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.

Johns Creek
Dermatology & Family Medicine

ADULT HEALTH QUESTIONNAIRE

Your answers to the following questions will help us to understand your medical history and the concerns you wish to discuss with your doctor. Please fill out as much of this questionnaire as possible. If you cannot answer any of the questions or feel uncomfortable answering them, leave them blank. Thank you for your help.

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____ **TODAY'S DATE:** _____

What would you like to talk to your doctor about today? _____
_____

MEDICAL HISTORY

Please list any medication allergies or reactions:

_____
_____

Please check to indicate if you have ever had the following conditions:

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Asthma
- ☐ Heart attack
- ☐ Kidney disease
- ☐ Hepatitis
- ☐ Thyroid disease
- ☐ Stroke
- ☐ Depression
- ☐ Emphysema
- ☐ Seizures
- ☐ Tuberculosis
- ☐ Coronary Artery Disease
- ☐ Congestive Heart Failure
- ☐ Arrhythmia
- ☐ STD – type: _____
- ☐ Eye problems – type: _____
- ☐ Cancer – type: _____
- ☐ Other, please explain: _____

Please list any surgeries or hospital stays you have had and their approximate date/year:

Type of surgery / reason for hospitalization / location *Date*

_____ _____

_____ _____

_____ _____

If you have any other medical problems or serious injuries that are not listed above, please describe them below:

_____
_____

When was your last physical?

_____

Please list all medications, including vitamins, herbal or natural supplements and prescription medications that you are currently taking. Please note the dosage if possible.

Medication Name	*Dosage*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you currently receiving care from any other doctors, chiropractors, or other health care professionals? If yes, we would like to know whom so that we can coordinate your care:

Provider's name	*Condition they are treating you for*
_____	_____
_____	_____
_____	_____

Please note dates of your most recent immunizations:

	Approximate Date		*Approximate Date*
Tetanus	_____	Influenza	_____
Pneumonia	_____	Hepatitis B	_____
Other: _____	_____	Other: _____	_____

If you have had any of the following tests listed below, please note when the test was done and what the result was, if known:

Test	*Approximate Date*	*Result*
Cholesterol	_____	_____
Pap smear/pelvic	_____	_____
Mammogram	_____	_____
Blood in stool	_____	_____
HIV	_____	_____
Colonoscopy	_____	_____
Hepatitis C	_____	_____

FAMILY HISTORY

Check any of the diseases that run in your family **and** please note who had it:

	None	Mother	Father	Sister	Brother	Grandmother (mother's side)	Grandfather (mother's side)	Grandmother (father's side)	Grandfather (father's side)	Child	Other (Please explain)
Alcoholism or Drug Use											
Cancer											
Cancer Type											
Diabetes											
Heart Disease											
High Blood Pressure											
High Cholesterol											
Osteoporosis											
Mental Illness											
Stroke											
Thyroid Disease											
Other											

Other Comments:

_____

_____

_____

_____

HEALTH HABITS

Do you smoke or use any tobacco products?…… ☐ Yes ☐ No ☐ Quit

Number of cigarettes each day? _____

For how many years? _____

Other forms of tobacco used? _____

Do you drink alcohol?…… ☐ Yes ☐ No ☐ Quit

How much? _____

How often? _____

Have you ever felt that you should cut down on your drinking?…… ☐ Yes ☐ No

Have you regularly used other drugs?…….. ☐ Yes ☐ No

If yes, are you still using them?…….. ……☐ Yes ☐ No

PERSONAL HISTORY

Are you currently married or living with a significant other?..... ☐ Yes ☐ No
Who lives with you at home?_____
Are you employed?..... ☐ Yes ☐ No
If yes, what kind of work do you do?_____
If no, is this by choice?___ Disability?____ Other reasons?_____
Do you exercise more than 2 times per week?..... ☐ Yes ☐ No
Do you often feel sad or depressed?..... ☐ Yes ☐ No
Do you feel there is something seriously wrong with your body?..... ☐ Yes ☐ No
Are you having money problems which limit your access to food, shelter or medical care?..... ☐ Yes ☐ No
In the last year, have there been any major changes in your life like marriage, divorce, death of a family member or close friend, illness or injury, or change in job situation?..... ☐ Yes ☐ No
Do you have some form of church or spiritual support? ..... ☐ Yes ☐ No

SEXUAL HISTORY

Are you sexually active? ..... ☐ Yes ☐ No
With: ☐ Men ☐ Women ☐ Both
Do you feel you are at risk for HIV/AIDS? ..... ☐ Yes ☐ No
Do you have children? ..... ☐ Yes ☐ No
How many children do you have? _____
Do you use any form of birth control? ..... ☐ Yes ☐ No
If yes, which type / brand? _____

WOMEN ONLY

Have you ever been pregnant? ..... ☐ Yes ☐ No
How many times? _____
How many miscarriages? _____
How many abortions? _____
How many children do you have living? _____
Do you have menstrual periods? ..... ☐ Yes ☐ No
If no, at what age did they stop? _____
If yes, are your periods regular? _____

OTHER COMMENTS

_____

_____

_____

_____

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)**