Patient Name:_____

Appt :_____

Time: _____

Chatham Dermatology

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Savannah, GA 31405
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PLEASE READ *NOW* TO PREPARE FOR YOUR VISIT!

*** SKIN CANCER SCREENINGS WILL NOT BE PERFORMED ON YOUR FIRST VISIT***

Dear Patient,

Welcome to Chatham Dermatology. We look forward to serving you in our practice. We need you to do your part as a new patient to ensure that your visit will go well.

The following items need to be completed for you to be accepted as a new patient in our practice:

1. **CONFIRM** – Contact our office at least 7 business days prior to your scheduled appointment to confirm your appointment. If we do not receive confirmation from you within this time period, your appointment will be cancelled and will not be rescheduled. Furthermore, if you confirm your appointment and then cancel the appointment without 2 working days notice, you will not be rescheduled. Our office has adopted this policy in consideration of other patients in need of this appointment time. This is similar to booking airline flights; you must call back and confirm.

2. **BRING YOUR *FULLY* COMPLETED FORMS** - Enclosed are important information forms that need to be completed *PRIOR* to your visit at our office. Please bring the *COMPLETED* forms with you on the day of your visit. Please do not leave blanks. Fill in the information thoroughly.

3. **BRING YOUR INSURANCE CARD** – Bring current insurance card(s) and any other important insurance information. It is best to know which laboratory your insurance company requires you use in case specimens must be sent for analysis.

4. **ARRIVE ON TIME** – It is best to arrive at the scheduled time (no need to come earlier). Your new patient information must be entered into the computer, your chart must be prepared, your insurance company must be contacted to authorize your visit, your history and information must be reviewed, and the nurses must prepare you for your visit. As you can see, it does take longer to prepare a new patient for a visit. (If you have not been seen in this office in over 3 years, you are considered a "new patient" according to your insurance company. All of the new patient policies will apply to you as well.)

5. **BRING OLD RECORDS ONLY IF NEEDED** – If you have a history of skin cancer, bringing a copy of the pathology reports for your records is often helpful.

6. **BRING A LIST OF YOUR CURRENT MEDICATIONS** and products/medications you are using for your skin problem (if any).

7. **DO NOT WEAR MAKE-UP** – If you are coming for any type of facial evaluation, please come with no make-up so you can be evaluated properly.

We look forward to seeing you soon.

Chatham Dermatology

DATE:_____ *Chatham Dermatology* Patient No:_____

PLEASE PRINT ☐PATIENT INFORMATION FORM☐ **DO NOT LEAVE BLANKS**

Last Name_____First_____MI_____Nickname_____SSN:_____
Street Address: (**No.** P.O. Box)_____ _____Mailing Address:_____
Apartment or Lot number_____-City_____State_____Zip_____
Home Phone (____)_____ Work Phone (____)_____
Mobile Phone (____)_____ Email Address _____
Date of Birth _____-_____-_____ Age _____ Sex: M F Marital Status: S M D W
Occupation _____Employer (or school)_____Address_____
□ Retired—Previous Occupation:_____
Do we see any of your family members? Please list:_____

Whom May We Thank for Referring You to Us? _____**Phone**:_____
If a doctor referred you, *would you like us to send a letter about* your visit? □ Yes □ No

Complete info about spouse if married. **OR** Complete info about BOTH parents if under 18.

Wife (or Mother's information if under 18)
Social Security No:_____
Last Name_____First_____MI___
Address_____
City, State, Zip _____
Home Phone_____Cell_____Work_____
Date of Birth: ____-____-_____ Marital Status: S M D W
Occupation_____Employer _____

Husband (or Father's information if under 18)
Social Security No: _____
Last Name_____First_____MI____
Address_____
City, State, Zip_____
Home Phone_____Cell_____Work_____
Date of Birth: ____-___-___ Marital Status S M D W
Occupation_____Employer _____

EMERGENCY CONTACTS
1. Nearest relative/friend not living with you_____Phone_____
2. Nearest relative/friend not living with you_____Phone_____

PLEASE PRESENT INSURANCE CARD (S) AND PICTURE ID TO RECEPTIONIST.

PRIMARY INSURANCE CARRIER/COVERAGE
Name_____
Insured's Name _____

SECONDARY INSURANCE CARRIER/COVERAGE
Name_____
Insured's Name_____

□ I have no medical insurance

WHICH PHARMACY DO YOU USE?
Name_____Location_____Phone_____

Who is /are your medical doctor (s) ?_____ **Are you under Hospice care?** □ Yes □ No
Females: Who provides your gynecologic care?_____

- What laboratory does your insurance company specify that you use?_____ □ Don't know
- Do you have a "prescription card" allowing discounts on medicines? □ Yes □ No □Don't know
- Do you use a mail order pharmacy supplying 3 month supplies of medicines? □ Yes □ No □Don't know
- With your prescriptions, which would you prefer? □ Brand □ Generic
- Can we leave a message on your home answering machine? □ Yes □ No
- Can we leave a message at your place of employment? □ Yes □ No
- Can we discuss your medical condition with any family/friends? □ Yes □ No

If yes ,whom:_____Relationship:_____

□ Check to schedule a skin cancer screening (i.e. if a history of excess sun, many moles, or skin cancer/ melanoma.) Be sure to schedule this exam with the front staff. Come with no make-up for this exam. You will be asked to remove all clothing for this exam, and a gown will be provided.

□ Check here if you may be interested in the cosmetic services/products we offer.

MEDICAL INFORMATION (Do NOT leave blanks)

The following information is very important to your health. Please take the time to fill out this form fully and accurately.

Reason (s) for visit:_____

Symptoms (itching, burning, etc.):_____ How Long?_____

What are you using for the problem?_____

List **skin** diseases you've had._____

List current medicines. _____ List medication allergies._____

MEDICAL HISTORY

	Patient	Family Member (who?)	None
Excessive sun	□	□_____	□
Acne	□	□_____	□
Skin Cancer	□	□_____	□
Malignant Melanoma	□	□_____	□
Eczema	□	□_____	□
Psoriasis	□	□_____	□
Seborrhea (dandruff)	□	□_____	□
Large Scars or keloids	□	□_____	□
Asthma	□	□_____	□
Sinus Problems	□	□_____	□
Allergies	□	□_____	□
Bleeding Problems	□	□_____	□
Heart valve Disease	□	□_____	□
Heart attack	□	□_____	□
High blood pressure	□	□_____	□
Rheumatic Fever	□	□_____	□
Arthritis	□	□_____	□
Artificial joints	□	□_____	□
Connective Tissue Disease	□	□_____	□
Diabetes	□	□_____	□
Kidney Disease	□	□_____	□
Thyroid Disease	□	□_____	□
Stroke	□	□_____	□
Seizures	□	□_____	□
AIDS/HIV	□	□_____	□
Hepatitis	□	□_____	□
Liver Disease	□	□_____	□
Ulcers	□	□_____	□
Lung Disease	□	□_____	□
Cold sores/Fever blisters	□	□_____	□
Prostate Enlargement	□	□_____	□

List Other Disease/Cancers:_____

List Prior Surgeries:_____

SURGICAL & SKIN HISTORY

Ethnic/Racial Heritage:_____

List any artificial materials in your body(i.e. pacemaker, joints, etc.).

Trouble with local anesthetics (i.e. Novacaine? □ Yes □No

Trouble with antibiotic ointment, tape, bandages? □ Yes □No

Need to take antibiotic before dental work/surgery? □ Yes □No

Radiation treatment in the past? □ Yes □ No

List prior cosmetic procedures (peels, laser, etc.)._____

List problems with prior cosmetic procedures._____

Is your skin? □Dry □Oily □Normal □Combination □Sensitive (check **ALL** that apply)

Pigmentation problems (i.e. after a burn, surgery, pregnancy)?

□ No □ Yes Explain:_____

SOCIAL HISTORY

Smoker	□ No	□ Yes
Alcohol Usage	□ No	□ Yes
Tanning Bed Usage	□ No	□ Yes
Regular exercise	□ No	□ Yes
Children	□ No	□ Yes (names & ages)
Pets	□ No	□ Yes

Average hours of sleep each night:_____

Weight:_____ Height:_____

Sexually Active □ No □ Yes

Specify any Birth Control used._____

1st day of last menstrual period:_____

Pregnant/Breast Feeding □ No □ Yes

List outdoor activities (i.e. gardening, fishing, sports, etc.)._____

In the sun, do you use? □hats □ long sleeve shirts □ sunscreen □ sunglasses

Which best describes your pattern of tanning?

□ Burn easily; get red and never really tan

□ Burn easily; light tan with some difficulty

□ May burn initially but able to tan

□ Rarely burn; tan easily Natural Hair Color_____

□ Never burn; tan deeply Eye Color_____

Products used:	**Brand/ Type**
Body soaps	
Body lotions	
Facial soaps / cleansers	
Sunscreen / sunblock	How often?
Scrubs / masks / peels	
Shaving creams/cologne	
Perfumes	
Toothpaste / mouthwash	
Past acne treatments (i.e. Accutane, Clearasil, antibiotics)	

	Brand/Type
Other (i.e. prescription products)	
ALL makeup used	
List products that have irritated your skin (caused a reaction).	

The above information is true and correct. Signature:_____ Date:_____

Payment Policy

How much will I have to pay today?

It is important that you understand *your* insurance policy. Everyone's insurance policy is different. Some insurance covers all services (office visits and procedures). Some insurance pays a percentage of the charges for office visits and procedures. *Most* have co-pay charges for office visits AND a "deductible" for procedures (surgery and certain tests). The ***"deductible"*** is the part that confuses many patients. Patients often assume that everything done in a doctor's office is covered by the co-pay. This is *not* true for most patients. When a patient has a "deductible," it means that the cost of office procedures (such as surgery and certain tests) is the ***patient's responsibility*** until the deductible is met.

In dermatology, there are numerous surgical procedures done in the office such as biopsies, growth removal, cryosurgery ("freezing"), destruction of warts, Botox for sweating, acne surgery, cancer surgery... For many patients, such procedures "go toward the deductible." This means that the patient is responsible for payment for the procedure (at the reduced amount allowed by the insurance company).

Medical facilities have real expenses that keep *increasing* with inflation. However, reimbursement for services keeps *decreasing*. Insurance companies often pay very slowly & incompletely only after stalling & harassing medical billing staff. Unfortunately, patients often put medical bills last failing to pay them promptly or pay them at all. This forces medical facilities to become stricter with collection of payment.

TODAY, you will be required to pay your co-pay and/or any unmet deductible for any procedures that you have done in this office. When you have a haircut, payment is due after the cut. When you buy groceries or other products, payment is due at check-out. Medical services are now the same. Your portion of payment is due at the time of service i.e. after your visit. Unfortunately, the office must still wait for your insurance company to pay its reduced portion (which often takes many months).

Check which of the following options you choose for today.

O 1. Payment in full *today* (co-pay and/or any unmet deductible) via cash or check

O 2. Payment in full *today* (co-pay and/or any unmet deductible) via credit card.

Signature _____ Date _____

OFFICE POLICY

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE DO NOT ROUTINELY "BILL."
We accept CASH, CHATHAM COUNTY CHECKS, and CREDIT CARDS (Visa, MC, Discover and AMEX).
I (the patient or guardian) assume financial responsibility for services rendered and agree to pay the reasonable costs and expenses incurred to collect amounts owed, including 15% as attorney fees and court costs. I understand that unpaid charges shall bear interest at a rate of 1.5% per month from date of service and that a service charge of $25.00 shall be applied each time my check is dishonored. If at any time I am concerned about the cost or coding of any services, I can discuss my concerns with the financial manager.

HEALTH INSURANCE

Insurance coverage is a contract between an insurance company and a patient. Responsibility for payment of fees is the obligation of each patient. If we are participating providers for your insurance company, we will file your claim. However, any unmet deductible or copay is due *at the time of service*. **Be aware that "COPAYS" usually cover office visits. Surgical Procedures usually fall under deductible.** If we do not "participate" with your insurance company, you will be given a statement of office services which should be sent (along with your insurance form) to your insurance company so you may be reimbursed directly.

MEDICARE

We accept assignment of benefits from Medicare. Claims will be filed in accordance with Medicare regulations, and payment will be accepted directly from Medicare. Medicare patients are responsible for any unmet deductibles as well as 20% of Medicare's allowable charge (unless your secondary insurance is a Medicare approved Medigap). Be aware that Medicare may consider some services provided as "non-covered / not reasonable or necessary" (i.e. cosmetic services). If such services are denied on these grounds, you are responsible for payment in full.

MISSED APPOINTMENTS

Please notify us at least **2 *working* days (i.e. M,T,W,Th,Fr)** in advance if you are unable to keep your appointment. This courtesy allows someone else to be treated - a courtesy you would want if the circumstances were reversed. If you miss scheduled appointments without **2 *working* days advance cancellation**, you will be responsible for a $50.00-$100.00 charge (for the missed visit). Higher charges will apply to no shows/cancellations without *adequate* notice for surgeries, skin cancer screening appointments, and *multiple* missed visits. You will **not** be rescheduled until the charge is paid in full. You will be discharged from the practice for repeated offenses.

PRESCRIPTION AND RECORDS/FORMS POLICIES

Hard copy prescriptions are safer, more accurate, and more likely to be filled properly. Prescriptions "called into" pharmacies are more prone to errors. We thus give hard copy prescriptions for your safety. Please do not ask us to "call in" prescriptions (local or mail order). If you "lose" your prescriptions, you will need to come back to the office to pick up replacements. If it has been over a year since your last visit, prescriptions cannot be refilled until your follow-up visit. Prescriptions will only be refilled during office hours when your chart may be reviewed properly.
Records/Forms can be copied and/or "filled out" for a small fee depending on the type of form and size of your chart. Our office will gladly give you **one** free copy of your chart. A fee will be charged for repeated requests.

AUTHORIZATION FOR SERVICES AND RELEASE OF INFORMATION

The signature on this form serves as authorization for treatment by Chatham Dermatology. I authorize the release of any medical or other information about me/patient (including psychiatric, drug and alcohol abuse, or HIV information) to my insurance company or the Social Security Administration and Health Care Financing Administration (or its intermediaries) in order to process this or future claims or for utilization review or quality assurance. I also authorize Chatham Dermatology to release or receive medical information for the purpose of patient referral. I hereby assign benefits and authorize payment under my insurance program be made to Chatham Dermatology on any bills for services furnished to me. Regulations pertaining to Medicare and Medicaid assignment of benefits apply. I understand I am financially responsible to the physician for any balance not covered by the insurance carrier. Regarding medical care to those under age 18, parents or legal guardians are financially responsible for payment.

The signature below serves as authorization for services and release of information as detailed above. The signature acknowledges understanding and compliance with all of the above stated policies. The signature signifies assumption of full financial responsibility as detailed on this sheet. The signature below also acknowledges receipt of a copy of Chatham Dermatology Notice of Privacy Practices.

****Do not sign this form until you have read it and understand it.****

Signature _____ Date _____
GUARDIAN OR ADULT SIGNATURE IS REQUIRED *IF PATIENT IS UNDER 18.*
(A copy of this signature is as valid as the original.)

Today's Date_____

Chatham Dermatology

Due to new requirements from the United States Department of Health and Human Services, we are requesting that all patients complete our Supplemental Patient Intake Form. We realize that some of the questions may be redundant. We appreciate your patience and apologize for any inconvenience.

Patient's Name (PRINT):_____

Date of Birth: _____/_____/_____ Sex: M ☐ F ☐ Patient Phone Number _____

We are in the process of implementing a Patient Portal to provide a communication option for our patients in compliance with Health and Human Service Requirements. Please provide a valid email address below:

(REQUIRED)_____@_____

Ethnicity: ☐ Non-Hispanic ☐ Hispanic

Language Preference: ☐ English ☐ Spanish Other: _____

Race: ☐ Caucasian or European American ☐ African or African American ☐ Asian or Asian American
☐ Native American or Native Alaskan ☐ Native Hawaiian or Other Pacific Islander ☐ Other

Family History of Skin Cancer? ☐ None ☐ Mother ☐ Father ☐ Sister ☐ Brother

Smoking Status:
☐ Never smoker
☐ Former smoker
☐ Current every day smoker
☐ Heavy tobacco smoker
☐ Unknown if ever smoked
☐ Smoker, current status unknown
☐ Current some day smoker
☐ Light tobacco smoker

Do you take any prescription or non-prescription medications?

☐ No ☐ Yes (If yes please list)_____

_____Dosage(s):_____

_____Dosage(s):_____

Allergies to Medications?

Reaction: _____

☐ No ☐ Yes (If yes please list)_____

Severity: ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe

Onset: ☐ Childhood ☐ Adult ☐ Unknown

Please check if you have a history of the following:

☐ Acne ☐ Herpes Zoster ☐ Psoriasis
☐ Depression ☐ Keloid Scar ☐ Rosacea
☐ Eczema ☐ Skin Cancer ☐ Sunburn
☐ Other_____

Signature:_____ Date: _____/_____/_____

(Parent or Guardian Signature if child is a minor)

Pharmacy Name_____, Pharmacy Phone Number_____