Dermatology Specialists of Alabama, Florida, Georgia & Mississippi
Southeastern Dermatology Group, P.A. | Dermatology Specialists of Georgia, LLC
•Aqua Medical Spa •30a Plastic Surgery •The Hair Transplant & Restoration Center •877.231.3376

FACE SHEET / PATIENT INFORMATION – Page 1 of 2

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_____Preferred Pharmacy (Name & Location) _____

Emergency Contact: Name_____Phone_____Relationship _____

Primary Physician_____Referring Physician_____

*Primary Insurance_____ID #_____ Group # _____

Cardholder's Name_____Cardholder's SSN # _____

Relationship to Patient_____Cardholder's Date of Birth_____

*Secondary Insurance_____ID #_____ Group # _____

Cardholder's Name_____Cardholder's SSN#_____

Relationship to Patient_____Cardholder's Date of Birth_____

Do you have an advanced care plan such as a Living Will or Power of Attorney? Yes___ 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, PA and/or Dermatology Specialists of Georgia, LLC, 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, PA and/or Dermatology Specialists of Georgia, LLC 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:_____

_____ X_____

Date **Signature of Patient/Authorized Representative**

FACE SHEET / PATIENT INFORMATION – Page 2 of 2

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, PA and/or Dermatology Specialists of Georgia, LLC. 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, PA and/or Dermatology Specialists of Georgia, LLC for services provided under their care. I also authorize Dermatology Specialists of Georgia, LLC 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, PA and/or Dermatology Specialists of Georgia, LLC 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, PA and/or Dermatology Specialists of Georgia, LLC to take digital photographs that relate to my care. Southeastern Dermatology Group, PA and/or Dermatology Specialists of Georgia, LLC 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, PA and/or Dermatology Specialists of Georgia, LLC'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.

_____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, PA and/or Dermatology Specialists of Georgia, LLC uses a variety of laboratories 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, PA and/or Dermatology Specialists of Georgia, LLC 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, PA and/or Dermatology Specialists of Georgia, LLC.

_____ _____

Date **Signature of Patient/Authorized Representative** **Print Patient Name**

_____ _____

Date **Witness** **Print Authorized Individual/Relationship**