Peterson Dermatology
305 First Street West
Vidalia, GA 30474
Ph (912)538-9080 Fax (912)538-9085

We welcome you to Peterson Dermatology. In order to make your visit more pleasant, please take a few moments to read this letter.

ALL FORMS HAVE TO BE RETURNED TO US BEFORE APPOINTMENT WILL BE SCHEDULED.

Enclosed is your new patient paperwork, **ALL FORMS ARE TO BE COMPLETED**. **Please make sure every question is answered, if certain questions do not pertain to the patient, please write N/A or none on the line provided**. **Failure to complete every line on forms will result in your paperwork being returned to you and will cause a delay in your appointment being scheduled.** You will need to bring your insurance card(s) and your driver's license or non-driver picture ID. (Proper ID is required for treatment). Also, you will need to be prepared to pay your co-pay, co-insurance or deductible at the time of service.

All minors MUST BE accompanied by a parent/legal guardian before the patient can be seen by the doctor.

Office visits and treatments not covered by insurance are payable at the time of service. As a courtesy to you, we will file your insurance claim at no charge. We are providers of Medicare and we participate with most commercial insurance plans. Patients can verify with their insurance company to make sure we are in their provider network.

We are located across from Food World grocery store in Vidalia. Our office is open Monday through Thursday 8:00 to 5:00 and Friday 8:00 to 12:00. We are closed for lunch 12:00 to 1:00.

For more information, please visit our website www.petersondermatology.com or find our "Peterson Dermatology" page on Facebook for recent updates.

We look forward to having you as our patient.

Peterson Dermatology
Patient Registration

PATIENT INFORMATION:

First Name: _____ MI___ Last Name: _____

Social Security #:____/____/____ Date of Birth___/___/____

Marital Status (S M W D) or Child___ Sex: Male____ Female____

Mailing Address: _____ Apt. #_____ Phone #: _____

City: _____ St: _____ Zip: _____ Cell #:_____

Race:_____ Ethnicity: (circle one) Hispanic/Latino or Not Hispanic/Latino Preferred language:_____

*Have we treated any of your family members or close friends, if so please list: _____

Email Address: _____

Are you currently enrolled in Hospice? _____ **If yes where?** _____

EMPLOYER INFORMATION:

Employer: _____ Occupation: _____ Phone #:_____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone #: _____ Secondary Phone #:_____

INSURANCE INFORMATION:

Primary Insurance Company: _____ Policy #_____ Group #_____

Policyholder Name: _____ Date of Birth: ___/___/____ SS#:_____

Secondary Insurance Company: _____ Policy #_____ Group #_____

Policyholder Name: _____ Date of Birth: ___/___/____ SS#:_____

MINOR INFORMATION:

IF PATIENT IS A MINOR (18 YEARS OR YOUNGER) PLEASE FILL OUT THE FOLLOWING:

Mother's Name: _____ Phone #:_____

Father's Name: _____ Phone #:_____

A Parent or Legal Guardian Must Be Present For Any Treatment of Minors!!

PLEASE READ AND SIGNED BELOW

I/We, the undersigned, hereby agree to pay all amounts and charges hereafter incurred by me or members of my family for services rendered by this office. I hereby authorize Peterson Dermatology to furnish information to insurance carriers concerning my illness and treatments. It is customary that payment be made when the service is rendered. I authorize benefits payable to the above physician. I understand that I am responsible for any amount not covered by insurance.

_____ _____

Date **Patient/Responsible Party Signature**

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, *Peterson Dermatology* originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that my protected health information (PHI) serves as:

- A basis for planning my care and treatment,
- A means for communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that *Peterson Dermatology* is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted.

I further understand Peterson Dermatology reserves the right to change their notice and practices. Should *Peterson Dermatology* change their notice, they will send a copy of any revised notice to the address I've provided.

LIST

I give permission to disclose my PHI to: (family members)	**I do not give permission to disclose my PHI to:**
_____	_____
_____	_____
_____	_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, i.e., lab, treatment/testing facility, insurance company, physician or pharmacy, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent. I further acknowledge that I have received a statement of the privacy practices.

If no names are listed on this from your PHI will not be disclosed to anyone other than yourself.

_____

Patient/Guardian Signature

_____

Date

FOR OFFICE USE ONLY

( ) Consent received by _____ on _____.

( ) Consent refused by patient, and treatment refused as permitted.

( ) Consent added to the patient's medical record on _____.

Peterson Dermatology

Policies

Patient Name:_____

MISSED APPOINTMENT POLICY

Your appointment time has been reserved especially for you. If you cannot keep your appointment, you must call at least 24 hours in advance to cancel or reschedule. If you are more than 15 minutes late, you must reschedule. If appointments are missed without notice, you will be charged a missed appointment fee. If you miss a regular visit your account will be charged $25. If you miss a surgery appointment your account will be charged $100 for excisions and $200 for MOHs surgery.

Patient Initial: _____

MEDICAL RECORDS POLICY

Your medical record is the property of *Peterson Dermatology*. We will send all pertinent information to any doctor we refer you to at no charge to you. If you move out of the area and transfer care to another Dermatologist, we will also forward necessary records at no charge. However, there will be a charge for any other request for medical records as allowed by Georgia Law.

INSURANCE POLICY

PLEASE REMEMBER THAT YOUR INSURANCE POLICY IS CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. YOU (THE PATIENT) ARE ULTIMATELY RESPONSIBLE FOR PAYMENT OF YOUR MEDICAL BILLS.

1) Many services we provide are considered "COSMETIC" or "NOT MEDICALLY NECESSARY." Obvious examples are Botox and other wrinkle treatments. Less obvious examples **of cosmetic / non-medically necessary services after removal of non-cancerous skin growths such as moles or skin tags that are not painful, bleeding, irritating, or have other symptoms.** We are happy to provide these services to you; however, it is unethical and illegal to bill your insurance company for them. Growths that are suspicious, cancerous, or have symptoms such as bleeding or pain are covered by insurance.
2) We prescribe individual treatments based on what is the best for you and your condition. Sometimes generic drugs are helpful and are cost effective. **GENERIC DRUGS ARE NOT ALWAYS EQUIVALENT TO BRAND NAME DRUGS**. Many times they are not as effective or have more side effects because of different delivery molecules or inactive ingredients. Your insurance company is motivated to have you use only drugs on their formulary. We are motivated to give you the best, safest, and most effective treatment. We will **Attempt** to get non-formulary drugs approved, but ultimately the decisions between you and your insurance company.
3) **Co-pays** and **deductibles** are due at time of service.
4) There will be a **$30 fee** on all **returned checks.**

MINORS: All services rendered to minor patients will be the financial responsibility of the parents/guardian.

- **I have read and understand the financial policy of the practice and I agree to be bound by its terms.**

_____ _____

Date **Signature of Patient/Guardian**

Peterson Dermatology Medical, Family, and Social History

Please answer ALL OF the following questions if any don't apply write N/A.

Patient Name: _____

Who is your primary doctor? _____

Please list your pharmacy, location, and phone number: _____

Do you now have, or have you ever had:

	YES	NO		YES	NO		YES	NO
Heart Disease	[ ]	[ ]	Thyroid Disease	[ ]	[ ]	Allergies/Hay fever	[ ]	[ ]
Heart Attack	[ ]	[ ]	Kidney Disease	[ ]	[ ]	Asthma	[ ]	[ ]
Pacemaker	[ ]	[ ]	Enlarged Prostate	[ ]	[ ]	Keloids	[ ]	[ ]
Defibrillator	[ ]	[ ]	Diabetes	[ ]	[ ]	Lupus	[ ]	[ ]
Artificial Heart Valve	[ ]	[ ]	Artificial Joints	[ ]	[ ]	Arthritis	[ ]	[ ]
High blood pressure	[ ]	[ ]	Hepatitis	[ ]	[ ]	Easy Bleeding	[ ]	[ ]
Blood clots	[ ]	[ ]	Venereal Disease, STD	[ ]	[ ]	Radiation Therapy	[ ]	[ ]
Stroke	[ ]	[ ]	HIV/AIDS risk factor	[ ]	[ ]	Artificial Joints	[ ]	[ ]
Cancer, other than skin cancer	[ ]	[ ]	Blood Transfusion	[ ]	[ ]	Phlebitis	[ ]	[ ]

Have you ever had skin cancer? **[ ] Yes [ ] No If yes, what kind (basal cell, squamous cell, melanoma) and where on your body?** _____

Do you have a history of any specific skin diseases (for example, psoriasis or eczema)? **[ ] Yes [ ] No**
If yes, list: _____

List any other disease or medical condition: _____

_____

List any major surgical procedures you have had: _____

_____

List all medications you are currently taking: _____

_____

Are you allergic to any medications? [ ] Yes [ ] No If yes, list: _____
Are you allergic to latex or adhesives? _____

Have you ever had any bad reaction to lidocaine or dental anesthesia (Novocain)? [ ] Yes [ ] No
Are you pregnant? [ ] Yes [ ] No If yes, due date: _____
Do you drink Alcohol? [ ] Yes [ ] No
Tobacco Smoker? Never_____ Current_____ Former _____. If Current, daily use? _____
Do you have a family history of skin cancer or a severe skin disease? [ ] Yes [ ] No
If yes, who and what type?

_____

Patient/Responsible Party Signature: _____ **Date:** _____

Peterson Dermatology

305 First Street West

Vidalia, Ga 30474

PHONE 912-538-9080 FAX 912-538-9085

Registration for Minors under 18

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Person Responsible for Payment

Name: _____ DOB: _____

SSN: _____ Relation to child: _____

Billing Address: _____

Home Phone: _____

Mobile Phone: _____

Cellular Phone: _____

Patient Information

If you have more than one child who is a patient in our office, please list each child's name who shares the same grantor and payment information.

Patient's Name: _____ DOB: _____

Child 2: _____ DOB: _____

Child 3: _____ DOB: _____

Child 4: _____ DOB: _____

I understand that whoever accompanies my child to their appointments has my authorization to consent to Dermatology treatment deemed necessary and is responsible for payment of services. I authorize payment to be made directly to this office by my insurance company, and I accept financial responsibility for all services not covered by my insurance.

Printed Name: _____ Date: _____

Parent/Responsible party Signature: _____