Southeast Dermatology Medical History Form

Patient Name:_____DOB:_____Date: _____

Primary Care Physician:_____Preferred Pharmacy: _____

Past Medical History

Do you now have, or have you ever been diagnosed with any of the following conditions: (Check if Yes)

__ Anxiety
__ Arthritis
__ Asthma
__ Atrial fibrillation
__ Benign Prostate enlargement
__ Bone Marrow Transplant
__ Breast Cancer
__ Colon Cancer
__ COPD
__ Coronary artery disease
__ Depression
__ Diabetes
__ End stage kidney disease
__ GERD/Acid reflux
__ Hearing loss
__ Hepatitis B
__ Hepatitis C
__ High blood pressure
__ HIV/AIDS
__ High cholesterol
__ Hyperthyroid (high)
__ Hypothyroid (low)
__ Leukemia
__ Lung Cancer
__ Lymphoma
__ Prostate cancer (males)
__ Radiation treatment
__ Seizures
__ Stroke
__ Other _____
__ Other _____
__ Other _____
__ None of these

Other medical problems not listed above: _____

_____

List any major surgeries: _____

Skin Disease History: Have you ever had skin cancer? □ Yes □ No □ Not Sure
If yes, check what type(s): □ Basal Cell □ Squamous Cell □ Melanoma □ Not sure
Do you use sunscreen? □ Yes □ No Have you ever used a tanning bed? □ Yes □ No
Do any of your blood relatives have melanoma? □ Yes □ No Relationship: _____

Medications: Current medications: _____

_____

List any medication allergies: _____

Social History: Do you drink alcohol? □ Yes □ No If yes,_____drinks per day
Do you smoke? □ Yes □ Quit □ No If yes,_____packs per day,

ROS

Do you have problems with healing? □ Yes □ No or excessive scarring (keloid)? □ Yes □ No
Do you have any problems with your immune system? □ Yes □ No

Alerts

Have you ever had a bad reaction to local anesthesia? □ Yes □ No
Are you allergic to adhesive? □ Yes □ No
Are you allergic to topical antibiotic ointments? □ Yes □ No
Do you have an artificial heart valve? □ Yes □ No
Are you on blood thinners? □ Yes □ No
Do you have a defibrillator? □ Yes □ No
Do you have a pacemaker? □ Yes □No
Have you been told to take antibiotics prior to dental or surgical procedures? □ Yes □ No
Do you get a rapid heartbeat with epinephrine? □ Yes □ No
Are you pregnant or planning pregnancy? □ Yes □ No If pregnant, due date: _

COSMETIC INTEREST QUESTIONNAIRE

This questionnaire is optional. Only fill out if interested
Additional information and consultation appointments are available.

Patient Name: _____ Date: _____

Please provide email address to be notified about product specials and upcoming promotional events.

_____

Do you have any cosmetic concerns today? (Please check all that apply)

___ Dry, itchy skin	___ Uneven skin tones	___ Skin tags
___ Clogged pores	___Spider veins	___ Dark spots
___ Tattoo removal	___ Acne scars	___ Acnes scars
___ Hair removal	___ Surgical/other scars	___ Hair loss
___ Frown lines, smile line Wrinkles on/around lips	___ Wrinkles on forehead, between eyebrows, around eyes	

Do you need a skin care routine? Please circle Yes No
If yes, ___ Simple is better or ___The more the better

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number:

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		True Age		Older Than
1	2	3	4	5

When looking in the mirror, how concerned are you about the appearance of your wrinkles.

Not Concerned		Somewhat Concerned		Very Concerned
1	2	3	4	5

Southeast Dermatology

Patient expectations: (Please review and initial)

- Compliance with recommendations and follow-up appointments is expected to provide you excellent care._____

- Please notify us of any change in your medications as soon as possible. Please bring all your medications or list of your medications to every visit. _____

- Please notify us 24 hours in advance if you need to cancel or reschedule your appointment. You may be charged a fee for No-show appointment. ___

- Please request your medication refill well in advance. A turnaround time of 3 business days is expected for medication refills, biologic medications may take longer. _____

- Make sure to update your contact information and insurance information on every visit._____

- Make sure that you notify us of all other healthcare providers involved in your medical care. Effective communication between healthcare providers is of utmost important to provide you safe and timely care._____

- If you are late for your appointment, you may be asked to reschedule._____

- Please provide your email address as requested on demographic page. This allows access to the Patient Portal, enabling you access to request appointments, medication refills, your medical records, questions to the provider among other things. This and more can be done through the patient portal. ____

- Please sign all consent forms. These forms, although cumbersome, are necessary under Federal and State Laws. Please do not leave any blanks on forms, you may write N/A for not applicable if necessary or does not apply. ___

- Any deductible, co-insurance and copays will be collected at the time of service. ___

Patient Financial Policy

Thank you for choosing us for your healthcare needs. As your physician, 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 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. In addition, you will be responsible for any amount the insurance plan deems not covered, up to the entire amount.

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.

*For insurance companies that we **DO NOT** participate with:*

If your insurance has an out-of-network benefit clause and we are able to verify coverage and obtain authorization, we will submit a claim to the insurance company on your behalf. PhyNet reserves the right to collect any unmet deductible or coinsurance at the time of service. It is ultimately the patient's responsibility to verify if we are in your network and what the out-of-pocket costs in using an out-of-network provider will be.

SELF PAY PATIENTS

If you do not have insurance or are seeking care outside of your insurance plan benefits, payment in full is required prior to the service. For your convenience, we accept cash, check, Visa, Mastercard, Discover, and American Express. 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.

COPAYMENTS

According to the agreement you have made with your insurance company, copayments are due at each visit. If you are not prepared to pay your co-pay, your appointment will be rescheduled.

COINSURANCE

Coinsurance is based on the pre-determined level of coverage outlined in your insurance policy. For example, you may have an 80/20 plan, meaning the insurance will consider and pay on 80% of the charges and the remaining 20% is your responsibility. It is very important to review your coverage to determine your level of coinsurance.

NO SHOW FEES

Patients who fail to keep appointments or cancel without 24 hours advanced notice may be charged a $50 fee for an office visit, a $100 fee for a missed surgery/ASC appointment and a $75 fee for a cosmetic appointment.

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.

DISABILITY AND OTHER SPECIAL FORMS

We recognize that special forms are sometimes necessary to provide documentation of medical conditions. Completing 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
- Medical Records - $35

Payment of the form filing fee is due at the time of request and a medical release form must be signed.

We will gladly discuss your proposed treatment and will do our best to answer any questions relative 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 is 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:_____ Date:_____

Patient Name:_____

Southeast Dermatology

IMPORTANT INSURANCE INFORMATION

Thank you for taking the time to read the following important information as it may directly affect you. Our staff is available to answer any questions you may have so we may work together to eliminate any possible confusion and provide you with assistance throughout the insurance billing process.

Due to the complex and ever-changing insurance industry, it is not possible to discern and understand all the various detailed insurance plan benefits. Southeast Dermatology makes every attempt possible to assist our patients throughout the process of insurance benefits and billing. Read the following information carefully.

- Southeast Dermatology may provide you information concerning insurance coverage. Any information we may provide you is not a guarantee of reimbursement for your specific plan benefits. This information includes, but is not limited to, coverage, exclusions, limitations, authorizations, out-of network benefits, pre-existing conditions, deductibles, co-payments or co-insurance. Southeast Dermatology is not responsible for incorrect, unclear or incomplete information provided by a patient, a patient's representative or by an insurance company. Southeast Dermatology does not accept responsibility for what your insurance pays or does not pay.
- Your insurance company will apply all benefits that are specific to your policy at the time a claim is processed. Should you have questions regarding a claim that has been denied, pended or processed you may contact your insurance plan or us if needed.
- Out-of-network *(a provider and/or a facility that does not participate with your insurance plan)* benefits may be subject to a higher patient out-of-pocket expense such as higher deducible, co-pay or co-insurance and are the responsibility of the patient. Patients are responsible to contact their insurance company for contracted providers and benefit information. Not all of Southeast Dermatology providers and/or facilities will participate with the same plans.
- If you participate with an insurance plan that requires pre-certification *(referral or authorization)* Southeast Dermatology requires this information be received from your referring physician prior to services being rendered. For new patients, this may mean you will need to bring a paper referral with you. Southeast Dermatology will make every effort to help the patient through the referral, authorization process. Non-urgent or non-emergent care may be postponed until the proper pre-certification has been received.
- Patients are ultimately responsible for the timely resolution of all outstanding balances. Please contact us if you need assistance. Southeast Dermatology does not accept responsibility for what your insurance pays or does not pay.

Signing below acknowledges that you have read and understand this information.

_____ _____

Patient or Legal Guardian Date

Southeast Dermatology
Acknowledgment of Receipt of Privacy Notice

I acknowledge that I have been offered a copy of the office's Notice of Privacy Practices.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)

I, _____ hereby authorize Southeast Dermatology and its Representatives to contact me via;

Please number in order of preference: 1,2,3, etc... and check if we May or May Not leave a message

____ Home Phone _____ A message _____ May _____ May Not be left

____ Cell Phone _____ A message _____ May _____ May Not be left

____ Work Phone _____ A message _____ May _____ May Not be left

I, _____ hereby authorize Southeast Dermatology and its Representatives to discuss my protected health information without limitations to the person(s) listed below. I further understand that I must provide written request to remove people from the list.

_____

Name Relationship Number

_____

Name Relationship Number

_____

Name Relationship Number

I, _____ hereby authorize Southeast Dermatology and its representatives to Monitor my prescription usage as required by Georgia Law. ___ Yes ___ No

I acknowledge that I have offered a copy of the office's Notice of Health Information Exchange

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)

Southeast Dermatology

Messaging System Patient Configuration

Today's Date _____

Patient Name _____ Date of Birth _____

As a patient of Southeast Dermatology, your preference matters. Please advise us as to how you would prefer to be contacted for routine matters.

Which contact number is preferred?
Home _____ Cell ____ Work ____

Do you prefer (CHECK ALL THAT APPLY)
Voice messages ____ Text messages ____ email ____

Home # _____
Cell # _____
Work # _____
Email _____

Preferred language? English ____ Spanish ____

Time of day to be contacted for appointment reminders?
Morning 8AM to noon ____
Afternoon noon to 5PM ____
Evening 5PM to 8PM ____

As a patient you also have the option to opt out of this service and receive phone calls from a member of our staff.
If you wish to opt out please initial here _____

Southeast Dermatology

Name Last: _____ First: _____ DOB: ___/___/_____ SSN: ___-___-____

As it appears on your insurance card

Mailing Address: _____ _____ City: _____ State: _____ Zip: _____

If you reside in more than one state please indicate approximate date range in Georgia: _____ *to* _____

Email Address: _____@_____ **(for access to patient portal)**

Out of State Address: _____ City: _____ State: _____ Zip: _____

Male ☐ Female ☐ Transgender ☐ **Marital Status:** Single ☐ Married ☐ Widowed ☐ Divorced ☐ Partner ☐

Employment Status: Unemployed ☐ Part Time ☐ Full Time ☐ Self Employed ☐ Full Time Student ☐ Retired ☐

Employer Name: _____

Address: _____ _____ City: _____ State: _____ Zip: _____

Work Phone (_____) _____-_____ Ext _____

Contact Information: Cell Phone: (_____) _____-_____ Home Phone: (_____) _____-_____

Ethnicity: Hispanic/Latino ☐ Not Hispanic nor Latino ☐ Unreported/Refused to Report ☐

Race: American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American ☐
White ☐ Hispanic/Latino ☐ Other Race ☐ Unreported/Refused to Report ☐

Emergency Contacts:

Name: _____ Relationship: _____ Phone (_____) _____-_____

Name: _____ Relationship: _____ Phone (_____) _____-_____

Pharmacy Information:

Name: _____ Phone (_____) _____-_____ Local ☐ Mail Order ☐

City: _____

Name: _____ Phone (_____) _____-_____ Local ☐ Mail Order ☐

City: _____

Insurance Information:

Primary Insurance Name: _____ Group Number _____

Employer: _____ Policy/ID Number: _____

Phone Number: (____) _____-_____ Insured's Name: _____

Relationship: _____ Insured's DOB: _____

Claims Address: _____ _____ City: _____ State: _____ Zip: _____

Secondary Insurance Name: _____ Group Number _____

Employer: _____ Policy/ID Number: _____

Phone Number: (____) _____-_____ Insured's Name: _____

Relationship: _____ Insured's DOB: _____

Claims Address: _____ _____ City: _____ State: _____ Zip: _____

CONDITIONS FOR FILING HEALTH CLAIMS

Insurance claims are filed for you as a courtesy. Southeast Dermatology will file with your primary and secondary insurance carriers. Any insurance check paid to you for services rendered by Southeast Dermatology must be endorsed and forwarded to us. Medicare patients: please note We DO accept assignment.

THE AUTHORIZATION BELOW MUST BE SIGNED BEFORE WE CAN FILE ANY CLAIMS

I authorize the release of medical information necessary for filing health claims for me by Southeast Dermatology. I also authorize the insurance companies to make payment directly to this company. I understand that any overpayment will be refunded to the appropriate party I understand that I am financially responsible for services not covered by my insurance company after contractual adjustments. **I understand that payment is due at the time of service. Any deductible or coinsurance amounts will be collected at the time of service. If you have questions about these amount please ask prior to services being rendered.**

Signature: _____ Date: _____