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.

Your appointment is ___________________________________. 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.

YOU MUST ARRIVE 30 MINS EARLY TO FILL OUT NEW PATIENT PAPER WORK OR BRING FORMS COMPLETED TO YOUR APPT. IF FORMS ARE NOT COMPLETED AT YOUR SCHEDULED APPT TIME WE MAY DELAY OR RESCHEDULE YOUR APPT.

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: ____

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**

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**

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

Dermatology Medical, Family, and Social History

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	[ ]	[ ]	Allergies/Hay Fever	[ ]	[ ]	Rheumatoid Arthritis	[ ]	[ ]
Heart Attack or Bypass	[ ]	[ ]	Psoriasis	[ ]	[ ]	Osteoarthritis	[ ]	[ ]
Pacemaker or Defibrillator	[ ]	[ ]	Eczema	[ ]	[ ]	Depression	[ ]	[ ]
Artificial Heart Valve	[ ]	[ ]	Stroke	[ ]	[ ]	Radiation Therapy	[ ]	[ ]
Thyroid Disease	[ ]	[ ]	Keloids	[ ]	[ ]	Blood Transfusion	[ ]	[ ]
Kidney Disease	[ ]	[ ]	Easy Bleeding	[ ]	[ ]	HIV/AIDS Risk Factors	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	(Men) Enlarged Prostate	[ ]	[ ]	Artificial Joints	[ ]	[ ]
Blood Clot in Leg or Lung	[ ]	[ ]	Hepatitis	[ ]	[ ]	Venereal Disease (STD)	[ ]	[ ]
Phlebitis	[ ]	[ ]	Cancer	[ ]	[ ]			
Asthma	[ ]	[ ]	Diabetes	[ ]	[ ]			

(Women) Are you pregnant? [ ] Yes [ ] No If yes, due date:

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 other skin diseases? [ ] Yes [ ] No

If yes, list: ____

List any other disease or medical condition we should know about: ______________________________

____

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: ______________________________

____

Have you ever had lidocaine or dental anesthesia (Novocain)? [ ] Yes [ ] No

If yes, did you have any bad reaction to it? [ ] Yes [ ] No

Do you drink alcohol? [ ] Yes [ ] No If yes, what kind and how often? __________________________

Have you ever used tobacco? [ ] Yes [ ] No

If yes, are you currently using tobacco? [ ] Yes [ ] No **If yes, what type and how much?**________________

Has anyone in your family had skin cancer or a severe skin disease? [ ] Yes [ ] No

If yes, who and what type?

____

Patient/Responsible Party Signature: ______________________________ **Date:** ____________