ACWORTH DERMATOLOGY AND SKIN CANCER CENTER
4450 CALIBRE CROSSING, SUITE 1208
ACWORTH, GA 30101

FIRST NAME _____ LAST NAME _____

REASON FOR VISIT _____

ADDRESS **(INCLUDE APARTMENT #, STREET, CITY, STATE AND ZIP CODE)**

_____

PREFERRED PHONE NUMBER _____(CIRCLE ONE) CELL, HOME, WORK

ALTERNATIVE PHONE NUMBER _____(CIRCLE ONE) CELL, HOME, WORK

SOCIAL SECURITY # _____GENDER _____ BIRTH DATE _____

MARITAL STATUES _____ EMAIL ADDRESS _____

(EMAIL WILL BE USED TO ACCESS YOUR PATIENT PORTAL)

EMPLOYER NAME _____EMPLOYER PHONE _____

MEDICAL INSURANCE INFORMATION (IF SUBSCRIBER IS DIFFERENT THAN PATIENT, ENTER THEIR NAME AND BIRTH DATE ETC)

NAME OF INSURANCE _____ ID# _____

SUBSCRIBERS NAME IF DIFFERENT THAN PATIENT'S _____

SUBSCRIBERS RELATIONSHIP TO PATIENT _____BIRTH DATE _____

IF YOU HAVE ADDITIONAL INSURANCE (INCLUDING SECONDARY INS OR SUPPLEMENTAL INS)

NAME OF INSURANCE _____ ID# _____

SUBSCRIBERS NAME IF DIFFERENT THAN PATIENT'S _____

SUBSCRIBERS RELATIONSHIP TO PATIENT _____BIRTH DATE _____

IF OTHER THAN PATIENT LIST THE NAME OF RESPONSIBLE PARTY, LEGAL GUARDIAN OR PATIENT REPRESENTATIVE

NAME _____RELATION TO PATIENT _____

RESPONSIBLE PARTY'S ADDRESS _____

RESPONSIBLE PARTY'S BIRTH DATE _____ PHONE_____

RESPONSIBLE PARTY'S SIGNATURE _____

EMERGENCY CONACT: NAME _____PHONE _____

RELATIONSHIP TO PATIENT: _____

_____ _____

Signature of patient or patient's legal guardian/patient representative DATE

Acworth Dermatology & Skin Cancer Center
4450 Calibre Crossing, Suite 1208
Acworth, GA 30101
Phone: 678-505-8030 Fax: 678-505-8263

ASSIGNMENT OF BENEFITS FORM

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment directly to Acworth Dermatology & Skin Cancer Center for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Insurance Disclaimer: "A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service."

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Acworth Dermatology and Skin Cancer Center to: Release any information necessary to insurance carriers regarding my illness and treatments; process insurance claims generated in the course of examination or treatment; and allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

AUTHORIZATION TO TREAT

I give my permission for the Physicians and staff of Acworth Dermatology & Skin Cancer Center to treat me as deemed necessary in the exercise of their professional judgment.

I have requested medical service from Acworth Dermatology & Skin Cancer Center on behalf of myself and/or my dependents, and understand that by making this request, I am fully financially responsible for all charges incurred in the course of authorized treatment. I understand that fees are due and payable on the date that services are rendered. Upon presentation of the appropriate statement, I understand that fees are due and agree to pay all such charges incurred in full immediately.

I understand I may be billed by an outside laboratory for work that is performed in this office, if my insurance company does not have a contracted lab or facility, or if services are not covered by my insurance company.

Patient Name or Legal Guardian/Patient Representative (Print) Date

Signature of patient or patient's legal guardian/patient representative

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

*You May Refuse to Sign this Acknowledgement

_____ I have received and/or reviewed a copy of this office's Notice of Privacy Practices.

_____ I was offered a copy of the Notice of Privacy Practices but declined to accept a copy.

Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communications barriers prohibited

___ Other (Please specify)

Acworth Dermatology and Skin Cancer Center

Patient Record of Disclosures

Generally, the HIPPA privacy rule gives individuals the right to request a restriction on use and disclosures of their protected health information.

Please list the manner in which you would like to be contacted regarding any appointments, test results, etc.

By Phone: _____ Phone Number

_____ Alternate Number

***Is it ok to leave a detailed message at any of the above numbers? Yes _____ No _____

We require written permission to release/discuss any of your medical records with any family members or friends. If you are least 18 years of age, please list anyone we can release information to:

Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient

_____ **Patient or Patient's Legal Guardian**

Print Name

_____ **Patient or Patient's Legal Guardian**

Signature **Date: _____**

ACWORTH DERMATOLOGY AND SKIN CANCER CENTER

HISTORY AND INTAKE FORM

PRINT NAME: _____DATE: _____

SIGNATURE: _____

Past Medical History; please circle all that apply. IF NO PAST MEDICAL HISTORY CIRCLE NONE

Anxiety	Coronary Artery Disease	Thyroid Problems
Arthritis	Depression	Leukemia
Asthma	Diabetes	Lung Cancer
Atrial fibrillation	End Stage Renal Disease	Lymphoma
Bone Marrow	GERD	Prostate Cancer
Transplantation	Hearing Loss	Radiation Treatment
Breast Cancer	Hepatitis	Seizures
Colon Cancer	High Blood Pressure	Stroke
COPD	HIV/AIDS	NONE
	High Cholesterol	

Other _____

Past Surgical History: please circle all that apply. IF NO PAST SURGERIES CIRCLE NONE

Appendix Removed	Joint Replacement, Knee (Right, Left, Bilateral)
Bladder Removed	Joint Replacement, Hip (Right, Left, Bilateral)
Mastectomy (Right, Left, Bilateral)	Joint Replacement within last 2 years
Lumpectomy (Right, Left, Bilateral)	Kidney Biopsy (Nephrectomy)
Breast Biopsy (Right, Left, Bilateral)	Kidney Removed (Right, Left)
Breast Reduction	Kidney Stone Removal
Breast Implants	Kidney Transplant
Colectomy: Colon Cancer Resection	Ovaries Removed: Endometriosis
Colectomy: Diverticulitis	Ovaries Removed: Cyst
Colectomy: IBD	Ovaries Removed: Ovarian Cancer
Gallbladder Removed	Prostate Removed: Prostate Cancer

Testicles Removed (right, Left, Bilateral)	Coronary Artery Bypass
Hysterectomy; Fibroids	Prostate Biopsy
Hysterectomy; Uterine Cancer	Mechanical Valve Replacement
Biological Valve Replacement	TURP (Prostate Removed)
Heart Transplant	Spleen Removed
Other	IF NO SURGERIES CIRCLE NONE. NONE

Skin disease history; please circle all that apply

Acne	Dry Skin	Poison Ivy
Actinic Keratosis	Eczema	Precancerous Moles
Asthma	Flaking or Itchy scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin
Blistering Sunburns	Melanoma	Cancer
IF NO SKIN DISEASE HISTORY CIRCLE NONE.		NONE

Other _____

Do you wear Sunscreen? Yes No

If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)?_____

_____

Medication: PLEASE LIST ALL CURRENT MEDICATIONS. IF NO MEDICATIONS WRITE NONE

_____

_____

_____

_____

_____

Allergies: PLEASE LIST ALL ALLERGIES: IF NO ALLERGIES WRITE NONE.

_____

_____

_____

_____

Social History; please circle all that apply

Cigarette Smoking:	**Alcohol Use:**
Currently smoke	None
Has smoked in the past	Less than 1 drink per day
Never smoked	1-2 drinks per day
Former smoker	3 or more drinks per day

Other_____

_____

Family History (Only first degree relatives) Parent, sibling, child

_____

_____

_____

_____

Preferred Language: _____

Race: _____

Ethnic Group: _____

Preferred Pharmacy Name: _____

Phone: _____

City or Zip Code: _____

NOTICE OF PRIVACY PRACTICES

Acworth Dermatology & Skin Cancer Center

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.

If you have any questions about this notice or to file a complaint, please contact our Privacy Officer at Acworth Dermatology & Skin Cancer Center, 4450 Calibre Crossing, Acworth, GA 30101.

It is the policy of the practice that all physicians, staff and business associates preserve the integrity, security and the confidentiality of your protected health information (PHI).

We understand that your health information is personal. We are committed to protecting the privacy of you PHI, including your medical records and billing information. This notice describes our privacy practices with respect to your PHI. This notice applies to all PHI maintained by us and related to your treatment and care, including information created by our staff or doctor while treating at our facility. This notice applies to the PHI we receive from your other treatment providers/

The law requires that we:

1. Safeguard your PHI.
2. Give you this notice of our legal duties and privacy practices
3. Follow the privacy practices outlined in this notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTE HEALTH INFORMATION

We may use and disclose your PHI for treatment and to coordinate or manage your healthcare and related services.

We may also use or disclose your PHI without your prior authorization for the following purposes: for public health activities; to comply with federal, state or local laws; to report incidents of abuse or neglect; for law enforcement purposes; in the course of a judicial or administrative proceeding; for health oversight audits or inspections.

We may contact you for appointment reminders or to relay laboratory or biopsy results or communicate with individuals directly involved in your care, e.g. your spouse, adult sibling, relative, friend or caregiver. By providing the practice with your email address and phone numbers, you are agreeing to email or voice mail appointment reminders. You must notify us in writing of your objections to be reminded of an appointment or to leave detailed message on your voice mail or answering machine.

In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing your PHI. If you choose to authorize our use or disclosure of your PHI, you can later revoke that authorization by notifying us in writing of your decision.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

In most cases, you have the right to request to look at or obtain a copy of your PHI. If you request copies, we may charge you a fee for the cost of copying, related supplies or postage.

If you believe that information in your designated record set is incorrect or if important information is missing; you have the right to request that we amend the records. Your request must be submitted in writing and include your reason for the amendment. We may deny your request to amend a record if the information was not created by us, if it is not part of our records or if we determine that the record is accurate. We will notify you of our decision in writing. If we deny your request to amend your PHI, you may submit a written request.

You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records.

CHANGES TO THIS NOTICE

We may change our privacy policies and the terms of this notice at any time. Changes will apply to the PHI we already have, as well as new information obtained after the change occurs. You can request a copy of the current notice at any time by contacting the Privacy Officer.

COMPLAINTS

If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you should contact our Privacy Officer.

You may file a complaint with our practice or with the US Department of Health and Human Services Office of Civil Rights. To file a complaint with our practice contact Privacy Officer, Acworth Dermatology and Skin Cancer Center, 4450 Calibre Crossing, Acworth, GA 30101.