# Atlanta West Dermatology, P.C. - Patient Profile

**Please Fill Out Completely:**

## Patient Patient ID:

| Patient's Last Name | First Name | MI |
|---|---|---|
| | | |

| Social Security Number | Date of Birth | Age | Cell Phone | Home Phone |
|---|---|---|---|---|
| | | | | |

| Address (Street, Route, Apt. No., etc.) | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Marital Status | Sex | Business Phone | Employed By |
|---|---|---|---|
| | | | |

| Referring Physician | Primary Care Physician | Employer's Address | City | State | Zip Code |
|---|---|---|---|---|---|
| | | | | | |

## Guarantor (If patient is a minor, this must be the accompaning parent.)

| Name | Address | City | State | Zip Code |
|---|---|---|---|---|
| | | | | |

| Home Phone | Social Security Number | Sex | Date of Birth | Relationship to Patient |
|---|---|---|---|---|
| | | | | |

| Employed by | Business Phone |
|---|---|
| | |

| Employer's Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

**Emergency Contact** (Friend or relative not at Patient's address who can get a message to you.) Daytime Phone

How did you hear about us?

Patient Top Doc magazine Yellow pages Wellstar

## Insurance Information

**Email address:** _____

**Primary Insurance**

Primary Ins Co: _____

Policy Holder Name: _____

Relation to Patient: _____

Policyholder DOB: _____

Policyholder SS# _____

Address: _____

City, State: _____

Home Phone: _____

**Secondary Insurance**

Secondary Ins Co: _____

Policy Holder: _____

Relation to Patient _____

Date of Birth _____

Social Security # _____

Address: _____

City, State: _____

Home Phone: _____

## DO WE HAVE PERMISSION TO:

Leave a message on your home answering machine? ☐ Yes ☐ No

Leave a message on your voice mail at work? ☐ Yes ☐ No

Discuss your medical condition with a friend or family member(s)' ☐ Yes ☐ No

If yes, whom: _____ Please list password for them to verify: _____

You must list the name(s) of ALL individuals that we may speak with(ex. caregiver, spouse, etc.) If they are not listed, we will not be able to speak with them.

Please give at least 24 hours of notice, if you cannot keep a scheduled appointment so another person can be served. Failure to give 24 hours notice of cancellation will result in a $50.00 charge.

Signature _____ Date _____

Patient/Responsible Party

Atlanta West Dermatology and Surgery Center, PC
1550 Mulkey Road
Austell, Georgia 30106
770-732-1137
770-732-2081

# Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

**PATIENT NAME** _____ **DATE** _____

**I understand** that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

**I understand** that Atlanta West Dermatology and Surgery Center, PC may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Atlanta West Dermatology and Surgery Center, PC has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

**I understand** that I have the right to read the *'Notice'* before signing this agreement. If I ask, Atlanta West Dermatology and Surgery Center, PC will provide me with the most current *Notice of Privacy Practices.*

**My signature** below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices.* My signature means that I agree to allow Atlanta West Dermatology and Surgery Center, PC to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Atlanta West Dermatology and Surgery Center, PC has taken action relying on this consent.

**SIGNATURE** (Patient or Legal Custodian/Authorized Representative) _____ **DATE** _____

**Relationship to Patient** if signed by another party _____ **DATE** _____

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: Atlanta West Dermatology and Surgery Center, PC.

**FORM Us**



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HIPAA Compliance Program

**Atlanta West Dermatology & Surgery Center, P.C.**
1550 Mulkey Road
Austell, Georgia 30106
770-732-1137

Financial Policy:

To provide care to as many patients as possible without excessive financial burdens to you, Atlanta West Dermatology & Surgery Center, P.C. makes an effort to accept a large number of health insurance policies. To further assist you, we usually file insurance claims on your behalf. For a variety of reasons, many insurance carriers have placed restrictions on covered benefits and covered medications. When medically essential, we will attempt to overcome these restrictions, but the ultimate decision rests with your insurance carrier.

These are a variety of conditions which are routinely NOT covered by health insurance. These include all treatment for cosmetic problems, including removal of benign lesions, such as skin tags, seborrheic keratoses and normal moles, revisions of scars, and evaluation and treatment of many types of hair loss. If you undergo a treatment for a procedure which is deemed medically unnecessary, you will be responsible for payment.

In some instances, your insurance carrier may determine that a procedure is considered to be a surgical procedure. If this occurs, the surgical procedure could be applied to your deductible and therefore you would be responsible for payment.

Our staff will make every effort to pre-certify medically essential medications. Please understand that even with letters of medical necessity from your doctor, certain plans do not cover specific medications or require failures of other treatment options. If your health insurance carrier denies coverage, you are still able to obtain these medications, but you will have to pay out-of-pocket. In addition, although most vitamin-A derived creams, such as Retin-A, Renova and Avage, are covered during adolescence and acne-prone years, because these creams are also used for anti-aging, they are often NOT covered in adult patients. We do not pre-certify coverage of these creams.

We appreciate the opportunity to care for you and will work with you and your insurance carrier to obtain the best possible treatment for you and your family. If you have any questions regarding billing or covered procedures, our office staff will be happy to assist you.

We have checked your benefits and you have a $_____ copay and $_____ remaining on your deductible. All payments are due on the date of service. If payment is not made on the date of service a $50 service fee will be added to your account. In addition to the $50 service fee we will not honor any prescriptions until your account has been satisfied.

I have read and understand the policies as stated above.

_____ _____
Signature Date

After patient has received notice of balance due for 60 days, the following protocol will be followed:
In the event that Obligor is 30 days in arrears, then the unpaid balance will accrue interest from the date of service at the rate of 1.5% monthly 18% annually. In the event of default and referral to an attorney or collections agency, the undersigned Obligor shall be liable for all collection fees incurred up to and including the maximum amount allowed under O.C.G.A. 13-1-11 (or such successor to said statute).

_____ _____
Signature Date

SAMPLE