PATIENT REGISTRATION FORM

371 E Paces Ferry Rd NE, Ste 900
Atlanta, GA 30305
Tax ID 581089205

Patient Information

Last Name: ____________________________________ **First Name:** __________________________________ **Middle Initial:** ______________

Preferred Nickname: ____________________________________ Social Security Number: _________ - ________ - _________

Date of Birth: _________ / ______ /_________ **Sex:** M / F (Circle One) Marital Status: Single/Married/Divorced/Widowed/Domestic Partner

Contact Information

Preferred contact Method? Phone / Email / Patient Portal (Circle One)

Mobile Number: __________ - _________ - ____________ **Alternate Number (Home / Work):** __________ - _________ - __________

Is it OK to leave a detailed message on your voicemail? YES / NO (Circle One)

Email Address: _______________________________________@_____________________________________

Would you like to opt-in to email notifications regarding appointments, administrative updates, health bulletins, and marketing information?

YES / NO (Circle One) (You may unsubscribe at any time)

Emergency Contact Full Name: ____ **Phone Number:** __________ - __________ - __________

Relationship to Patient: ____

Address Information

Street Address: ____ **City:** _____________________**State:** _______ **Zip Code:** ___________

Insurance Information

Primary Insurance Company: _________________________ **Policy/Member/ID #:** ____

Group Number: _________________ Effective Date of Coverage: _______ /_____ /_______ Policy Holder: _______________________________

Policy Holder's Date of Birth: _______ /_____ /_______ Claims Mailing Address: ____

Provider Customer Service Phone Number: __________ - ________ - __________

Secondary Insurance Company: ______________________________ **Policy/Member/ID #:** ____

Guarantor (person responsible for bill, if different from patient)

Guarantor Name: ____ Relationship to Patient: _____________________________

Social Security Number: _______ - _______ - ______ Date of Birth: _______ /_____ /_______ Phone Number: ________ - ________ - ___________

Guarantor's Address: ____ City: _____________________State: _______ Zip code: ___________

Preferred Pharmacy

Pharmacy Name: _______________________________ Address: ____

Pharmacy Phone Number: __________ - __________ - __________ Pharmacy Fax Number: __________ - __________ - __________

Primary Care Physician

Physician's Name: ________________________________ Address: ____

Physician's Phone Number: __________ - __________ - __________ Physician's Fax Number: __________ - __________ - __________

I attest that the information on this form is accurate and complete to the best of my knowledge. I authorize Peachtree Dermatology Associates, PC to release any medical information necessary to process claims through my insurance company(s). I authorize my insurance benefits to be paid directly to Peachtree Dermatology Associates, PC. I understand that I am financially responsible for any balance, whether or not covered by insurance.

Patient / Guarantor Signature: ____ **Date:** ____________________________

If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

Revised 03-2021

NOTICE OF PRIVACY PRACTICES

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, ____, hereby acknowledge that Peachtree Dermatology Associates, PC (PDA) has given me the opportunity to read a detailed notice of their Privacy Practices.

(A copy is posted for the general public at the front desk, and online at www.peachtreedermatology.com under "About Us" and "Privacy Policy", or a printed copy can be made available upon request)

Patient / Guarantor Signature*: ____ Date: __________________

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If not signed, please provide a reason why the acknowledgement was not obtained:

____

Witness (Staff) Signature: ____ Date: __________________

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

In the event I cannot be reached, I, ____, give permission for a representative from PDA to speak with the appointed person(s) listed below regarding my care or test results.

Name____Phone _____________________________________

Relationship to Patient ____

Name____Phone _____________________________________

Relationship to Patient ____

Is it OK to leave results or other health information on your voicemail? _______YES _______NO (Check One)

Patient / Guarantor Signature*: ____ Date: ________________

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PATIENT PORTAL CONSENT

While PDA takes reasonable precautions to protect your confidential health information, email is not a completely secure method of communication. Therefore, PDA strongly encourages the use of our secure patient portal to communicate electronically. PDA's Patient Portal allows patients to review and update their medical record, schedule appointments, access test results, and send private messages through encrypted transmission. We will generally use your email address to activate your patient portal access.

I give permission for PDA to enable my portal access. _______YES _______NO (Check One)

I confirm that my email address is ____@______________________________

Patient / Guarantor Signature*: ____ Date: ________________

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FINANCIAL DISCLOSURE STATEMENT

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Thank you for choosing Peachtree Dermatology Associates, PC (PDA). You can expect to receive the following bills as a result of your visit:

- Physician Fee: Fee to be paid to the physician for performing the medical service. This bill will be from PDA.
- Lab Fee: If a lab test is ordered, a second bill will come from an outside lab.
- Pathology Fee: When a pathology test is ordered, a second bill will come from an outside pathology lab.

Insurance: It is the responsibility of the patient to verify whether PDA is "in-network" with their insurance plan. You may call your insurance provider and give them our Tax ID number, #58-1089205, to verify your in-network benefits. We are credentialed through Piedmont Healthcare, and we submit claims to most insurance plans with which Piedmont Healthcare participates. You reserve the right to request that PDA not submit a claim to your insurance plan for medical services. However, you must pay for those medical services out-of-pocket, in full. You may revoke this option at any time to begin submitting claims to your insurance plan. To protect against fraud you must present your insurance card at each visit, and we must have a government-issued photo ID on file. PDA will submit primary, secondary and tertiary claims to our contracted payers on your behalf, as long as the information is obtained and verified before your visit. If this information is obtained after your visit, the patient or guarantor is responsible for the balance.

Co-Payments: PDA collects co-payments at the time of service. Additional payment may be required based on your insurance plan. In the event your account has a credit, a refund will be issued in a timely manner.

Refunds: All refunds will be processed within 3-5 weeks after the overpayment is discovered on the patient's account, or at the time the refund is requested. Patients who have insurance but made partial payment or payment in full will not be refunded until their claim has been processed and paid. Refunds for prepaid events will be processed within 5-7 business days.

Telehealth: All telehealth visits require a $75 deposit to be scheduled. We will submit telehealth claims to your insurance plan, if this information has been provided. Any credit resulting from this initial deposit will be refunded as outlined above.

Initial below:

______If we are unable to verify you have active coverage on the date of your appointment you will be required to pay for the visit in full at the time of service. If your insurance information is later provided, and the plan pays for your visit after we have submitted your claim, we will issue you a refund as outlined above.

______In the event that you are unable to keep your appointment, please reschedule at least 48 hours in advance. A missed office appointment will result in a $40 fee. A missed cosmetic/aesthetic appointment will result in a $75 fee.

______A $45 fee will be incurred for each returned check.

Additional questions regarding billing or payment arrangements should be directed to our billing department as follows:
Call the office at **404-355-1919**, select option 5 for the Billing Department.

______In the event we need to contact you regarding a billing matter, we may call you on your cell phone, if you have listed this number as your primary or alternate contact number.

Patient's Reassignment and Release Statement

By signing below I indicate my understanding of PDA's billing practices and that I may receive multiple bills related to my office visit as explained above. I authorize payment of my medical benefits to PDA and authorize them to release any medical information necessary to process claims. I understand that I am financially responsible for any co-payment, co-insurance, deductible and non-covered services amounts as outlined by my health plan. This agreement applies to all visits that take place one year from the date this form is signed, and any bills resulting from those visits.

Patient / Guarantor Signature*: ____ Date: _______________

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Revised 03-2021

PATIENT MEDICAL HISTORY FORM

Patient Name____**Date** ________________

Reason for today's visit____

Who is your primary care/referring physician? ______________________________________

If this is your first visit, how did you hear about us? ________________________________

Please check those medical conditions that apply to you:

- — Arthritis
- — Asthma / Hayfever
- — Blood Clotting Disorder
- — Breathing Difficulties
- — Cancer
- — Chronic Obstructive Pulmonary Disease
- — Coronary Artery Disease
- — Diabetes
- — Endocrine or Hormone Problems
- — Gastrointestinal Problems
- — Heart Disease
- — Heart Failure
- — Heart Murmur
- — Heart valve, artificial
- — Hepatitis
- — Herpes Infections
- — HIV Positive
- — Hypertension
- — Jaundice
- — Kidney Disease
- — Liver disease
- — Pacemaker
- — Poor Healing
- — Seasonal Allergies
- — Seizure Disorders
- — Sexually Trans. Diseases
- — Shingles
- — Skin Cancer
- — Stroke
- — Tuberculosis
- — Ulcers
- — Other (please list below)

Please explain any conditions checked above ____

Please list **ALL MEDICATIONS** you are currently taking (including aspirin, birth control pills, & vitamins). Continue on back of sheet, if needed.

Drug name	Dosage (strength)	Frequency taken (ex: daily, as needed)

ALLERGIES (list all known allergies)____

DRUG ALLERGIES (list all known medication allergies) ____

Do you have a family history of skin cancer? ____________ **YES** **NO**

If so, what type? ____

Do you have changing/suspicious moles?____________ **YES** **NO**

Unusual colors or bleeding? ____________________________________

Are you taking a blood thinner?__________________ **YES** **NO**

If so, which one? ____

Do you have a heart problem or artificial joint that requires you to take antibiotics before surgical or dental procedures? ________ **YES** **NO**

Have you been hospitalized in the last 30 days?__________ **YES** **NO**

If so, when? ____

Tobacco Use

Do you use tobacco (in any form)?__________________ **YES** **NO**

How frequently? ____

Alcohol Use

Do you drink alcohol?__________________________ **YES** **NO**

How frequently? ____

COVID-19

Have you been infected with COVID-19? __________ **YES** **NO**

Have you received the COVID-19 vaccine? __________ **YES** **NO**

If yes, which of the vaccines did you receive and when?

____

Flu Season only (Oct-March)

Have you received the flu vaccine this season? _______ **YES** **NO**

Women only

Are you pregnant or nursing? ____________________ **YES** **NO**

If not, are you trying to conceive? _________________ **YES** **NO**

1st day of last menstrual cycle? ____________________________

65 and older only

Have you ever had the Pneumonia vaccine?________ **YES** **NO**

If you cannot make your own medical decisions, do you have an Advance Care Directive or a living will? ____________ **YES** **NO**

Indicate whom you have named as your surrogate decision maker/healthcare proxy? ________________________________

Thank you for your time in completing your medical history. This helps your doctor to keep current with your health. It is our goal to provide you the best care possible.

Patient / Guarantor Signature* ____**Date** ________________

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