Dermatology Specialists of Augusta
Medical, Surgical & Cosmetic Dermatology

Patient History

Please Fill Out Completely:

Patient's Name: _____ SSN: _____
First M.I. Last

Preferred Name: _____

Date of Birth: _____ Age: _____ Marital Status: _____ Sex: _____
Married, Single, Divorced M/F

Patient's Address: _____
Address City State Zip

Patient's Phone (Primary): _____ Patient's Phone (Secondary): _____

Employer: Employer Phone:

Responsible Party: _____ Date of Birth: _____
First M.I. Last

Resp. Party Address: _____
Address City State Zip

Resp. Party Phone: Primary _____ Secondary: _____

Emergency Contact Name: _____ Emergency Contact Relationship: _____

Address: _____ Phone: _____

How did you hear about us? ☐ **Phone Book** ☐ **Advertisement**
☐ **Insurance Company** ☐ **Our Website** **(www.DermatologyAugusta.com)**
☐ **Referred by Physician** _____

If Worker's Compensation, please answer the questions below:

Is this visit related to a car accident? ☐Yes ☐No Is this visit related to a work injury? ☐Yes ☐No

Date of Accident or Injury: _____

Primary Insurance Information

Primary Insurance Co: _____ Sex: ☐Male ☐Female

Member Name: _____ Member ID No.: _____
First M.I. Last

Group Number: _____ Group Name: _____

Relationship: _____ SSN: _____ Date of Birth: _____

Secondary Insurance Information

Secondary Insurance Co: _____ Sex: ☐Male ☐Female

Member Name: _____ Member ID No.: _____
First M.I. Last

Group Number: _____ Group Name: _____

Relationship: _____ SSN: _____ Date of Birth: _____

Dermatology Specialists of Augusta
1203 Town Park Lane Evans, GA 30809
(Ph) 706 650-SKIN (7546) (Fax) 706 922-9168

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Patient's Name:_____

TEST RESULTS POLICY

If unable to reach me by phone, I give permission to the physicians or staff of Dermatology Specialists of Augusta, Inc., to release my test results to my **(initial all that apply):**

____ Spouse,_____ Parent,_____ Child, _____ Answering Machine, _____ Other:_____.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been offered a Notice of Privacy Practices for Dermatology Specialists of Augusta, Inc., as required by the Health Insurance Portability and Accountability Act of 1996.

_____ (Initial by patient or guardian)

MISSED APPOINTMENT POLICY

Your appointment time has been reserved especially for you. If you cannot keep your appointment, please call at least 24 hours in advance to cancel or reschedule. If appointments are missed without notice, you will be charged a missed appointment fee. If you repeatedly miss a scheduled appointment, you may be dismissed from the practice.

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.

****INSURANCE POLICY****

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 ARE NOW IN THE ERA OF "MANAGED-CARE." INSURANCE COMPANIES ARE CONCERNED ABOUT THE RISING COSTS OF HEALTHCARE. IN AN ATTEMPT TO CONTROL THEIR COSTS, THEY SHARE THE BURDEN OF PAYING FOR YOUR HEALTHCARE WITH YOU. **PLEASE UNDERSTAND THAT WE DID NOT SELECT YOUR INSURANCE PLAN.**

1) Some services we provide are considered "Cosmetic" or "not medically necessary." Obvious examples are Botox and other wrinkle treatments. Less obvious **examples of cosmetic / non-medically necessary services are removal of non-cancerous skin growths such as moles or skin tags that are not painful, bleeding, irritating, or have other symptoms.** We are happy to provide these services to you; however it is unethical and illegal to bill your insurance company for them. **Growths that are suspicious, cancerous, changing, or have symptoms such as bleeding or pain are generally covered by insurance.**

   _____ (Initial by patient or guardian)

2) We prescribe individual treatments based on what is the best for you and your condition. Often generic drugs are helpful and are cost effective. **Generic drugs 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.

   _____ (Initial by patient or guardian)

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3) **Co-pays:** Co-pays are a way insurance companies have of sharing the cost of your healthcare with you, the patient. Every time you come to our office for a medical visit, you will be expected to pay a co-pay. 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.**

_____ (Initial by patient or guardian)

4) **Deductibles:** Most insurance plans have a deductible. A deductible is an amount of money your insurance company wants you to pay for your healthcare before they will "kick-in" and pay the rest. **Almost every procedure (major or minor) that doctors perform will be applied to a deductible.** This means that if you have a yearly $1000 deductible that you have not met, any non-cosmetic procedures we do such as freezing a wart, removing a cancer, etc will go towards your deductible. This means you will receive a statement from our office for these charges and are expected to pay them in a timely manner. We reserve the right to collect deductibles up front prior to certain procedures.

_____ (Initial by patient or guardian)

5) **Miscellaneous:** 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. Growths that are suspected to be a skin cancer will first need to be biopsied. 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.

_____ (Initial by patient or 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 HIPPA policy.

Signature of patient or guardian_____ **Date**:_____

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OUR PRACTICE 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.**

- For your convenience, we accept personal checks, cash, Visa and MasterCard.

- 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.

INSURANCE:

- 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 your insurance coverage.

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.

_____ _____

Signature of Patient or Responsible Party **Date**

_____

Please Print the Name of the Patient

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Patient Name: _____ Date:_____

Primary Care Doctor: _____ Pref. Pharmacy: _____

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 _____
- ☐ Other _____
- ☐ HIV / AIDS _____

Skin history: *Check all that apply and explain if needed.*

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

Family History: *Check all that apply and explain if needed.*

- ☐ 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 alchohol? ☐No ☐Yes How much?_____
Do you smoke? ☐No ☐Yes How much? _____
Occupation _____

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

_____

_____

List any drug or food allergies:

_____

_____