ADVANCED DERMATOLOGY, P.C.
www.skinangel.com

Todays Date ____/____/____ Date of Birth _____/_____/_____

Patient Name_____
Last First M.I. Race/Nationality

_____
Street Address City State Zip

Home Phone _____Cell_____Work_____Pharmacy_____

SSN#_____Gender_____ Marital Status_____ Email Addres_____

Emergency Contact Relationship _____Phone_____

Patient Insurance Information

Name of primary insurance carrier:_____
Policy Holder (if different from Patient)_____
Policy Holder's Date of Birth_____/_____/_____ SSN#_____
Patient's Relationship to Policy Holder_____
Claims Address:_____

Name of Secondary Insurance Carrier:_____
Policy Holder (if different from patient)_____
Policy Holder's Date of Birth_____/_____/_____SSN#_____
Patient's Relationship to policy Holder_____
Claims Address:_____

Responsible party information, if not the patient. Note: We do not bill absent parents. The adult presenting the minor for care is the responsible party.
Name:_____ Relationship to patient:_____
Address:_____Phone:_____

How did you hear about our Practice? ☐ *Phone Book* ☐ *Insurance* ☐ *Friend*
☐ *Referred by Dr.* _____ ☐ *ad in*_____

What type of skin condition are you having?_____
How long have you had this problem?_____
Do you feel this is work related?_____
Have you been treated before for this problem?_____
If yes, who and when?_____
Are you allergic to any medications?_____If yes, what?_____
Do you smoke?_____Do you drink alcohol?_____
Are you pregnant?_____Are you trying to become pregnant?_____

Please list your current medications:

_____

_____

_____

_____

Patient's Past Medical History

HAY FEVER	N	Y	_____
SKIN CANCER	N	Y	_____
PREVIOUS SKIN PROBLEMS	N	Y	_____
ASTHMA	N	Y	_____
DIABETES	N	Y	_____
ARTHRITIS	N	Y	_____

Family History

DANDRUFF	N	Y	_____
PSORIASIS	N	Y	_____
SKIN CANCER	N	Y	_____
MELANOMA	N	Y	_____
OTHER SKIN DISEASES	N	Y	_____
ASTHMA	N	Y	_____
DIABETES	N	Y	_____
ARTHRITIS	N	Y	_____
OTHER	N	Y	_____

Authorization

I authorize the release of any medical information necessary to process medical claims and request payment of Medicare benefits to the party who accepts assignment. I authorize payment directly to the provider of care shown. I understand I am financially responsible for all charges not covered by this assignment. I agree that a photographic copy of authorization shall be valid as the original. I also authorize submission of surgical/biopsy specimen and release of insurance and medical information to the pathologist who will bill separately.

Please sign and date below

Date_____ **X**_____

Patient Consent for Physician to Use or Disclose Health Care Information for Treatment, Payment and Health Care Operations

Advanced Dermatology
Amr Agha, M.D.
6043 Prestley Mill Rd Ste. B
Douglasville, GA 30134
7707397546

Patient's Name:_____ Date of Birth:_____

Social Security:_____ Date of Today:_____

I understand that my health information is private and confidential. I understand that Advanced Dermatology will work very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that signing this document means that the Advanced Dermatology may use and disclose my personal health information to help provide health care to me to handle billing and payment, and to take care of other health care operations. Failure to sign this consent may result in the physician declining to treat you.

Advanced Dermatology has detailed document called the "Notice of Privacy Practice." It contains more information about the policies and practices used to protect their patients' privacy. I understand that I have the right to read the "Notice" before signing this agreement.

Advanced Dermatology may update this "Notice of Privacy Practice." If I ask, the Advanced Dermatology will provide me with the most current "Notice of Privacy Practice."

Under the terms of this consent, I can ask Advanced Dermatology, P.C. to restrict how my personal information is used or disclosed to carry out treatment, does not have to agree to my request. If Advanced Dermatology does agree to my request, I understand that Advanced Dermatology may have already used or disclosed information about myself, and canceling this consent would not effect the information already used or disclosed.

I cancel this consent at any time by doing one of the following:

1.- Signing and dating a form Advanced Dermatology van give me a called "Revocation of Consent for Use and Disclosure of Health Care Information", or

2.- Writing, signing, and dating a letter to Advanced Dermatology, If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment and health care operations.

I understand if I cancel this consent, Advanced Dermatology does not have to provide any further health care services to me.

My signature below indicates that I have been given the chance to review a current copy of the Advanced Dermatology "Notice of Privacy Practice."

I (Initial Here)_____authorize Advanced Dermatology to email me at the following address_____

You may leave a voice message on my answering machine regarding medical condition(s) (Initial here) _____

Patient or legally authorized individual signature_____ Name :_____

I authorize Advanced Dermatology to discuss any and all medical information with the following:

_____

_____

_____

Advanced Dermatology
Dr. Amr Agha, M.D.
6043 Prestley Mill Rd Ste. B
Douglasville, GA 30134
770-739-7546

Patient Liability form

Patient Name:_____ Date:_____

Insurance Carrier:_____

My signature below acknowledges that Advanced Dermatology, the office of Dr Amr Agha, has informed me that they will verify my benefits with my insurance carrier prior to my evaluation and treatment. I understand that verification of my benefits is not a guarantee of payment from my insurance carrier. As a courtesy, the office will file claims with my insurance carrier on my behalf and I agree to pay any co-pays, percentages, deductibles, etc. that my insurance carrier states is my portion during the verification process. I clearly understand that my insurance carrier may consider the charges on the claims in excess of their fee schedule, consider a service (s) medically unnecessary, bundle certain services, or apply benefits to the annual deductible. If charges are not covered in full, I understand that I am responsible for the entire outstanding balance, regardless of the reason for any reductions in payment made by my insurance carrier. If the office receives no payment within 90 days, my signature acknowledges that I will be responsible for the bill in its entirety regardless of my insurance carriers reason for denial of payment. I also agree to make this payment within (10) days of the receipt of the statement after my insurance carrier has made it's determination or if no payment has been received in the aforementioned 90 days, I'm aware that my account will go to a collection agency and their will be a 35% recovery fee plus my outstanding balance unless other payment arrangements have been made between myself and Advanced Dermatology.

Signature or Patient:_____ _____

Signature of Parent if minor

Witness:_____

NO CALL NO SHOW AND LATE CANCELATION POLICY

In order to provide the highest quality care to our patients, we have established a formal "No Show/Cancellation Policy". This is intended to increase physician and staff productivity, to improve timely access to all patients, to reduce/ eliminate empty slots in the appointment schedule and to reduce the fiscal impact due to loss of revenues.

We understand that there may be circumstances that require you to cancel an appointment, but we require that you notify our office no less than 48 hours in advance. **If you fail to notify us in 48 hours, there will be a $40.00 cancellation/no show fee. You will be required to pay the $40.00 fee before your next appointment.**

Your appointment time has been reserved for you, and if you do not keep it, this results in being wasted time for other patients who could have been seen as well as for our staff. This is not fair to anyone. When you do not show or cancel an appointment, the failure to keep your scheduled appointment is documented.

DEFINITIONS:

NO-SHOW occurs when a patient:

-makes an appointment then fails to keep the appointment
-forgets to cancel the appointment
-neglects to cancel the appointment 48 hours prior to the scheduled time.

CANCELLATION occurs when a patient contacts the office and provides a 48 hour notification prior to the appointment that they cannot keep the appointment.

15 MINUTES LATE occurs when a patient arrives 15 minutes late for an appointment without prior notification. Should this occur, a patient may be asked to reschedule. This late arrival may also be classified as a no show.

APPOINTMENT CONFIRMATION PROCEDURE

Unable to Contact by Telephone In the event you are unable to provide a telephone contact number, **it will be your responsibility to call our office (770) 739-7546 at least 48 hours prior** to your scheduled appointment time to confirm.

24 Hour Friendly Telephone/Text/Email Confirmation- ALL patients A representative of our staff will telephone/text/email you 24 hours prior to your scheduled appointment as a friendly reminder

Signature _____ Date _____