# ADS / ACWORTH DERMATOLOGY & SKIN CANCER CENTER

**REASON FOR VISIT** _____

FIRST NAME _____ LAST NAME _____NICKNAME_____

HOME ADDRESS _____CITY _____ST _____ ZIP_____

BILLING ADDRESS _____CITY _____ST _____ZIP _____

DOB ____/_____/_____ PHONE: HOME _____CELL _____

EMPLOYER'S NAME _____SOC SEC NUMBER _____-_____-_____

GENDER _____ MARITAL STATUS _____EMAIL _____

**RESPONSIBLE PARTY OR GUARDIAN**

PERSON RESPONSIBLE FOR ACCOUNT _____RELATIONSHIP _____

BILLING ADDRESS _____CITY _____ST_____ZIP _____

PHONE: HOME _____CELL _____

**INSURANCE INFORMATION**

**1ST INS** _____ID# _____GRP# _____

POLICY HOLDER**:** _____DOB _____RELATIONSHIP TO PATIENT_____

IF SAME AS PATIENT CHECK HERE _____

**2ND INS** _____ID#_____GRP#_____

POLICY HOLDER: _____DOB _____RELATIONSHIP TO PATIENT _____

IF SAME AS PATIENT CHECK HERE _____

**3RD INS** _____ID#_____GRP#_____

POLICY HOLDER: _____DOB _____RELATIONSHIP TO PATIENT _____

IF SAME AS PATIENT CHECK HERE _____

**RACE (CHECK ALL THAT APPLY)** AMERICAN INDIAN ____ ASIAN ____ AFRICAN AMERICAN ____

WHITE _____ DECLINE TO PROVIDE _____

**ETHNICITY:** HISPANIC OR LATINO ____ NOT HISPANIC OR LATINO ____

**PREFERRED LANGUAGE:** ENGLISH _____ SPANISH _____ OTHER _____

**EMERGENCY CONTACT INFO**: NAME _____ PHONE _____

**PREFERED PHARMACY**: NAME _____LOCATION _____

**YOU MAY LEAVE A MESSAGE ON MY ANSWERING MACHINE OR VOICE MAIL?** YES _____ NO _____

**IF YOU WOULD LIKE US TO RELEASE YOUR MEDICAL INFORMATION TO ANYONE ELSE, WE REQUIRE WRITTEN PERMISSION TO DISCUSS ANY OF YOUR MEDICAL RECORDS WITH FAMILY OR FRIENDS. IF YOU ARE AT LEAST 18 YRS OF AGE, PLEASE LIST ANYONE WE CAN RELEASE INFO TO:** NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

**PATIENT/RESPONSIBLE PARTY SIGNATURE** _____ **DATE** _____

## ADS/ ACWORTH DERMATOLOGY AND SKIN CANCER CENTER

**PATIENT NAME: _____ DOB: _____**

**ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF INFORMATION**

I 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) TO ISSUE PAYMENT DIRECTLY TO ACWORTH DERMATOLOGY FOR MEDICAL SERVICES RENDERED TO MYSELF AND/OR MY DEPENDENTS REGARDLESS OF MY INSURANCE BENEFITS, IF ANY. I AUTHORIZE ACWORTH DERMATOLOGY 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.

**_____ PLEASE INITIAL**

**HIPPA (HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT)**

I CONSENT TO THE USE OR DISCLOSURE OF MY PROTECTED HEALTH INFORMAITON (PHI) BY ACWORTH DERMATOLOGY FOR THE PURPOSE OF DIAGNOSING OR PROVIDEING TREATMENT TO ME, OBTAINING PAYMENT FOR MY HEALTH CARE BILLS OR TO CONDUCT HEALTH CARE OPERATIONS.

**_____ PLEASE INITIAL**

I HAVE RECEIVED AND/OR REVIEWED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES OR I WAS OFFERED A COPY OF THE NOTICE PR PRIVACY PRACTICES BUT DECLINED TO ACCEPT A COPY. (**NOTICE OF PRIVACY PRACTICES IS ON DISPLAY IN THE WAITING AREA. IF YOU WOULD LIKE A COPY, NOTIFY THE FRONT DESK)**

**_____ PLEASE INITIAL**

**AUTHORIZATION TO TREAT**

I GIVE MY PERMISSION FOR THE PHYSICIAN AND STAFF OF ACWORTH DERMATOLOGY TO TREAT ME. I HAVE REQUESTED MEDICAL SERVICE FROM ACWORTH DERMATOLOGY ON BEHALF OF MYSELF AND/OR MY DEPENDENTS AND UNDERSTAND THAT BY MAKING THIS REQUEST, I AM FULLY FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURED 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.

**_____ PLEASE INITIAL**

**PATIENT OR RESPONSIBLE PARTY SIGNATURE _____ DATE _____**

# ADS / ACWORTH DERMATOLOGY & SKIN CANCER CENTER

**PATIENT NAME** _____

**ARE YOU CURRENTLY TAKING ANY BLOOD THINNERS** YES _____ NO _____

**LIST YOUR CURRENT MEDICATIONS**

NAME _____ DOSAGE _____ FREQUENCY _____
NAME _____ DOSAGE _____ FREQUENCY _____
NAME _____ DOSAGE _____ FREQUENCY _____
NAME _____ DOSAGE _____ FREQUENCY _____
NAME _____ DOSAGE _____ FREQUENCY _____
NAME _____ DOSAGE _____ FREQUENCY _____
NAME _____ DOSAGE _____ FREQUENCY _____
NAME _____ DOSAGE _____ FREQUENCY _____
NAME _____ DOSAGE _____ FREQUENCY _____
NAME _____ DOSAGE _____ FREQUENCY _____

**ALLERGIES – ARE YOU ALLERGIC TO ANY OF THE FOLLOWING: IF NO ALLERGIES CIRCLE "NONE"**

ADHESIVE TAPE _____ ANTIBIOTICS _____ LATEX _____
CODEINE _____ LOCAL ANESTHETICS _____ NONE
LIST ANY OTHER ALLERGIES:
_____

**YOUR PAST MEDICAL HISTORY. 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 | LYMPHOMA | BONE MARROW |
| END STAGE RENAL DISEASE | GERD | PROSTATE CANCER |
| TRANSPLANTATION | HEARING LOSS | BREAST CANCER |
| RADIATION TREATMENT | HEPATITIS | SEIZURES |
| COLON CANCER | HIGH BLOOD PRESSURE | STROKE |
| COPD | HIV/AIDS | HIGH CHOLESTEROL **NONE** |

OTHER _____

**PAST SURGICAL HISTORY: 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 **NONE** |

OTHER _____

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**PATIENT NAME** _____

**SKIN DISEASE HISTORY; PLEASE CIRCLE ALL THAT APPLY. IF NO PAST SKIN DISEASE HISTORY CIRCLE "NONE"**

| | | | |
|---|---|---|---|
| ACNE | DRY SKIN | POISON IVY | ACTINIC KERATOSIS |
| ECZEMA | PRECANCEROUS MOLES | BASAL CELL SKIN CANCER | FLAKING OR ITCHY SCALP |
| PSORIASIS | SQUAMOUS CELL SKIN CANCER | BLISTERING SUNBURNS | MELANOMA |
| CANCER | **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): _____

_____

**SOCIAL HISTORY; PLEASE CIRCLE ALL THAT APPLY**

| **CIGARETTE SMOKING:** | **ALCOHOL USE:** |
|---|---|
| CURRENTLY SMOKE | NONE |
| HAS SMOKE IN THE PAST | LESS THAN 1 DRINK PER DAY |
| NEVER SMOKED | 1-2 DRINKS PER DAY |
| FORMER SMOKER | 3 OR MORE DRINKS PER DAY |

**FAMILY HISTORY OF SKIN CANCER - ONLY <u>FIRST DEGREE RELATIVES – PARENT, SIBLING, CHILD</u>**

_____

_____

## HOW DID YOU HEAR ABOUT US? _____

# 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 PROTECTED 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.