Marietta Dermatology and The Skin Cancer Center

PATIENT REGISTRATION

MRN: _____

PLEASE REVIEW THIS FORM AND VERIFY IF THERE ARE NO CHANGES.	Date	**Employee Initials**

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

LAST NAME	FIRST NAME, MI	PREFERRED NAME	DATE OF BIRTH	GENDER

STREET ADDRESS	CITY, STATE, ZIP CODE

HOME PHONE #	MOBILE PHONE #	EMAIL ADDRESS

MARITAL STATUS **Married Single Widowed Divorced Separated Partner**	RACE/ETHNICITY **Asian Black Caucasian Hispanic or Latino Other:_____ Declined**
PATIENT'S EMPLOYER	OCCUPATION ☐ Employed ☐ Not Employed ☐ Self- Employed ☐ Retired ☐ Active Military ☐ Student

EMPLOYER'S STREET ADDRESS	CITY, STATE, ZIP CODE	WORK #	HOW DID YOU HEAR ABOUT US

IN CASE OF EMERGENCY. please call	EMERGENCY CONTACT #	REFERRING PROVIDER	PRIMARY CARE PROVIDER

PREFERRED PHARMACY NAME (Please provide a copy of your prescription card)	PHARMACY PHONE #	PHARMACY, CITY, STATE

HIPPA PHI COMMUNICATIONS TO PATIENT. Please provide your consent to use your PHI for the following

You may contact me at the phone number(s) listed below with test results and other medical information. I have verified and listed the numbers that I prefer you to call. **(INITIAL HERE) :** _____

YES / NO : You may leave a detailed message on my answering machine or voicemail regarding my test results and other medical information.

PLEASE LIST ANY PERSONS TO WHOM OUR STAFF MAY DISCUSS AND OR DISCLOSE YOUR HEALTH OR FINANCIAL INFORMATION
(PLEASE PRINT LEGIBLY)

NAME	RELATIONSHIP	PHONE NUMBER	PLEASE CIRCLE			
			MEDICAL	**YES / NO**	**FINANCIAL**	**YES / NO**
			MEDICAL	**YES / NO**	**FINANCIAL**	**YES / NO**

PATIENT'S INSURANCE INFORMATION (PLEASE PRINT LEGIBLY AND PROVIDE A COPY OF YOUR INSURANCE CARD)

LAST NAME _____	FIRST NAME, MI _____	RELATIONSHIP TO RESPONSIBLE PARTY ☐ Minor Child ☐ Dependent Adult ☐ Other
STREET ADDRESS _____	CITY, STATE, ZIP CODE	PRIMARY #

PRIMARY INSURANCE COMPANY	MEMBER # (or ID #)	GROUP #
POLICY HOLDER'S NAME	DATE OF BIRTH	SOCIAL SECURITY #
POLICY HOLDER'S ADDRESS	CITY, STATE, ZIP CODE	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Parent ☐ Other

SECONDARY INSURANCE COMPANY	MEMBER # (or ID #)	GROUP #
POLICY HOLDER'S NAME	DATE OF BIRTH	SOCIAL SECURITY #
POLICY HOLDER'S ADDRESS	CITY, STATE, ZIP CODE	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Parent ☐ Other

ACKNOWLEDGEMENT. I acknowledge all information above is accurate.

Signature of Patient or Parent/Guardian (if a minor) or Power of Attorney	**Date**	**Employee Initials**

MARIETTA DERMATOLOGY & THE SKIN CANCER CENTER

MRN: _____

PATIENT INTAKE FORM

Patient Name: _____ D.O.B: _____Today's Date:_____

PAST MEDICAL HISTORY:

Personal history of cancer other than skin?_____

__Anxiety	__COPD	__High Blood Pressure	__Thyroid Issues
__Arthritis	__ Depression	__Inflammatory Bowel Disease	__Radiation Treatment
__Asthma	__ Diabetes	__Organ Transplant, Type:_____	__Stroke
__Eczema	__Psoriasis	__Hay Fever	__Heart Disease

Other Medical History not listed**:**_____

HISTORY OF SKIN DISEASE:

Personal History of Skin Cancer? __Basal Cell Carcinoma __Squamous Cell Carcinoma __Melanoma

DO YOU HAVE A FAMILY HISTORY OF MELANOMA? Relative (s):_____

MEDICATION: Check here if you have an attached list _____

Please include dosage and strength if known_____

_____

_____

Patient Height: _____ Patient Weight: _____ (Required for prescriptions)

ALLERGIES: _____

SOCIAL HISTORY: Do you smoke? __Yes __No **Do you drink alcohol? __Yes __No**

Number of packs per day ____ **Number of drinks per week? _____**

ALERTS:

__Allergy to Adhesive	__On Blood Thinners/Aspirin	__MRSA
__Allergy to Lidocaine	__History of Fever Blisters	__Seizures
__Allergy to Latex	__Pacemaker	__Kidney disease
__Allergy to Iodine	__Defibrillator	__C-Diff
__Artificial Joint	__HIV/AIDS	__Pregnant or trying to get pregnant
__Artificial Heart Valve	__Hepatitis B	__Breast Feeding
__Allergy to Oral Antibiotics	__Hepatitis C	__Neurostimulator/implantable device
__Requires Antibiotics prior to procedure	__Rapid Heartbeat with epinephrine	

PREFERRED PHARMACY:

Pharmacy Name:_____ Pharmacy Number:_____

Pharmacy Address:_____

PCP:_____ Referring Provider:_____

I AUTHORIZE MARIETTA DERMATOLOGY & THE SKIN CANCER CENTER TO RETRIEVE MY MEDICATION HISTORY THROUGH THEIR PRESCRIBING SYSTEM AND IMPORT IT INTO MY ELECTRONIC MEDICAL RECORD

SIGNATURE:_____ DATE:_____

Updated: October 2020

MRN: _____

Patient Acknowledgement and Consents

CONSENT FOR TREATMENT. I consent to all diagnostic and treatment procedures/examinations provided at all offices Marietta Dermatology and The Skin Cancer Center. This will include, but not limited to injections, biopsies, administration of medications, treatments, and procedures considered medically necessary for the care of my dermatologic condition. I understand that the procedures will be explained to me and that I will have the opportunity to ask questions concerning the associated risks, alternatives and prognosis before allowing the procedures to be performed. I consent to treatment and care provided by a team of healthcare providers, which may include dermatologists, mid-level providers such as physician assistants or advanced care practice nurse practitioners.

CONSENT FOR DISPOSAL OF HUMAN TISSUE. I agree that any tissues or specimens that are removed from my body while performing my Procedures or providing my care and treatment will be examined and disposed of by Marietta Dermatology and The Skin Cancer Center.
In-House Dermatopathology Lab I understand that Marietta Dermatology has an in-house pathology lab that my biopsies will be sent to and that my biopsies will be read by a certified Dermatopathologist. I understand that I may receive additional billing from Marietta Dermatology for portions of my deductible not yet met, coinsurance and in some cases, an additional co-pay.

TELEPHONE CONSUMER PROTECTION ACT CONSENT. I expressly consent to receive telephone calls and text messages from Marietta Dermatology and The Skin Cancer Center, its affiliates, agents, vendors or third parties calling or texting on its or their behalf at any number that I provide or that they may obtain for me. Such calls or texts may be made using an automatic telephone dialing system and/or prerecorded or artificial voice and may be made for any non-marketing purpose. , including but not limited to: communications about my treatment, medication assistance, insurance benefits or account; appointment reminders; balance due and payment reminders; and debt collection attempts.

MEDICATION CONSENT. I provide consent to access and obtain a history of my medications purchased at pharmacies.

PHOTOGRAPHS, VIDEOTAPES, AND RECORDINGS: I agree to turn off all recording devices prior to entering the exam room. I understand that physicians or staff may request to take photographs, videotapes, or other recordings of me for purposes of ensuring proper patient identification or for medical documentation, care, or treatment purposes. I understand the photograph(s) or videotape(s), will be used for documentation of my medical condition. For example, my clinical team will take pictures of my skin condition, biopsy site, or surgical site. They will also take before and after pictures to monitor the progression of my condition. I consent to being photographed, videotaped, or recorded for these purposes. I further acknowledge that such photographs, videotapes, recordings and related information may be used for internal operations including, but not limited to quality improvement activities and training programs that do not include treatment.

PRIVACY PRACTICES. I acknowledge that I have been provided a copy of the Notice of Privacy Practices from Marietta Dermatology and The Skin Cancer Center and that I have read (or had the opportunity to read if I so chose) the Notice. *(Please Initial)* _____

ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENTS

ASSIGNMENT OF BENEFITS. If I am entitled to benefits under the Medicare program or any insurance policy or other health benefit plan, in consideration for services provided to me by Marietta Dermatology Associates PA, dba Marietta Dermatology and The Skin Cancer Center, I assign, transfer, and convey the benefits payable under such program, policy, or plan for services rendered to Marietta Dermatology and The Skin Cancer Center. I authorize payment of benefits directly to Marietta Dermatology Associates PA dba Marietta Dermatology and The Skin Cancer Center, with such benefits applied to my bill.

PATIENT RESPONSIBILITY. I understand and acknowledge that the assignment of benefits does not relieve me of my financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts and deductibles and any charges for services deemed to be non-covered, or not preauthorized by my insurance plan. I agree to provide all known insurance information at the time that services are rendered. If I overpay on my account, I authorize the application of such overpayment to satisfy any outstanding charges I owe for services rendered by any facility of Marietta Dermatology and The Skin Cancer Center.

INFORMATION RELEASE. I authorize Marietta Dermatology and The Skin Cancer Center to release all protected health information to my insurance, (including Medicare, if appropriate) and third-party collection agencies to secure payment for services rendered. I also authorize Marietta Dermatology and The Skin Cancer Center to release my medical information to my Primary Care Provider or Referring Provider for continuity of my care.

REFERRALS. I understand that it is my responsibility to obtain any referrals required by my insurance company from my primary care physician or insurance carrier. It is my responsibility to make sure that my referral is accurate and denial of payment because of my failure to do this will result in my being personally responsible for the charges incurred.

DEPOSIT POLICY. I understand that a $75 non-refundable deposit will be required when being seen for an appointment with a High Deductible Health Plan. Any amount owed in addition to this $75 deposit will be billed by mail and the patient will be responsible for the balanced as determined by the Health Plan.

RETURN POLICY. I understand that we cannot accept returns of skin care products and prescription pharmaceutical preparations. These products are non-refundable.

TREATMENT GUARANTEE. Although good results are anticipated, I understand that there can be no guarantee or warranty, expressed or implied, by anyone as to the actual results I may get. I also understand that additional charges, for which I will be responsible, will be applied for the management of problems and/or complications.

Signature of Patient or Parent/Guardian (if a minor) or Power of Attorney	Date	Employee Initials
Printed Name of Parent/Guardian or Power of Attorney, if applicable	**RELATIONSHIP TO PATIENT, if other than self** ☐ PARENT/GUARDIAN ☐ POWER OF ATTORNEY ☐ OTHER	

MRN: _____

MARIETTA & DERMATOLOGY & THE SKIN CANCER CENTER

NO-SHOW & CANCELLATION POLICY

"No Show" shall mean any patient who fails to arrive for a scheduled appointment. "Same Day Cancellation" shall mean any patient who cancels an appointment *less than* 24 hours before their scheduled appointment.

A patient is notified of the appointment "No-Show & Cancellation Policy" at the time of scheduling.

An appointment must be canceled or rescheduled at least 24 hours prior to the scheduled appointment time.

Any established patient who fails to show, cancels, or reschedules an appointment less than 24 hours of the scheduled appointment will be considered a No-Show and will be charged a $25.00 fee.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office at 770-422-1013.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

Signature (Patient/Legal Guardian)_____

_____
Relationship to patient

Print Name: _____

Date: _____