Patient Agreement Information

LAST Name _____ **MI** _____ **FIRST Name** _____

Home Street Address _____

City _____ **State** _____ **Zip+4**_____-_____

Billing Address (if different from above): _____

Phone Numbers (CELL) _____**(HOME)**_____**(WORK)**_____

Guardian Name (for patients under 18):_____ **Relationship** _____

Primary Care Physician _____**Phone** _____

Referring Physician _____**Phone** _____

Patient DOB _____/_____/_____ **Gender:** ☐ **Male** ☐ **Female**

Marital Status: ☐ **Married** ☐ **Divorced** ☐ **Single** ☐ **Widowed**

Patient (or Guardian's) Social Security Number (*MANDATORY) _____-_____-_____

Employer_____ **Occupation**_____

EMERGENCY CONTACT

Name_____ **Phone #** _____ **Relationship**_____

Patient (or Guardian) Email Address _____

Race ☐ **White** ☐ **African American** ☐ **Hispanic** ☐ **Other** _____

Ethnicity (Country) _____ **Primary Language** _____

Pharmacy (Name)_____ **(Phone)**_____ **(City & Street)**_____

Do we have permission to speak with a family member regarding your medical care? ☐ **YES** ☐ **NO**

Can we leave information regarding your medical care on your voicemail/messaging system? ☐ **YES** ☐ **NO**

How did you hear about us? _____

I consent for treatment by the Physicians of Johns Creek Dermatology & Family Medicine, as well as, I agree to allow the Physician to diagnose and treat my condition based on their extensive knowledge and recommendation pertaining to my medical condition.
_____(Patient Initials)

I acknowledge that all information supplied by myself to Johns Creek Dermatology & Family Medicine is true and correct.
_____ (Patient Initials)

Signature: _____**Date:** _____

INSURANCE INFORMATION

Name of *PRIMARY* Insurance Company:
Member/Subscriber ID: **Group#:**
Primary Policy Holder Information (self, spouse, mother/father/guardian):
Name: **DOB: / /** **Relationship to the patient?**

Name of *SECONDARY* Insurance Company:
Member/Subscriber ID: **Group#:**
Primary Policy Holder Information (self, spouse, mother/father/guardian):
Name: **DOB: / /** **Relationship to the patient?**

Name of *TERTIARY* Insurance Company:
Member/Subscriber ID: **Group#:**
Primary Policy Holder Information (self, spouse, mother/father/guardian):
Name: **DOB: / /** **Relationship to the patient?**

HIIPA and Privacy Policy

- I have read (available on website) a copy of Johns Creek Dermatology and Family Medicine's HIIPA and Privacy Policies.

X_____ **Date:** _____

Patient Signature or Guardian if under 18

Johns Creek
Dermatology & Family Medicine

MUTUAL AGREEMENT

Johns Creek Dermatology and Family Medicine, PC (collectively labeled "Practice") is committed to providing the best possible medical care to our patients. Our doctors and staff work very hard to make all interactions as welcoming and efficient as possible.

There may be a time when the expectation of the patient is different than what is provided. We offer each patient an opportunity to provide feedback in writing during check out at each visit. All comments and concerns are reviewed promptly by our staff and, if necessary, escalated to the appropriate supervisor for further action. Additionally, nursing, administrative and billing managers are available to assist patients if their requests are not managed appropriately.

Johns Creek Dermatology and Family Medicine takes pride in our established reputation for outstanding medical care. We take any attempt in false degradation of our practice very seriously. The Practice reputation is our foremost priority, second only to patient care. Please note that any false, written statements published in social, print or other media will be considered libel, which is punishable through civil and punitive litigation.

I have read and agree to the Mutual Agreement.

X_____

Patient Signature or Guardian if under 18

Johns Creek
Dermatology & Family Medicine

NO SHOW/LATE CANCELLATION POLICY

Our office strives to see our patients on time and work in patients the same day if necessary. No shows for appointments are disruptive to the flow of the office, prevents other patients from accessing our medical care and are disrespectful to us.

Many physician office's charge anywhere from $50 - $75 per no show.

While we do not want to cause any undue financial burden, we will assess a $30 no show fee for missed appointments or if not provided with 24 hours' notice to cancel or reschedule.

- We require ***24 hours advance notice*** to cancel or reschedule an appointment.
- No Show fees will be collected before scheduling any future appointments.
- Multiple no shows are grounds for dismissal from practice.

I have read and agree to the No Show/Late Cancellation Policy.

X_____

Patient Signature or Guardian if under 18

FINANCIAL POLICY

Johns Creek Dermatology & Family Medicine

Insurance Filing

- We file insurance as a courtesy to our patients.
- Any balance unpaid after 30 days will be your responsibility and is due upon receipt of invoice.
- Unpaid balances after 90 days will accrue interest of 6.5%.
- Unpaid accounts will result in deferment to a collection agency. This will damage your credit and incur an additional administrative charge of $25.
- Account credits posted once insurance payment is received will be credited immediately. Insurance companies typically pay within 4-10 weeks of claim submission.

Co-Payment if your deductible has been met

- Office Visit co-pay assigned by insurance
- Surgical Visit (excisions of cysts, skin cancers, etc.): co-pay assigned by insurance
- Office procedure (biopsy, liquid nitrogen, skin tag removal, etc.): co-pay assigned by insurance

Co-Payment if your deductible has *NOT* been met

- Office Visit $75 inclusive of co-pay assigned by insurance
- Surgical Visit (excisions of cysts, skin cancers, etc.): $250
- Office procedure (biopsy, liquid nitrogen, skin tag removal, etc.): payment due in *FULL* at time of visit

Self-Pay

- Office Visit Dermatology $150 First Visit, $95 Follow Up Visits
- Office Visit Family Medicine $185 First Visit, $95 Follow Up Visits
- Surgical & Office Procedures payment due in *FULL* at time of visit

Cosmetic Visits

- $150 towards the consultation that will be applied to the services
- All cosmetic surgeries & procedures (microderm, chemical peels, veinwave, schlerotherapy, Botox/Dysport, fillers, mole removal & facials) are due in *FULL* at time of service
- Partial payments are not permitted
- We do not file with insurance

Appointment Deposits

- Cosmetic Consultation or Services $50 deposit
- Additional Family Member same appointment time $40 per appt
- Surgical Procedure $75 deposit

I have read and agree to the Financial Policy.

X_____

Patient Signature or Guardian if under 18

Johns Creek
Dermatology & Family Medicine

ADMINISTRATIVE POLICY

Medical Records

- Medical Records requested directly by a patient will be assessed a base charge of $25 plus $0.93 each for the first 20 pages and $0.82 each additional page
- Please allow *2 weeks* for preparation of medical records

Lab Fees

- Please advise our staff *PRIOR* to lab work if your insurance company has any lab restrictions
- Blood draws are performed as a courtesy

Administrative Fee

- $45 annual administrative fee that covers all documents below

- Administrative fee per document
    - Prescription Prior Authorization $10 each
    - Physical, Disability, FMLA & Life Insurance Form $50 each
    - Assisted Living Admission Form $50 each
    - Other miscellaneous form required by 3rd parties $50 each

- Prior Authorizations are *NOT* a guarantee of approval from insurance. Our specialized team does everything possible, but the final decision is at the discretion of your insurance company.

Initial *ONE* choice below

_____(Initials) I chose to pay the flat annual $45 third party document fee.
Immediate payment due

OR

_____(Initials) I chose to ***NOT*** pay the flat annual $45 third party document fee.

Family Medicine Health Questionnaire

Patient's Name:_____ Today's Date: _____ / _____ / _____

Date of Birth: _____ / _____ / _____ Date of last Physical: _____ / _____ / _____

Is the patient (circle all that apply): **Single** **Married** **Divorced** **Widowed** **Living Together**

How many adults live in your home? _____ How many children? _____ Religious Affiliation:_____

MEDICATIONS

Are you allergic to any medications? ☐ **NO** ☐ **YES** If yes, which medication and explain what happens: _____

_____

_____

Please list ***ALL*** medications you are taking now, including over the counter medications, vitamins, eye drops, oral contraceptives, home remedies and herbal supplements/remedies)

Medication Name	Dose	Medication Name	Dose

HOSPITALIZATION & SURGICAL HISTORY

Have you been hospitalized recently? ☐ **NO** ☐ **YES**

List ***ALL*** hospitalizations starting with most recent

Year	Name of Operation or Illness	Year	Name of Operation or Illness

SOCIAL HISTORY

Do you drive? ☐ **NO** ☐ **YES** If yes, do you have difficulty seeing when driving**?** ☐ **NO** ☐ **YES** If yes, then please describe: _____

Do you use tobacco products? ☐ **NO** ☐ **YES** If yes, type/amount/how long: _____

Do you use drink alcohol? ☐ **NO** ☐ **YES** If yes, type/amount/how long: _____

Do you use illegal drugs? ☐ **NO** ☐ **YES** If yes, type/amount/how long: _____

Have you ever been exposed or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following:

DISEASE/CONDITION	NO	YES	RELATIONSHIP TO PATIENT
Blindness	☐	☐	_____
Cataracts	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment/Disease	☐	☐	_____
Arthritis	☐	☐	_____
Osteoporosis	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
Heart Attack before age 50	☐	☐	_____
High Blood Pressure	☐	☐	_____
High Cholesterol	☐	☐	_____
Kidney Disease	☐	☐	_____
Lupus	☐	☐	_____
Thyroid Disease	☐	☐	_____
Alcohol or Drug Abuse	☐	☐	_____
Mental Illness	☐	☐	_____
Suicide	☐	☐	_____

PSYCHOSOCIAL HISTORY

In the ***PAST YEAR*** have you noticed any of the following?

Felt depressed, "blue", have trouble sleeping or sleeping a lot? ☐ **NO** ☐ **YES**

Had difficulty relaxing or calming down, been anxious or worried a lot? ☐ **NO** ☐ **YES**

Felt like you (or others) would be better off if you were dead? ☐ **NO** ☐ **YES**

Are there concerns about home, family, work, money or legal issues that you would like to speak with someone about? ☐ **NO** ☐ **YES**

RISK ASSESSMENT

Do you wear a seatbelt? ☐ **NO** ☐ **YES** Do you exercise? ☐ **NO** ☐ **YES** How often & type_____

Do you have smoke detectors in your home? ☐ **NO** ☐ **YES** A fire extinguisher? ☐ **NO** ☐ **YES**

Are there guns in your home? ☐ **NO** ☐ **YES** Are the kept locked away? ☐ **NO** ☐ **YES**

Do you think you are: ☐ **Underweight** ☐ **Overweight** ☐ **Just about right**

Do you diet frequently? ☐ **NO** ☐ **YES** What diets have you tried? _____

Are you on a special diet for health reasons? ☐ **NO** ☐ **YES** Do you salt your food? ☐ **NO** ☐ **YES**

REVIEW OF SYSTEMS

Do you currently or have you ever had any problems in the following areas?

	NO	YES
CONSTITUTIONAL		
Fever, Weight Loss/Gain	☐	☐
Assistance device for walking	☐	☐
INTEGUMENTARY (SKIN)	☐	☐
NEUROLOGICAL		
Difficulty with memory	☐	☐
Headaches or Migraines	☐	☐
Seizure or Epilepsy	☐	☐
Stroke	☐	☐
EYES		
Glaucoma	☐	☐
Blurred or loss of vision	☐	☐
Red, dry or itchy	☐	☐
Excessive tearing or watering	☐	☐
Corrective Lenses	☐	☐
ENDOCRINE		
Thyroid or other glands	☐	☐
Goiter	☐	☐
EARS, NOSE, THROAT & MOUTH		
Allergies / Hay Fever	☐	☐
Sinus Congestion / Runny Nose	☐	☐
Chronic Cough	☐	☐
Dry Throat or Mouth	☐	☐
RESPIRATORY		
Asthma	☐	☐
Chronis Bronchitis	☐	☐
COPD / Emphysema	☐	☐
Use Oxygen Treatment	☐	☐
Tuberculosis	☐	☐
LYMPHATIC / HEMATOLOGIC		
Anemia	☐	☐
Bleeding Problems	☐	☐
Easily Bruises	☐	☐
Received a blood transfusion	☐	☐

	NO	YES
VASCULAR/CARDIOVASCULAR		
Diabetes	☐	☐
Heart pain	☐	☐
Murmur	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Vascular Disease	☐	☐
GASTROINTESTINAL / HEPATIC (LIVER)		
Diarrhea	☐	☐
Constipation	☐	☐
Ulcers	☐	☐
Other Bowel Problems	☐	☐
Liver Disease / Cirrhosis	☐	☐
Fecal Incontinence	☐	☐
GENITOURINARY		
Genitals	☐	☐
Kidney Disease	☐	☐
Urinary Incontinence	☐	☐
Frequent Urinary Tract Infections	☐	☐
BONES / JOINTS / MUSCLES		
Have you ever fallen?	☐	☐
Rheumatoid Arthritis	☐	☐
Arthritis	☐	☐
Gout	☐	☐
Back Pain or Injury	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐
PSYCHIATRIC		
Emotional Problems	☐	☐
Depression / Anxiety	☐	☐
Alcohol or Drug Use	☐	☐

If you answered YES to any of the above or have a condition NOT listed, then please explain & list medications:

_____

_____

_____

IMMUNIZATIONS

List the year of your last:

Tetanus shot? _____ Hepatitis B shot? _____ Flu Shot? _____ Pneumonia shot? _____

Tuberculosis (TB) test? _____ What was the result? _____

Have you traveled outside of the country in the past two years? ☐ **NO** ☐ **YES**

WOMEN ONLY

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

When was your last pap smear? _____

40 or older, when was your last mammogram? _____

50 or older, when was your last colonoscopy? _____

MEN ONLY

40 or older, when was your last rectal exam? _____

50 or older, when was your last colonoscopy?_____

Johns Creek
Dermatology & Family Medicine

6300 Hospital Pkwy, Suite 100
Johns Creek, GA 30097
Phone: 770-771-6591 Fax: 770-771-6599

Release Medical Records From:

☐ Johns Creek Dermatology & Family Medicine

OR

_____
Name of Doctor/Hospital

_____
Street Address

_____
City, State, Zip Code

_____ _____
Phone Number **Fax Number**

Send Medical Records To:

☐ Johns Creek Dermatology & Family Medicine

OR

_____
Name of Doctor/Hospital

_____
Street Address

_____
City, State, Zip Code

_____ _____
Phone Number **Fax Number**

Patient Information:

_____
Print Patient's Full Name

_____
Patient's Date of Birth

_____
Street Address

_____
Patient's Phone Number

_____
City, State, Zip Code

Information to be released:

Choose all that apply

☐ Complete Medical Records ☐ Biopsy Reports ☐ Consultation Report
☐ Surgical Procedures ☐ X-Ray/Imaging Reports ☐ Hospital Records
☐ Lab Results ☐ Medication Records ☐ Other (specify)_____

Purpose of Disclosure:

☐ Coordination of Care ☐ Changing Physicians ☐ Change of Insurance
☐ Other (specify):_____

This authorization is valid for 1 year unless another date is indicated: _____/_____/_____

_____ _____
Patient or Legally Authorized Individual Signature **Date Signed**

_____ _____
Printed name of person signing on behalf of patient **Relationship (parent/legal guardian/POA)**