

**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 \_\_\_\_\_ Preferred Pharmacy \_\_\_\_\_

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 CONSENT**

I, the patient or his/her legal representative, do hereby authorize Southeastern Dermatology Group, P.A., to use or disclose my health related information as outlined in the **Privacy Notice** that has been provided to me. I have received, read, and understand the information detailed in the **Privacy Notice**.

**I hereby give permission to disclose, discuss and speak with the individuals listed below regarding my personal health information or treatment.** I understand that unless specifically listed below, Southeastern Dermatology Group, P.A. cannot speak to any individual concerning my medical or financial information including, but not limited to appointments, test results, prescriptions, school or work excuses. This includes my spouse, children, siblings, or parent, if I am 18 years or older. I understand that I can amend this list at any time by submitting a request in writing.

I consent to the release of my health information to the following individual(s):

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Health Information Disclosure Restriction Requests: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient/Authorized Representative

**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, securing, or attempting to collect or secure payment, including reasonable attorney fees or collection agency fees.

\_\_\_\_ **STATEMENT AUTHORIZING PAYMENT BY MEDICARE AND OTHER INSURANCES**

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 dependent 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. ~~ESK WF [ X^i [^TWUgjdWSf fZW] Vax~~

\_\_\_\_ **PRIVACY POLICY NOTICE**

A copy of Southeastern Dermatology Group's Privacy Notice has been provided to me which outlines how my private health information may be used or disclosed and my rights related to the use and disclosure of this information. I have read and understand the information outlined in the notice.

\_\_\_\_ **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.

\_\_\_\_ **FINANCIAL DISCLOSURE NOTICE TO PATIENTS**

This is a notice informing you that Southeastern Dermatology Group, PA, owns and operates Southeastern Pharmacy, PA for the convenience of our patients. You always have a choice in pharmacies and are in no way obligated to use our pharmacy.

\_\_\_\_ **ELECTRONIC MESSAGES**

If you have provided your email address, we would like to send you periodic news and information. This would include satisfaction surveys, 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 ensure 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 an answering machine, if reached using your provided phone number? Yes No**

\_\_\_\_\_  
**Date Signature of Patient/Authorized Representative**

\_\_\_\_\_  
**Print Patient Name**

\_\_\_\_\_  
**Date Witness**

\_\_\_\_\_  
**Print Authorized Individual/Relationship**