



**Marietta Dermatology and The Skin Cancer Center**

MRN: \_\_\_\_\_

**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		
IN CASE OF EMERGENCY	EMERGENCY CONTACT#	REFERRING PROVIDER	PRIMARY CARE PROVIDER	
PREFERRED PHARMACY NAME <i>(Please provide a copy of your prescription card)</i>		PHARMACY PHONE#	PHARMACY, CITY, STATE	

**HIPAA PHI COMMUNICATION TO PATIENT** *(Please provide your consent below to use your PHI for the following)*  
 (If left blank, we are unable to communicate with anyone regarding your personal health information. No Exceptions.)

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):** \_\_\_\_\_

You may leave a detailed message on my answering machine or voicemail regarding my test results and other medical information. **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

Please list any persons to whom our staff may discuss and/or disclose your health or financial information.  
**(PLEASE PRINT LEGIBLY. If left blank, we are unable to communicate with anyone but you, our patient. No Exceptions!)**

NAME	RELATIONSHIP	PHONE NUMBER	PLEASE CIRCLE
			<b>MEDICAL: YES/ NO    FINANCIAL: YES/ NO</b>
			<b>MEDICAL: YES/NO    FINANCIAL: YES/ NO</b>
			<b>MEDICAL: YES/NO    FINANCIAL: YES/ NO</b>

**ACKNOWLEDGEMENT.** I acknowledge all the information above is accurate. (Print Name of Patient)

<b>Signature of Patient or Parent/Guardian (if minor) or Power of Attorney</b>	<b>Date</b>	<b>Employee Initials</b>
--	-------------	--------------------------



**PATIENT ACKNOWLEDGEMENT AND CONSENT**

**CONSENT FOR TREATMENT:** I consent to all diagnostic and treatment procedures/examinations provided at Marietta Dermatology and The Skin Cancer Center. This will include, but not be 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 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 where my biopsies will be sent and examined by a certified Dermatopathologist. I acknowledge 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 conditions, 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 choose) 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, 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 overpayments 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 ensure 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 balance as determined by the Health Plan.

**RETURN POLICY:** I UNDERSTAND THAT WE CANNOT ACCEPT RETURNS OF SKIN CARE PRODUCTS AND PRESCRIPTION PHARMACEUTICALS 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 achieve. I also understand that additional charges for which I will be responsible will be applied for the management of problems and/or complications.

<b>Signature of Patient or Parent/Guardian (if a minor) or Power of Attorney</b>	<b>Date</b>	Employee Initials
<b>Printed Name of Parent / Guardian or Power of Attorney, if applicable</b>	<b>Relationship to Patient, if other than self:</b> <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Other	



---

## 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 "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 before 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: \_\_\_\_\_



MRN \_\_\_\_\_

**PATIENT INTAKE FORM**

Patient Name \_\_\_\_\_ D.O.B: \_\_\_\_\_ Today's Date \_\_\_\_\_

**PAST MEDICAL HISTORY:**

Personal history of cancer other than skin cancer? \_\_\_\_\_

- |                                    |                                     |   |  |
|------------------------------------|-------------------------------------|---|--|
| <input type="checkbox"/> Anxiety   | <input type="checkbox"/> COPD       | <input type="checkbox"/> High Blood Pressure          | <input type="checkbox"/> Thyroid Issues      |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Inflammatory Bowel Disease   | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Asthma    | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Organ Transplant, Type _____ | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Eczema    | <input type="checkbox"/> Psoriasis  | <input type="checkbox"/> Hay Fever                    | <input type="checkbox"/> Heart Disease       |

Other medical history not listed above: \_\_\_\_\_

**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) with history: \_\_\_\_\_

**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 \_\_\_\_\_  
Number of packs per day \_\_\_\_\_

Do you drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_  
Number of drinks per week \_\_\_\_\_

**ALERTS:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Allergy to Adhesive                     | <input type="checkbox"/> On Blood Thinners / Asprin       | <input type="checkbox"/> MRSA                                 |
| <input type="checkbox"/> Allergy to Lidocaine                    | <input type="checkbox"/> History of Fever Blisters        | <input type="checkbox"/> Seizures                             |
| <input type="checkbox"/> Allergy to Latex                        | <input type="checkbox"/> Pacemaker                        | <input type="checkbox"/> Kidney Disease                       |
| <input type="checkbox"/> Allergy to Iodine                       | <input type="checkbox"/> Defibrillator                    | <input type="checkbox"/> C-Diff                               |
| <input type="checkbox"/> Artificial Joint                        | <input type="checkbox"/> HIV / AIDS                       | <input type="checkbox"/> Pregnant or trying to be pregnant    |
| <input type="checkbox"/> Artificial Heart Valve                  | <input type="checkbox"/> Hepatitis B                      | <input type="checkbox"/> Breast Feeding                       |
| <input type="checkbox"/> Allergy to Oral Antibiotics             | <input type="checkbox"/> Hepatitis C                      | <input type="checkbox"/> Neurostimulator / Implantable Device |
| <input type="checkbox"/> Requires Antibiotics Prior to Procedure | <input type="checkbox"/> Rapid Heartbeat with Epinephrine |   |

**PREFERRED PHARMACY:**

Pharmacy Name: \_\_\_\_\_ Pharmacy Number \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ 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:** \_\_\_\_\_