GEORGIA SKIN CANCER
& Aesthetic Dermatology

PATIENT CLIPBOARD: HISTORY & INTAKE FORM
(Please Print)

Patient: _____ **Date of Birth:** _____ **Medical Record #:** _____

Alerts/Past Medical History: (Please circle all that apply)

Alerts:
Blood Thinners
Defibrillator
Pre-meds Prior to Procedure
HIV/Hepatitis
Pregnant/Nursing

NONE
Anxiety Disorder
Arthritis
Atrial fibrillation
B-cell lymphoma
Chronic obstructive lung disease
Coronary arteriosclerosis
Cutaneous T-cell lymphoma
Depressive disorder
Diabetes mellitus
Disease caused by 2019-nCoV
Elevated blood pressure
End-stage renal disease
Epilepsy
Gastroesophageal reflux disease
H/O: hypertension
Hearing loss
Human immunodeficiency virus infection
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Inflammatory disease of liver
Leukemia
Malignant lymphoma
Malignant neoplasm of bone
Malignant tumor of body of pancreas
Malignant tumor of breast
Malignant tumor of colon
Malignant tumor of lung
Malignant tumor of prostate
Primary cutaneous lymphoma
Radiation therapy treatment management
Transplantation of bone marrow
Other: _____

Past Surgical History: (Please circle all that apply)

NONE
Abdominoperineal resection
Bilateral replacement of knee joints
Biopsy of breast
Biopsy of prostate
Coronary artery bypass graft
Entire transplanted kidney
Excision of basal cell carcinoma
Excision of melanoma
Excision of squamous cell carcinoma
H/O: colostomy
H/O: tubal ligation
History of appendectomy
History of bilateral mastectomy
History of cholecystectomy
History of colectomy
History of tissue graft heart valve
History of total cystectomy
History of transurethral prostatectomy
Hysterectomy
Kidney biopsy
Low anterior resection of rectum
Lumpectomy of breast
Lumpectomy of left breast
Lumpectomy of right breast
Mastectomy of left breast
Mastectomy of right breast
Mechanical heart valve replacement
Oophorectomy
Pancreatectomy
Prostatectomy
Prosthetic arthroplasty of hips
Splenectomy
Surgical of biopsy of skin
Total nephrectomy
Total orchidectomy
Total replacement of left hip joint
Total replacement of left knee joint
Total replacement of right hip joint
Total replacement of right knee joint
Transplantation of heart
Transplantation of liver
Other: _____

Medical Record #: _____

Skin Disease History/Sun Exposure: (Please circle all that apply)

NONE	**H/O: asthma**	**Pruritus of skin**
Acne	**H/O: hay fever**	**Psoriasis**
Actinic keratosis	**Infection of skin**	**Rosacea**
Basal cell carcinoma of skin	**Light-for-dates with signs**	**Squamous cell carcinoma**
Contact dermatitis	**of fetal malnutrition**	**Sunburn of second degree**
Dry skin	**MRSA Infection**	**Tinea corporis**
Dysplastic nevus of skin	**Malignant melanoma**	**Tinea pedis**
Eczema	**Pityriasis versicolor (tinea)**	**Other: _____**

Do you wear sunscreen? **YES NO** What SPF? _____ Do you tan in a tanning salon? **YES NO**

Do you have a family history of Melanoma? **YES NO** If yes, what relative? _____

Medications: (Please list - or attach list)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Allergies/ Drug Allergies: (Please list)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Social History:

Smoking History: □ **Currently Smoke** □ **Have Smoked in the Past** □ **Never Smoked**

Alcohol Consumption: □ **None** □ **< 1 drink per day** □ **1-2 drinks per day** □ **>3 drinks per day**

All patients please sign:

- I authorize the release of any medical information needed to process Medicare and/or other insurance.
- I authorize Georgia Skin Cancer and Aesthetic Dermatology to treat the above named patient (including minors) as necessary.
- I authorize the release or acquisition of any medical information to/from any physician or physician's office, laboratory, pharmacy, hospital, or surgical facility involved in my care. I have read the HIPAA privacy policy of Georgia Skin Cancer & Aesthetic Dermatology.

Signature: _____ **Date:** _____

Signature of Patient, Parent or Legal Guardian

Medical Record #: _____

GEORGIA SKIN CANCER
& Aesthetic Dermatology

PATIENT DATA:
(Please Print)

Patient Information:

Name: _____ □Jr. □Sr.
First Middle Last

Nickname (if applicable): _____ **Date of Birth:** _____
Month/Day/Year

Sex: □ Male □ Female **Marital Status:** _____ **Social Security #:** _____

Contact Information:

Patient Home phone #: _____ **Patient Cell phone #:** _____
Preferred contact number: HOME CELL **May we leave voicemail on this number? YES NO**

Email address: _____

Mailing Address:

_____
Address City State Zipcode

Emergency Full Name: _____ **Phone #:** _____
Spouse Full Name: _____ **Phone #:** _____
Caretaker Full Name: _____ **Phone #:** _____

Guarantor:
For patients under 18, we must document a guarantor. Skip this section if the patient is 18 or older.
Patient's Relationship to Guarantor (circle): SPOUSE CHILD EMPLOYEE OTHER: _____
Guarantor's Name: _____ □Jr. □Sr.
First Middle Last
Guarantor's Date of Birth: _____
Guarantor's Mailing Address (if different from patient's):

_____
Address City State Zipcode

Guarantor's Home phone #:_____ **Guarantor's Cell phone #:**_____
Guarantor's Email address: _____

Medical Record #: _____

Release of PHI:

May we discuss your medical condition with any member of your household? **YES NO**

If yes, who? **SPOUSE PARENT CHILD FRIEND OTHER**

Name: **_____Phone #: _____ (CELL / HOME)**

Name: **_____Phone #: _____ (CELL / HOME)**

Name: **_____Phone #: _____ (CELL / HOME)**

Pharmacy:

Pharmacy Name: _____ **Location OR Phone #:** _____

Practice Data:

Primary Care Provider: _____

Referring Provider (if applicable): _____

Patient Referral Source:

How did you hear about us? _____

If patient is a Minor: It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service.

_____ _____ _____ _____

Signature of Parent/Legal Guardian Printed Name of Parent/Legan Guardian Date of Birth Date

In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA, MASTERCARD, DISCOVER, AND AMERICAN EXPRESS FOR YOUR CONVENIENCE. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the doctor when assigned claim is filed.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

NOTICE OF PRIVACY PRACTICES **Effective Jan. 1, 2024**

GEORGIA SKIN CANCER & AESTHETIC DERMATOLOGY, LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may disclose your records to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure all patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and service you receive at the Practice. We need this record to provide you with quality care and comply with certain legal requirements. This notice applies to all records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected health information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. You must submit your request in writing to the Privacy Officer, Georgia Skin Cancer & Aesthetic Dermatology, 1180 Resurgence Drive Suite 100 Watkinsville, GA 30677. Please include your name, date of birth, and the service dates of the records you wish to inspect. We may deny your request to inspect and copy in certain circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing to the Privacy Officer, Georgia Skin Cancer & Aesthetic Dermatology, 1180 Resurgence Drive Suite 100 Watkinsville, GA 30677. You must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit of the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer, Georgia Skin Cancer & Aesthetic Dermatology, 1180 Resurgence Drive Suite 100 Watkinsville, GA 30677. Please include your name, date of birth, what information you want to limit, and to whom you want the limitation to apply.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving communications from the Practice.

Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosure of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters by alternate means or at alternative locations. For example, you may ask to be contacted only by mail, and not by phone. You must make your request in writing to the Privacy Officer, Georgia Skin Cancer & Aesthetic Dermatology, 1180 Resurgence Drive Suite 100 Watkinsville, GA 30677. Please include your name, date of birth, and how you would like to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of medical information about you in the six years prior to the date on which the accounting is requested. This accounting will not include disclosures 1) made to carry out treatment, payment and health care operations 2) made to individuals of protected health information about then, 3) that were incidental to a use or disclosure otherwise permissible or required, 4) made pursuant to your written authorization, 5) made to persons involved in your care or payment for your care, 6) made for national security or intelligence purposes, 7) made to correctional institutions or law enforcement officials, and 8) containing limited portions of your health information that excludes identifiers. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer, Georgia Skin Cancer & Aesthetic Dermatology, 1180 Resurgence Drive Suite 100 Watkinsville, GA 30677. Please include your name and date of birth.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room.

COMPLIANTS. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact Trinity Carithers, Privacy Officer, at 1180 Resurgence Drive Suite 100 Watkinsville, GA 30677. All complaints must be in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you have questions about this notice or want a more detailed explanation, contact our Privacy Officer, 706-543-5858 ext. 3208.