NORTHWEST GEORGIA DERMATOLOGY

Diseases & Surgery of the Skin, Hair & Nails

____ New Patient   Date: ______________

____ Existing Patient   Account #: ______________

PATIENT INFORMATION ***(This form should be completed by the parent or guardian of the minor patient.)***

Last Name: ______________________________ **First Name:** ______________________________ **Middle Initial:** ______

Name of the parent/guardian(s) the minor patient resides with:______________________________ **Relationship to patient:**_____________

Birth Date: ____/____/____ **Sex: Male or Female** **Social Security Number:** __________________________

Mailing Address: ____ **City/State/Zip:** _________________________________

Home Phone: _______________________ **Work Phone:** _______________________ **Cell Phone:** ______________________

Email Address: ____

Employer: ____ **Referring Doctor:** _____________________________________

Primary Language: ☐ **English** ☐ **Other** **(please specify)** ____________________________ ☐ **Declined to Provide**

Race: ☐ **White** ☐ **American Indian/Alaska Native** ☐ **Asian** ☐ **African American/Black** ☐ **Hispanic/Latino**
☐ **Native Hawaiian/Pacific Island** ☐ **Other** **(please specify)** ____________________ ☐ **Declined to Provide**

PLEASE INDICATE YOUR PREFERRED PHARMACY: Name: ___________________ **Location:**_________________

EMERGENCY CONTACT INFORMATION

Name: ____ **Phone:** ____

RESPONSIBLE PARTY INFORMATION

Relationship to Patient: ________________________

This section should be completed with the person(s) information responsible for receiving statements and paying account balances.

Last Name: ____________________________ **First Name:** ______________________________ **Middle Initial:** ______

Birth Date: ____/____/____ **Sex: Male or Female** **Social Security Number:** __________________________

Mailing Address: ____ **City/State/Zip:** _________________________________

Employer: ____ **Work Phone:** ___________________________________

Home Phone: ____________________ **Cell Phone:** ____________________ **Email:** __________________________________
(if different than above)

INSURANCE AND MEDICAL RECORD AUTHORIZATION

I, the undersigned, hereby authorize Northwest Georgia Dermatology to furnish information to my insurance carriers concerning my illness and treatment, and I hereby assign to the physician all payments for medical services rendered. I authorize the release of my medical records to the referring physician and to my insurance company should it be requested.

PHONE MESSAGE / CALL AUTHORIZATION

I, the undersigned, hereby authorize Northwest Georgia Dermatology to leave/send messages by the following method(s) regarding my care or for appointment reminders:

Northwest Georgia Dermatology's preferred method for our automated appointment reminder system is by **TEXT MESSAGE** or **EMAIL**; however, calls to your home phone or cell phone may be done.

☐**Home Phone** ☐**Cell Phone** ☐**Text Message** ☐**Email:** ____

*******PLEASE SEE REVERSE SIDE – SIGNATURE REQUIRED TWICE*******

CONSENT FOR TREATMENT / INSURANCE RELEASE

I, the undersigned, hereby authorize Jason L. Smith, MD, Keith R. Harris, MD, MPH, Christin T. Smith, PA-C, or Dora McIver Broom, PA-C, to examine and treat me, including any biopsy or procedure(s), as deemed necessary to provide dermatologic care and aid in the diagnosis of my skin disorder. I understand that any procedure involves risks including, but not limited to, bleeding, infection and scarring. I am aware that scarring can result from any procedure and the type of severity of such scarring cannot always be predicted before the procedure.

I, the undersigned, hereby authorize Northwest Georgia Dermatology to take photographs of me for my medical records and for educational purposes. I understand the photographs may include appropriate portions of the body to demonstrate procedures and that every effort will be made to protect my identity in those materials.

➡ **____ I do ____ I do not give authorization for photographs to be taken of me. _____ *(Initials)*** ⬅

I, the undersigned, authorize that the payment of insurance benefits be made on my behalf to Northwest Georgia Dermatology for any services rendered to me. I further understand that prior to disbursing payment for services, my insurance company may require documentation from my medical records in order to process claims and approve payments.

I, the undersigned, understand that my insurance may not cover procedures and/or medications. I further understand that I am personally and fully responsible for any non-covered services, services deemed medically unnecessary, denied services, health insurance deductibles and co-insurance payments. I agree to assume full responsibility for the balance not covered.

We will not bill your insurance for services deemed medically unnecessary and payment is due at time of service.

I, the undersigned, understand that if my insurance company requires referrals from my primary care physician, it is my responsibility to verify a referral is current and on file at Northwest Georgia Dermatology prior to receiving treatment. I further understand that I am personally and fully responsible for the full amount of any claims denied due to not obtaining a referral from my primary care physician.

I, the undersigned, understand that it is my responsibility to provide correct insurance information at the time of each visit. I further understand that I am personally and fully responsible for the full amount of any claims denied due to incorrect insurance information provided to Northwest Georgia Dermatology.

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

I, the undersigned, understand that in order to collect past due monies on your account, Northwest Georgia Dermatology may contract with an outside collection agency. This agency may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. The collection agency may also contact you by sending text message or emails, using any email address you provide to Northwest Georgia Dermatology. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

X ______________________________ ______________________

Patient Signature ***(may be signed by parent/guardian of minor patient)*** **Date**

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Northwest Georgia Dermatology has made available to you, a Notice of Privacy Practices. You have the right to request a copy of the Notice of Privacy Practices prior to signing this consent. A current copy of the Notice is posted in our office in a visible location at all times. The terms of the Notice may be revised or amended and you have the right to request a current copy of the Notice at any time.

The Notice provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a section explaining the patient's rights regarding your PHI. You have the right to request that we restrict or limit how PHI is used or disclosed for treatment, payment, or health care operations.

By signing this consent, you acknowledge that you have either received or waived your right to receive a current copy of the Notice. At any time, you have the right to revoke this consent by submitting your request in writing and signed by you, to Northwest Georgia Dermatology.

In an effort to provide you with quality care, please provide the name(s) of all individuals you authorize Jason L. Smith, MD, physicians, physician's assistants, nurse practitioners, and staff of Northwest Georgia Dermatology to discuss or provide information in regards to your care (i.e. family, friends, etc.):

______________________ ______________________

______________________ ______________________

Names of Authorized Individuals

X ______________________________ ______________________

Patient Signature ***(may be signed by parent/guardian of minor patient)*** **Date**