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_____

Home Phone_____ Cell Phone_____

E-mail Address_____Social Security #_____ _____

Employer _____ _____Employer Phone #_____ _____

Marital Status_____Occupation_____Preferred Pharmacy_____

Emergency Contact: Name_____ Phone_____Relationship _____

PrimaryPhysician_____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. **N_wkclr gl dsjj ugjj `c pcosgpcb _r rfc rgkc md qcptgac,**

_____ 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 diclosed and my rights related to the use and disclosure of this informatin. 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.

_____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.

_____	_____	_____
Date	**Signature of Patient/Authorized Representative**	**Print Patient Name**
_____	_____	_____
Date	**Witness**	**Print Authorized Individual/Relationship**