

GEORGIA DERMATOLOGY PARTNERS PATIENT REGISTRATION

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

LAST NAME	MIDDLE	FIRST NAME	DATE OF BIRTH
PREFERRED NAME		LAST 4 DIGITS OF SSN: XXX-XX-	
STREET ADDRESS		CITY, STATE, ZIP CODE	
HOME PHONE #		MOBILE PHONE #	
EMAIL ADDRESS		PREFERRED LANGUAGE	
MARITAL: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		ETHNIC GROUP: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Prefer Not to Say <input type="checkbox"/> Unknown	
RACE: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White or Caucasian <input type="checkbox"/> Other _____ <input type="checkbox"/> Prefer Not to Say <input type="checkbox"/> Unknown			
EMERGENCY CONTACT		EMERGENCY PHONE	
HOW DID YOU HEAR ABOUT OUR OFFICE? <input type="checkbox"/> Referral (Friend/Family) <input type="checkbox"/> Referral (Doctor) <input type="checkbox"/> Google <input type="checkbox"/> Social Media <input type="checkbox"/> Insurance <input type="checkbox"/> Walk-In <input type="checkbox"/> Other: _____			
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: OK to leave message with detailed information Leave message with call back number only

Mobile Phone: OK to leave message with detailed information Leave message with call back number only

Email Marketing Consent: OK to receive newsletters with special offers or promotions.

PLEASE LIST PEOPLE TO WHOM OUR STAFF MAY DISCUSS AND/OR DISCLOSE YOUR HEALTH INFORMATION

NAME	RELATIONSHIP	CONTACT #

RESPONSIBLE PARTY, IF OTHER THAN PATIENT (PLEASE PRINT LEGIBLY)

LAST NAME	FIRST NAME, MI	RELATIONSHIP TO RESPONSIBLE PARTY <input type="checkbox"/> Minor Child <input type="checkbox"/> Dependent Adult <input type="checkbox"/> Other
STREET ADDRESS	CITY, STATE, ZIP CODE	PRIMARY #

PATIENT INSURANCE INFORMATION (PLEASE PRINT LEGIBLY)

PRIMARY INSURANCE COMPANY	MEMBER # (or ID #)	GROUP #
POLICY HOLDER'S NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH
POLICY HOLDER'S ADDRESS	CITY, STATE, ZIP CODE	RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent
SECONDARY INSURANCE COMPANY	MEMBER # (or ID #)	GROUP #
POLICY HOLDER'S NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH
POLICY HOLDER'S ADDRESS	CITY, STATE, ZIP CODE	RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent

ACKNOWLEDGEMENT. I acknowledge all information above is accurate.

Signature of Patient <u>or</u> Parent/Guardian (if a minor) <u>or</u> Power of Attorney	Date
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GEORGIA DERMATOLOGY PARTNERS

PATIENT MEDICAL INFORMATION

LAST NAME	MIDDLE	FIRST NAME
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EMERGENCY CONTACT	EMERGENCY PHONE:
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MEDICAL POWER OF ATTORNEY OR HEALTHCARE PROXY:

DESIGNEE'S NAME	PHONE:
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ALLERGIES
 Are you allergic to: Adhesive Y N Epinephrine Y N Lidocaine Y N Antibiotic Y N Latex Y N
 Other: _____

Do you have a living will? Yes No

HEALTH HISTORY: Please check appropriate box (Y/N) as each applies to your current or past medical history:

Arthritis	Y <input type="checkbox"/> N <input type="checkbox"/>	Pregnant or Planning	Y <input type="checkbox"/> N <input type="checkbox"/>
Artificial Heart Valve / Infection	Y <input type="checkbox"/> N <input type="checkbox"/>	Cold Sores/Herpes	Y <input type="checkbox"/> N <input type="checkbox"/>
Artificial Joint (Past 2 Years)	Y <input type="checkbox"/> N <input type="checkbox"/>	Bleeding Disorder or Bruise Easily	Y <input type="checkbox"/> N <input type="checkbox"/>
Asthma	Y <input type="checkbox"/> N <input type="checkbox"/>	Depression	Y <input type="checkbox"/> N <input type="checkbox"/>
Hepatitis, Type: _____	Y <input type="checkbox"/> N <input type="checkbox"/>	Diabetes	Y <input type="checkbox"/> N <input type="checkbox"/>
HIV/AIDS	Y <input type="checkbox"/> N <input type="checkbox"/>	Alzheimer's/Dementia	Y <input type="checkbox"/> N <input type="checkbox"/>
Organ Transplant	Y <input type="checkbox"/> N <input type="checkbox"/>	High Blood Pressure	Y <input type="checkbox"/> N <input type="checkbox"/>
Pacemaker/Defibrillator	Y <input type="checkbox"/> N <input type="checkbox"/>	Hypothyroid	Y <input type="checkbox"/> N <input type="checkbox"/>
Heart Disease	Y <input type="checkbox"/> N <input type="checkbox"/>	Hyperthyroid	Y <input type="checkbox"/> N <input type="checkbox"/>
Irregular Heartbeat	Y <input type="checkbox"/> N <input type="checkbox"/>	Autoimmune Condition	Y <input type="checkbox"/> N <input type="checkbox"/> Type: _____
Vasovagal Reaction (Fainting)	Y <input type="checkbox"/> N <input type="checkbox"/>	Cancer (Other than Skin)	Y <input type="checkbox"/> N <input type="checkbox"/> Type: _____
		Other: _____	

SKIN HISTORY: Please check appropriate box (Y/N) if you have had any of the following skin conditions or treatments:

Accutane (Last 6 Months)	Y <input type="checkbox"/> N <input type="checkbox"/>	Melanoma Skin Cancer	Y <input type="checkbox"/> N <input type="checkbox"/> Location: _____
Acne	Y <input type="checkbox"/> N <input type="checkbox"/>	Basal Cell Carcinoma Skin Cancer	Y <input type="checkbox"/> N <input type="checkbox"/> Location: _____
Actinic Keratosis	Y <input type="checkbox"/> N <input type="checkbox"/>	MRSA / Staph Infection	Y <input type="checkbox"/> N <input type="checkbox"/>
Blistering Sunburns	Y <input type="checkbox"/> N <input type="checkbox"/>	Psoriasis	Y <input type="checkbox"/> N <input type="checkbox"/>
Flaking or Itchy Scalp	Y <input type="checkbox"/> N <input type="checkbox"/>	Rosacea	Y <input type="checkbox"/> N <input type="checkbox"/>
Keloids	Y <input type="checkbox"/> N <input type="checkbox"/>	Suspicious Mole Or Growth	Y <input type="checkbox"/> N <input type="checkbox"/>
		Other: _____	

SURGICAL HISTORY: List all surgical procedures within the past 5 years

Do you wear sunscreen? Y N SPF: _____

Do you tan in a tanning salon? Y N

Has anyone in your family had squamous cell carcinoma skin cancer? Y N Which Relative(s): _____

Has anyone in your family had melanoma skin cancer? Y N Which relative(s): _____

Do you drink alcohol? Y N If yes: < 1 drink/day 1-2 drinks/day 3+ drinks/day

Do you use recreational drugs? Y N

Do you smoke currently? Y N If no: Never Former

CURRENT MEDICATIONS: List all medications (including prescriptions, chemotherapy, herbals, vitamins, over-the-counter)

Signature of Patient or Parent/Guardian (if a minor) or Power of Attorney	Date
Printed Name of Parent/Guardian or Power of Attorney, if applicable	RELATIONSHIP TO PATIENT, if other than self <input type="checkbox"/> PARENT/GUARDIAN <input type="checkbox"/> POWER OF ATTORNEY <input type="checkbox"/> OTHER

GEORGIA DERMATOLOGY PARTNERS PATIENT FINANCIAL POLICY

Thank you for choosing us for your healthcare needs. As your healthcare provider, we are committed to providing you with the best possible care. Please read our financial policy and, if you have any questions, please ask one of our associates for assistance or call our billing office at (844) 733-1400.

You will be asked to show the front office staff your current insurance card at each visit. Please come prepared. This allows us to verify the information and assist you in collecting the benefits from your insurance company to which you are entitled.

PATIENTS WITH INSURANCE POLICIES

For Insurance companies that we participate with:

We are pleased to bill services to your insurance on your behalf. If your insurance requires you to make a copay, coinsurance, and/or deductible, we expect this payment at time of service. We will verify coverage and assist with obtaining authorization for services. However, it is your responsibility to obtain any referrals required by your insurance from your primary care physician. You will be responsible for any amount the insurance plan deems not covered, up to the entire amount. If you are not prepared to pay your co-pay or coinsurance, your appointment will be rescheduled.

For insurance companies that we DO NOT participate with:

If your insurance has an out-of-network benefit clause and we can verify coverage and obtain authorization, we will submit a claim to the insurance company on your behalf. We will collect any unmet deductible or coinsurance at the time of service. It is ultimately your responsibility to verify that we are in your network and confirm the out-of-pocket costs due to using an out-of-network provider.

If we do not hear from your insurance company:

If we have not received payment or rejection from your insurance company in a timely manner, we will transfer the balance to your responsibility. We request your assistance in following up with your insurance company to resolve any non-payment issues.

SELF PAY PATIENTS

If you do not have insurance or are seeking care outside of your insurance plan benefits, payment in full at the time of the service. For your convenience, we accept cash, check, Visa, Mastercard, Discover, and AMEX. A returned check fee of \$35 will be assessed on any check returned by the bank. Future services will require payment by cash, money order or credit card.

CANCELLATION AND NO-SHOW POLICY

Medical appointments missed with no notice or cancelled with less than one (1) business day notice will be assessed a \$35.00 no show/late cancellation fee. We charge a \$100 fee for each surgical procedure or cosmetic procedure missed or cancelled with less than three (3) business days' notice. Appointments cancelled during non-business hours, such as on Saturday or Sunday, will be assessed a late cancellation fee for appointments scheduled on Monday. Patients who miss or cancel without notice on more than two (2) occasions will be required to pay a \$100 deposit when scheduling future appointments.

PAST DUE ACCOUNTS

In the event a balance becomes past due, your account will be considered delinquent. Delinquent accounts are subject to further collection action, including placement with a collection agency. The patient will be responsible for any collection fees associated with collecting the outstanding balance.

COSMETIC SERVICES

We assess a fee of \$50 for consultations for aesthetic services. The consultation fee will be applied to aesthetic services and retail products received within 30 days of the consultation. The consultation fee will not be applied to prescription products received after 30 days of the consultation.

Fees for in-office cosmetic treatments such as dermal fillers, neurotoxins (such as Botox®, Dysport®), chemical peels, laser treatments and other aesthetic services are priced either on a per treatment basis or as a treatment package. Deposits may be required when scheduling for specific aesthetic services, such as fillers, Fraxel, or Bellafill. Payment is due in full at the time of service. Payment for treatment rendered is non-refundable.

When injecting neurotoxins, we always apply a determined number of units per area that may not be enough for some patients. If extra doses of neurotoxins are needed, a charge for extra units will be assessed.

DISABILITY AND OTHER SPECIAL FORMS

We recognize that special forms are sometimes necessary to provide documentation of medical conditions. The completion of forms is time-consuming and generally falls outside of the contractual relationship between you and your insurance company. We will be happy to complete these forms at the following rates:

- FMLA - \$25
- Disability/Physician Attestation - \$25
- Miscellaneous Forms - \$25

Payment for the completion of a form is due at the time of the request. A medical release form must be signed.

RETURN POLICY

If you receive skin care products or prescription pharmaceutical preparations from our office, these products are non-refundable.

TREATMENT GUARANTEE

The practice of medicine and surgery is not an exact science. 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 that I may get. The results of certain procedures may not last as long as expected or meet the degree of your expected improvement. I also understand that additional charges, for which I will be responsible, will be applied for the management of problems and/or complications.

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.

We will gladly discuss your proposed treatment and will do our best to answer any questions related to your insurance. You must realize that: A) your insurance is a contract between you, your employer, and the insurance company. B) not all services are a covered benefit in all contracts. Your insurance plan may elect to not cover certain services for various reasons.

As your medical provider, our relationship and concern are with you and your health, not your insurance company. While the filing of insurance claims is a courtesy, **all charges are your responsibility from the date services are rendered.**

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY.

Signature of Patient <u>or</u> Parent/Guardian (if a minor) <u>or</u> Power of Attorney	Date	Employee Initials
Printed Name of Parent/Guardian or Power of Attorney, if applicable	RELATIONSHIP TO PATIENT, if other than self <input type="checkbox"/> PARENT/GUARDIAN <input type="checkbox"/> POWER OF ATTORNEY <input type="checkbox"/> OTHER	

GEORGIA DERMATOLOGY PARTNERS

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

CONSENT FOR TREATMENT: I hereby give my consent for Georgia Dermatology Partners to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Georgia Dermatology Partners Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Georgia Dermatology Partners reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Georgia Dermatology Partners management.

I consent to 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.

COMMUNICATION CONSENT: With my consent, Georgia Dermatology Partners may call my home or other designated location and leave a message on voice mail or in-person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Georgia Dermatology Partners may communicate with me via SMS/Text or iMessage in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Georgia Dermatology Partners may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

PHOTOGRAPHY CONSENT: 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 of me for purposes of ensuring proper patient identification or for medical documentation, care, or treatment purposes. I understand the photograph(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.

By signing this form, I am consenting to Georgia Dermatology Partners use and disclosure of my PHI to carry out TPO and I verify that I have read and accepted Georgia Dermatology Partners Notice of Privacy Policies.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Georgia Dermatology Partners may decline to provide treatment to me.

Results notification will be primarily through the patient portal for benign or normal pathology/lab results. Benign or normal reports will be uploaded to your portal once reviewed by your provider and you will receive an email informing you when your report(s) have been uploaded. We will call you at the phone number(s) provided for any abnormal results or those that require further explanation. If you wish to opt out of portal notifications, you must do so in writing.

Signature of Patient <u>or</u> Parent/Guardian (if a minor) <u>or</u> Power of Attorney	Date	Employee Initials
Printed Name of Parent/Guardian or Power of Attorney, if applicable	RELATIONSHIP TO PATIENT, if other than self <input type="checkbox"/> PARENT/GUARDIAN <input type="checkbox"/> POWER OF ATTORNEY <input type="checkbox"/> OTHER	

**GEORGIA DERMATOLOGY PARTNERS
PHOTO/VIDEO RELEASE FORM**

I. Parties Involved

• **Patient/Releasor:**

- Printed Name: _____ Date of Birth: _____
- Address: _____
- Phone: _____ Email: _____

• **Healthcare Practice/Releasee:** Gwinnett Dermatology P.C., dba Georgia Dermatology Partners

II. Consent and Scope of Release

I, the Patient named above (or legal guardian if the patient is a minor), hereby grant and authorize the Healthcare Practice, and its agents, assignees, and clients ("Grantees"), the irrevocable right to capture, use, edit, alter, copy, exhibit, publish, distribute, and make use of my image, likeness, voice, and/or Protected Health Information (PHI) as described below.

• **Media Types Covered (initial all that apply):**

- _____ Still photographs
- _____ Video recordings
- _____ Audio recordings
- _____ Quotes/written testimonials
- _____ My Protected Health Information (PHI), which may include before/after images, treatment details, etc.

• **Purpose and Use (initial all intended uses):** I authorize the use of the media for:

- _____ Educational purposes (e.g., medical teaching, training, research presentations)
- _____ Marketing and advertising (e.g., website, social media, print materials, email marketing, brochures)
- _____ Internal medical records only (images used solely within my confidential medical chart)

• **Platforms (where the media may appear):**

The media may be used by the practice and its affiliates in any format and on any platform, including websites, social media, digital ads, print materials, educational or internal use, and any other current or future media.

III. Terms and Waivers

By signing this form, I confirm my voluntary participation and understand that no compensation will be provided for the use of the media. I waive the right to approve the final product and release the Healthcare Practice, and its agents from liability for claims such as invasion of privacy or defamation. I also acknowledge that my healthcare will not be affected by my decision to sign or not sign this release and that I can revoke this authorization in writing, though not for media already in use.

IV. Patient/Guardian Signature

I am over 18 and understand the terms of this release.

Signature of Parent/Legal Guardian _____

Date _____

If the patient is a minor, a parent or legal guardian must complete the following section.

I am the parent or legal guardian and have the authority to sign for the minor. I am over 18.

Signature of Parent/Legal Guardian _____

Date _____