SOUTHEASTERN DERMATOLOGY GROUP, P.A.
Dermatology Specialists of Alabama, Florida, Georgia and Mississippi
877.231.DERM (3376)

FACE SHEET / PATIENT INFORMATION

Name______________________________ Date of Birth____________ Age______ Sex______

Mailing Address______________________________ City____________________ State________ Zip________

Primary Phone______________ ______________ Secondary Phone______________________

E-mail Address______________________________ Social Security #____________ ____________

Employer____________ ______________ Employer Phone #____________ ______________

Marital Status______________________________ Occupation______________________________

Emergency Contact: Name________________ Phone______________ Relationship ______________

Primary Physician______________________________ Referring Physician______________________________

*Primary Insurance ______________________________ ID Number ______________________________

Cardholder's Name______________________________ Cardholder's SSN # ______________________

Relationship to Patient__________ Cardholder's Date of Birth__________ Cardholder's Employer______________________

*Secondary Insurance ______________________________ ID Number ______________________________

Cardholder's Name______________________________ Cardholder's SSN#______________________

Relationship to Patient__________ Cardholder's Date of Birth__________ Cardholder's Employer______________________

Do you have an advanced care plan such as a Living Will or Power of Attorney? No___ If Yes, Specify:______________________

RACE: ___ American Indian or Alaska Native ___ Asian ___ Native Hawaiian or Other Pacific Islander ___ Hispanic
___ Black or African American ___ White ___ Unreported / Refused to Report ___ Other Race__________

Ethnicity: ___ Hispanic or Latino ___ Non-Hispanic or Latino ___ Unreported / Refused to Report

Primary Language: ___ Arabic ___ Chinese ___ English ___ French ___Korean ___ Spanish ___ Other ______________

RELEASE OF MEDICAL INFORMATION

I, the undersigned, as the patient OR his/her representative, do hereby authorize Southeastern Dermatology Group, P.A., to release to my insurance company(ies) or other appropriate agency(ies) that information which is necessary to validate this claim. Southeastern Dermatology Group, P.A., is also hereby authorized to release to my physician(s), wither as an individual(s) or as a professional association, who perform services for me, the patient, on a fee for service basis such information as is necessary for billing purposes. I hereby authorize Southeastern Dermatology Group, P.A., to release any medical information to physicians other than original referring providers, who may be involved in my or my dependent's health care treatment, when requested by these physicians. By signing this consent, information will be given to requesting providers without further signed authorization. I hereby give permission to disclose, discuss and speak with personal medical information about my treatment to the below listed individuals. Unless specifically listed below, we cannot speak to any individual concerning your medical or financial information including, appointments, test results, prescriptions, school or work excuses, etc. This includes your spouse, children, parents, etc. We *must* have each individual listed by name.

☐ Release my medical information to (below):

Name:______________________ Phone:______________ Relationship:______________

Name:______________________ Phone:______________ Relationship:______________

Name:______________________ Phone:______________ Relationship:______________

OR ☐ Restrict / DO NOT RELEASE ANY INFORMATION

Please initial each section below to indicate you have read and understand the information:

_____ **ASSIGNMENT OF INSURANCE AND FINANCIAL RESPONSIBILITY**
I do, hereby, authorize payment of all insurance benefits, basic and major medical, for the services I receive, to be made directly to Southeastern Dermatology Group. I understand that I am ultimately responsible for any unpaid balance or non-covered service. I agree to pay all costs of collecting, sercuring, or attempting to collect or secure payment, including reasonable attoryney feels or collection agency fees.

_____ **STATEMENT TO PERMIT OF MEDICARE BENEFITS TO PROVIDER PHYSICIANS AND PATIENT**
I request that payment of authorized Medicare or other applicable private insurance benefits be paid directly to Southeastern Dermatology Group for services provided under their care. I also authorize Southeastern Dermatology Group to release necessary medical information to my insurance company, its agents, or any third party in order to determine payable benefits for the services rendered.

____ **CONSENT FOR MEDICAL SERVICES**
I authorize Southeastern Dermatology Group to render treatment to me/my dependents for dermatological care/medical procedures as may be deemed necessary.

____ **DIGITAL PHOTOGRAPHY**
I authorize the medical providers and staff of Southeastern Dermatology Group to take digital photographs that relate to my care. Southeastern Dermatology Group will only disclose information relevant to current treatment and is authorized to use photographs for educational or publication purposes, provided my identity is protected. I may change this authorization at any time.

_____ **REFERRALS/AUTHORIZATIONS**

I understand that if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral at the time of service, no services will be rendered until I obtain a referral or sign a waiver of financial responsibility. Payment in full will be required at the time of service.

_____ **PRIVACY POLICY NOTICE**
A copy of Southeastern Dermatology Group's Notice of Privacy Policies may be requested detailing how my information may be used and disclosed as permitted under federal and state law.

_____ **MISSED APPOINTMENTS**
Our office requires a 24 hour notice for cancellations. Failure to do so may result in a $25 fee for medical appointments and a$50 fee for cosmetic appointments.

_____**ePRESCRIBING CONSENT**
ePrescribing is a federally mandated initiative that requires all physicians to prescribe in this manner. ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, utilizing secure technology to protect the privacy of your personal information. ePrescribing software also allows our providers to see important information, such as drug interactions and your prescription history. The benefit to you: less confusion over handwritten prescriptions or unclear phone calls, reduced possibility of medical errors, fewer trips to drop off at the pharmacy, and a safer, faster, easier way to get your prescription filled.

______**ELECTRONIC MESSAGES**
If you have provided your email address, we would like to send you monthly or quarterly news and information. This would include information about new treatments and procedures, skin health information, physician announcements and special events. If you do not wish to receive this news, click the UNSUBSCRIBE function at the bottom of the email and we will remove your address from this list.

_____**CONSENT FOR LAB SERVICES**
Southeastern Dermatology Group uses a centralized laboratory in Panama City, Florida, to process biopsy specimens. It is my responsibility to esnure that these lab services are in network with my insurance company. If the lab is out of network, I will notify Southeastern Dermatology Group in advance. I am responsible for any out of network fees associated with lab processing if I have not made arrangements in advance with Southeastern Dermatology Group.

May we leave personal information on your answering machine at home? Yes No

______________________ ____ ______________________________

Date **Signature of Patient/Authorized Representative** **Signature of Spouse/Relationship**

______________________ ____

Date **Witness**