policy Holder Name: _____
Relationship to Patient: _____
DOB: _____/_____/_____ SSN: _____

EMERGENCY CONTACT

Emergency Contact Name: _____ **Phone:** _____

Address: _____ **Relationship to Patient**: _____

How did you hear about us?

☐ Phone Book ☐ Advertisement
☐ Insurance Company ☐ Our Website (www.AugustaDermatology.com)
☐ Referred by Physician _____
☐ Other _____

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HEALTH HISTORY

Patient Name: _____ **Date:** _____

Primary Care Doctor: _____
Pref. Pharmacy: _____ Phone:

Medical History: *Check all that apply and explain if needed*

- ☐ Diabetes _____
- ☐ Kidney Disease _____
- ☐ Heart Disease _____
- ☐ Lung disease _____
- ☐ Liver Disease _____
- ☐ Hepatitis _____
- ☐ Depression _____
- ☐ High Cholesterol _____
- ☐ High Blood Pressure _____
- ☐ Cancer _____
- ☐ HIV / AIDS _____
- ☐ Other _____

Skin History:

- ☐ Skin Cancer _____
- ☐ Melanoma _____
- ☐ Lupus _____
- ☐ Psoriasis _____
- ☐ Eczema _____

Family History:

- ☐ Skin Cancer _____
- ☐ Melanoma _____
- ☐ Lupus _____
- ☐ Psoriasis _____
- ☐ Eczema _____

Social History:

Lifetime sun exposure: ☐Little ☐Moderate ☐A lot
Do you wear sunscreen regularly? ☐No ☐Yes _____
Do you drink alcohol? ☐No ☐Yes How much? _____
Do you smoke? ☐No ☐Yes How much? _____
Occupation: _____

For Office Use

Updated on	***By***

List the names (dose not needed) of all medications you are taking:

Drug allergies: ☐ Yes *(list name of drug below as well as reactions)* ☐ No known drug allergies

1203 Town Park Lane Evans, GA 30809 ● (Ph) 706 650-SKIN (7546) ● (Fax) 706 922-9168

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PATIENT POLICIES

Patient Name: _____

I. AUTHORIZATION FOR RELEASE OF INFORMATION

A. INFORMATION TO RELEASE: All of my health information including but not limited to test results may be disclosed to the following people:

I hereby authorize Dermatology Specialists of August to use or disclose my individually identifiable health information to the individuals listed below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my request in writing to Dermatology Specialists of Augusta, ATTN: Privacy Officer.

NAME:_____ PHONE:_____ ☐**Spouse** ☐ **Parent** ☐ **Child** ☐ **Other**

NAME:_____ PHONE:_____ ☐**Spouse** ☐ **Parent** ☐ **Child** ☐ **Other**

B. TEST RESULTS

If unable to reach me by phone, I give permission to the physicians or staff of Dermatology Specialists of Augusta, Inc., to leave my test results on my answering machine at the number below. I understand that if this mailbox is not secure, Dermatology Specialists of Augusta cannot guarantee your results will remain private. I understand that as a reasonable safeguard, voicemails may not be left on an unconfirmed voice mailbox that does not identify in the greeting that it belongs to me.

☐ **Answering Machine/Voicemail #** _____ ☐ **Do not leave results on my answering machine.**

This authorization will expire 3 years from the date indicated below and is made at the request of the patient or authorized signer.

PATIENT/GUARDIAN Signature _____ **DATE** _____

II. RECEIPT OF NOTICE OF PRIVACY PRACTICES

A Notice of Privacy Practices can be obtained at www.AugustaDermatology.com/Privacy.shtml. Additionally, printed copies are readily available in office at the check-in counter. I acknowledge that a Notice of Privacy Practices for Dermatology Specialists of Augusta, Inc., has been made available to me as required by the Health Insurance Portability and Accountability Act of 1996.

_____ **(Initial by patient/guardian)**

III. MISSED APPOINTMENT POLICY

Your appointment time is reserved especially for you. If you cannot keep your appointment, please call at least 24 ***business*** hours in advance. If appointments are missed without proper notice may be charged a missed appointment fee. Surgeries or Procedures cancelled without proper notification will incur a $100 cancellation fee. All other appointments cancelled without proper notice may incur a $25 cancellation fee. If you repeatedly miss scheduled appointments, you may be dismissed from the practice.

_____ **(Initial by patient/guardian)**

IV. MEDICAL RECORDS POLICY

Your medical record is the property of Dermatology Specialists of Augusta. We will send all pertinent information to any doctor we refer you to at no charge to you. If you move out of the area and transfer care to another Dermatologist, we will also forward necessary records at no charge. However, there will be a charge for any other request for medical records as allowed by Georgia Law. Please allow 5-7 business days to process medical records requests.

_____ **(Initial by patient/guardian)**

V. APPOINTMENT REMINDERS

Although it is the patients' responsibility to maintain their own appointment schedule, as a courtesy to our patients, we may offer appointment reminders via email, phone, and text message. By providing your email address and/or phone numbers, you are allowing us to contact you via those means. We respect your privacy and will only use email correspondence to remind you of upcoming appointments or to relay pertinent information about our office. You are able to opt out or change your email or text settings at any time. There is no fee from our office for this service; however, standard text message rates may apply depending upon your individual carrier and data plans.

_____ **(Initial by patient/guardian)**

VI. LAB WORK

A. BIOPSIES: **All tissue samples** will be sent to a dermatopatholgist for examination to ensure there is no abnormal pathology present. Tissue samples sent to a pathologist will incur two separate and distinct charges: one for the biopsy where the tissue sample is removed here in the office and another charge from the pathologist for examining and diagnosing the specimen.

B. BLOODWORK: We maintain accounts with CPL Southeast, Labcorp, and Quest Laboratories. Using these labs for your blood work will allow us to receive your results in a timely manner and avoid confusion and delays. If you choose to use the services of another lab or doctors office due to your insurance or personal preference then you are responsible for ensuring that we receive your test results.

_____ **(Initial by patient/guardian)**

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VII. CERTIFIED LETTERS:

We make every attempt to contact you using the information you provided us at check in. If we are unable to reach you or you do not return our calls regarding abnormal test results we will be forced to send you a certified letter. If you are notified of abnormal test results and do not schedule appropriate follow up or treatment, we will also send you a certified letter. Certified letters sent to you will incur a $10 administrative charge to your account.

_____ **(Initial by patient/guardian)**

VIII. REFERRAL POLICY

Tricare Prime as well as some private insurance companies require members to have an authorization or referral to be seen at our office. If you have this type of coverage, please understand that **it is your responsibility to request referrals from your primary care doctor/manager, to know how many visits you have remaining, and to know when your current referral expires**. If unsure, our front desk associates are happy to verify this information for you *upon request*. If you chose to be seen without a referral, you will be responsible for any balance not covered by your insurance.

_____ **(Initial by patient/guardian)**

IX. CAMERA POLICY

Studies have proven the benefits of photo documentation in medical records. Treatment responses can be more closely and effectively monitored and surgery sites can be accurately documented. Our practice utilizes camera phones for the purposes of photo documentation. These phones are NOT activated and are used solely for the purpose of medical photo documentation. Each phone is identified by a label that includes our company logo and states that it is NOT for personal use. Personal cell phone use is prohibited by our staff during working hours. Each photo is printed, placed in your private medical record and then deleted from the phone following your appointment. Photos are printed via a HIPAA complaint, secure, encrypted network.

_____ **(Initial by patient/guardian)**

X. MISCELLANEOUS:

1.) TREATMENT PLANS: We will always attempt to address your concerns at each visit but sometimes it takes additional visits before we can complete your treatment. Warts and other skin growths routinely take multiple visits to treat completely. Often very thick warts or growths are frozen at the first visit. The remainder of the lesion is frozen again at subsequent visits until the lesion is entirely gone. Each treatment session will be billed according to your insurance policy rules. Additionally, growths that are suspected to be a skin cancer will first need to be biopsied before a comprehensive treatment plan can be made. This involves taking a small amount of the growth to send to the lab to make an accurate diagnosis. Growths are biopsied first so that we can avoid unnecessary surgery and to gain more information about the growth so that we can best treat you. Many insurance plans also require a biopsy before a larger more invasive surgery is performed. This also allows us the time necessary to gain any prior authorization required by your insurance company prior to surgery to ensure you receive the full benefits available to you.

2.) COSMETIC SERVICES: Some services we provide are considered "Cosmetic" or "not medically necessary." Obvious examples are Botox and other wrinkle treatments. Less obvious examples of treatments that may not meet medical necessity may include hairloss evaluation and treatment or the removal of non-cancerous skin growths such as moles or skin tags. **Some signs and symptoms that do typically qualify a removal as medically necessary would include symptoms such as pain, bleeding, irritation, or a change in color or size. If you just don't like the way a growth looks, this does not meet the definition of medical necessity and insurance will not cover the removal.** We are happy to provide these services to you; however, it is unethical and illegal to bill your insurance company if your condition lacks the medical necessity to support the claim.

3.) PRESCRIPTION DRUGS: We prescribe individual treatments based on what is the best for you and your condition. Often generic drugs are helpful and are cost effective and we strive to prescribe them when appropriate. **Generic drugs, however, are not always equivalent to brand name drugs.** Many times they are not as effective or have more side effects because of different delivery molecules or inactive ingredients. Your insurance company is motivated to have you use only drugs on their formulary. We are motivated to give you the best, safest, and most effective treatment. We will **ATTEMPT** to get non-formulary drugs approved, but ultimately the decision is between you and your insurance company. **If you know that your insurance company requires you to try generic drugs first, please let us know. This will save you a lot of time and confusion at the pharmacy.**

_____ **(Initial by patient/guardian)**

CONSENT TO TREATMENT & INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize examination and treatment by Dermatology Specialists of Augusta, Inc. I authorize release of any medical information necessary to process claims to insurance carriers (and/or the Social Security Administration / HCFA or intermediaries), and I assign payments (including Medigap benefits) for medical services to the physician(s). **I understand that it is my responsibility to remit payments for charges not covered by my insurance company. I understand that it is my responsibility to see that all claims, pre-certification, and authorizations are completed by my insurance company, since I am responsible for all professional services rendered to myself and/or dependent.** I permit a copy of this authorization to be used in place of the original. All information gathered will remain confidential per our HIPAA policy.

PATIENT/GUARDIAN Signature _____ **DATE** _____

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FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service and regard your understanding of our financial policy as an essential element of your care and treatment. If you have any questions, please feel free to call and discuss them with our staff.

- **Unless other arrangements have been made in advance by either you or your health insurance carrier, payment is due at the time of service.**
- **Co-payments are always due at the time of your visit and are collected at check-in.**
  Co-pays are a way that insurance companies share the cost of your healthcare with you, the patient. If your plan benefits state you have a specialist copay, we are obligated to collect it at every visit. No exceptions will be made. If you have a condition requiring frequent visits to our office, expect a co-pay for each visit. **For example, if you come in on Monday and are seen, you will pay a co-pay. If you need medical attention again on Thursday, you will have another co-pay**. **These rules are set by your insurance carrier.**
- **Any balance not paid by your insurance will be billed to you and is due immediately. Examples may include deductibles, coinsurance, etc.**
  Deductibles: Most insurance plans have a deductible. A deductible is an amount of money your insurance company requires you to pay for your healthcare before they will "kick-in". **Almost every procedure (major or minor) that doctors perform will be applied to a deductible.** This means, for example, that if you have a yearly $1000 deductible that you have not met, your insurance company will not pay for the cost of any procedures that are covered under your plan, such as freezing a wart, removing a cancer, having a biopsy, etc until your deducible has been met. This means you may receive a statement from our office for these charges. **We reserve the right to collect deductibles prior to certain procedures.**
- **For your convenience, we accept personal checks, cash, Visa, MasterCard, Discover, and CareCredit.**
- **If a check is returned by your financial institution for any reason, a $30 fee will be assessed to your account. This fee and all future balances must be paid with cash, credit card, money order, or cashier's check.**
- **Self-pay patients for whom we do not file insurance must pay in full at the time of service. As a courtesy, self-pay patients will receive a discount of 25% off our normal fees.**

PAST DUE ACCOUNTS: We do use the services of an outside collection agency for past due accounts. Accounts in bad debt are then blocked so no further appointments can be made until balance is paid in full. If your account is assigned to an attorney or collection agency for collection and/or suit, Dermatology Specialists of Augusta shall be entitled to any / all attorney's fees and collection costs. *Collection costs are 35% of your balance unless your balance is under $100, goes before a court, or is over 1 year old in which case it will be subject to a collection fee of 50% of the balance due.*

INSURANCE: Please remember that your insurance policy is a contract between you and your insurance company. You, the patient, are ultimately responsible for payment of your medical bills. We can only assist you in obtaining your specified contract benefits. Filing insurance is a service that we provide as a courtesy to you.

- We require our staff to check your insurance card at the time of your visit, so please have it ready at the time of check-in.
- If your insurance changes or is no longer in effect, you should advise the receptionist at the time of check-in.
- We participate with most major carriers and will bill those plans with which we have an agreement. All co-payments or deductibles are due at the time of service. In the event your health plan determines a service to be "not covered," you will be responsible for the charge(s).
- It is impossible for our office to know all employer insurance changes and plans in the CSRA. It is the responsibility of the patient to know their insurance coverage. If there are any questions about insurance and/or network coverage, please contact your insurance plan for clarification. Any benefits quoted by the office are not a guarantee of coverage. Actual coverage determinations cannot be made until the time your claim is processed by your insurance company.

MINORS: All services rendered to minor patients will be the financial responsibility of the adult accompanying the minor.

I have read and understand the financial policy of the practice and I agree to be bound by its terms.

_____ _____

PATIENT/GUARDIAN Signature **DATE**

_____

Patient Name (PLEASE PRINT)

1203 Town Park Lane Evans, GA 30809 ● Ph (706)650-SKIN (7546) ● Fax (706)922-9168