GEORGIA SKIN CANCER
& Aesthetic Dermatology

HISTORY & INTAKE FORM
(Please Print)

Patient: _____ **Date of Birth:** _____ **Medical Record #:** _____

Past Medical History/Alerts: (Please circle all that apply)

Alerts:
Blood Thinners
Defibrillator
Pre-meds Prior to Procedure
HIV/Hepatitis
Pregnant/Nursing

Allergic To:
Latex
Lidocaine
Epinephrine

Past Medical History: (Please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplant
BPH
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Other: _____
NONE

Past Surgical History: (Please circle all that apply)

Appendix Removed
Bladder Removed

Breast:
Breast Biopsy
Lumpectomy (Right, Left, Bilateral)
Mastectomy (Right, Left, Bilateral)

Colon:
Colectomy (Colon Cancer Resection)
Colectomy (Diverticulitis)
Colectomy (IBD)
Colostomy

Gallbladder Removed

Heart:
Biological Valve Replacement
Coronary Artery Bypass
Heart Transplant
Mechanical Valve Replacement
PTCA

Joint Replacement:
Hip (Right, Left, Bilateral)
Knee (Right, Left, Bilateral)

Kidney:
Kidney Biopsy
Kidney Stone Removal
Kidney Transplant
Nephrectomy

Liver:
Hepatectomy
Liver Transplant
Shunt

Ovaries:
Oophorectomy (Endometriosis)
Oophorectomy (Ovarian Cancer)
Oophorectomy (Ovarian Cyst)
Tubal Ligation

Pancreas Removed

Prostate:
Prostatectomy (Biopsy)
Prostatectomy (Prostate Cancer)
Prostatectomy (TURP)

Rectum:
APR
Low Anterior Resection

Skin:
Biopsy
Basal Cell Carcinoma
Squamous Cell Carcinoma
Melanoma

Spleen Removed
Testicles Removed

Uterus:
Hysterectomy (Fibroids)
Hysterectomy (Uterine Cancer)
Hysterectomy (Cervical Cancer)

Other: _____
NONE

Skin Disease History/Sun Exposure: (Please circle all that apply)

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

Do you wear sunscreen? **YES NO** What SPF? _____ Do you tan in a tanning salon? **YES NO**
Do you have a family history of non-melanoma skin cancer? **YES NO** If yes, what relative? _____
Do you have a family history of Melanoma? **YES NO** If yes, what relative? _____

Medications: (Please list all current medications)

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

Allergies: (Please list all allergies and drug allergies)

_____
_____

Social History:

Smoking History: ☐ **Currently Smoke** ☐ **Have Smoked in the Past** ☐ **Never Smoked**

Alcohol Consumption: ☐ **YES** ☐**NO**

- May we leave a message on your home phone? **YES NO** Cell phone? **YES NO**
- May we discuss your medical condition with any member of your household? **YES NO**
- If yes, with whom: _____ Relationship: _____
- Primary Care Physician: _____ Referring Dermatologist: _____
- Do you work in the sun? **YES NO** Occupation/Employer: _____

Pharmacy Name: _____ Location OR Phone #: _____

All patients please sign:

- I authorize the release of any medical information needed to process Medicare and/or other insurance.
- I authorize Georgia Skin Cancer and Aesthetic Dermatology to treat the above named patient (including minors) as necessary.
- I authorize the release or acquisition of any medical information to/from any physician or physician's office, laboratory, pharmacy, hospital or surgical facility involved in my care. I have read the HIPAA privacy policy of Georgia Skin Cancer & Aesthetic Dermatology.

Signature: _____ **Date:** _____
Signature of Patient/Parent or Guardian

GEORGIA SKIN CANCER
& Aesthetic Dermatology

MRN _____

PATIENT REGISTRATION FORM

Please present your insurance cards and your photo ID to the receptionist so copies may be made.

Name: _____ ☐ Jr. ☐ Sr.
First Middle Last

☐ Married ☐ Single ☐ Wid. ☐ Div. ☐ Other_____ Date of Birth: _____ Sex: ☐ Male ☐ Female
Month / Day / Year

Address: _____
Street Name City State Zip Code

Home Phone #: _____ Social Security #: _____

Cell Phone #: _____ E-mail: _____

Race:	**Language:**	**Ethnicity:**
White	English	Hispanic/Latino
Black/African American	Spanish	Not Hispanic or Latino
Asian	Other: _____	
American Indian or Native American		
Native Hawaiian/Pacific Islander		

Primary Care Physician: _____

How did you hear about us? ☐ Specialist _____ ☐ Primary Care Physician ☐ Friend/Family ☐ Internet
☐ Social Media ☐ Yellow Pages ☐ Newspaper ☐ Magazine ☐ Skin Screening ☐ Ins. Directory ☐ Other:_____

Emergency Contact:

_____
Name Phone # Relationship

If Patient is a Minor: It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service.

_____ _____ _____ _____
Signature of Parent or Legal Guardian | Printed Name of Parent or Legal Guardian | (Date of Birth) | Date

In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA, MASTERCARD, DISCOVER, AND AMERICAN EXPRESS FOR YOUR CONVENIENCE. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the doctor when assigned claim is filed.

_____ _____
Signature of Patient, Parent or Legal Guardian Date

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Consent for Treatment/Financial Agreement

Patient Name: _____ Account Number:_____

Consent for Treatment/Financial Agreement: I consent to treatment necessary or desirable to the care of the patient first mentioned above, including but not restricted to, whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray or other studies that may be used by the attending doctor, his nurse or qualified designate. Common treatments include skin biopsies (shave or punch biopsy methods), that have risks not limited to scarring, infection, bleeding, scabbing, incomplete removal, nerve damage and allergy to anesthesia; and cryotherapy with liquid nitrogen that has risks not limited to crusting, scabbing, blistering, scarring, darker or lighter pigmentary change, recurrence, incomplete removal and infection. I also acknowledge full responsibility for the payment of all services, and agree to pay all amounts due in full at the time of service. I understand that the patient or responsible party is solely responsible for payment of all services, though the insurance may be filed. **If Patient is a Minor:** It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service. If this account becomes delinquent, I agree to pay all costs of collection, including a reasonable attorney's fee. I understand that I will be charged $32.00 for any returned check.

I understand that my insurance may not cover all services. **These plans cover services based on medical necessity. Injections, intralesional injections, hair loss treatment, keloid removal/treatment, wart removal/treatment, skin tags, clavus (corns) removal/treatment and other skin lesions are not always considered medically necessary on many insurance plans.** I understand that if any treatment is rejected by my insurance plan as a non-covered procedure that I will be billed for those services. I also acknowledge as a member of these plans, that this office will submit my insurance and I will be responsible for paying all copays and/or deductibles at the time of the visit as well as any cosmetic treatment.

I understand that if my insurance requires a referral from my Primary Care Physician **that it is my responsibility as the patient to confirm that my referral is current and in effect before I arrive for my appointment.** If no referral is obtained I understand that I may be responsible for the visit. If you have any questions concerning your referral, please contact our billing department at (706) 995-0033.

I understand that I will receive a separate bill for any pathology services performed by outside laboratories or by Georgia Skin Cancer and Aesthetic Dermatology.

I authorize Medicare, MEDIGAP insurer, or my insurance company to remit payment of medical benefits direct to this office for services provided by our physicians.

I have read the HIPAA privacy policy of Georgia Skin Cancer and Aesthetic Dermatology.

I hereby give permission to any employee of Georgia Skin Cancer & Aesthetic Dermatology to perform a historical search of my prescription medications which will allow the practice to better manage the risk of adverse drug effects, enable more informed treatment decisions across care transitions, and gain insight into patient medication adherence.

I hereby authorize the release of all medical records on the patient listed above to the referring and family physicians, as well as all records necessary for the processing of insurance claims.

Patient Signature: _____ Date: _____

Signature of Parent/Guardian (Child under 18 years old) or Power of Attorney

Revised 5/30/19

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Quality Measures Required by Insurance

Our practice is required to submit statistics related to the following questions to most insurance companies as a part of our participation in their networks.

Please know that your name and personal answers are **NOT disclosed-*only the statistics*.**

Name: _____ **Date of Birth:** _____/_____/_____

Social History: (Please circle your answer)

Do you consume alcohol? YES NO

If yes: How many drinks per week? _____

Smoking/Tobacco use: FORMER CURRENT NEVER

Immunization History: (Please circle your answer)

Have you received the Influenza (Flu) vaccination in the last year? YES NO

Have you received the Pneumonia vaccination in the last year? YES NO

Advanced Care: (Please circle your answer)

Do you have a living will? YES NO

Do you have someone to make medical decisions if you're unable to? YES NO

If yes: Who? _____

GEORGIA SKIN CANCER
& Aesthetic Dermatology

NOTICE OF PRIVACY PRACTICES Effective September 12, 2013

GEORGIA SKIN CANCER & AESTHETIC DERMATOLOGY, LLC
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND
HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosure, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.
For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.
For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. WHO WILL FOLLOW THIS NOTICE. This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel.
POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Practice. Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an “accounting of disclosures”. This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice’s waiting room. COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact Richard L. McKinney, Privacy Officer, at 1180 Resurgence Dr. Watkinsville, GA 30677. All complaints must be in writing. **You will not be penalized for filing a complaint.** OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.