ADVANCED DERMATOLOGY, PA

4021 Balmoral Dr. SW | Huntsville, AL 35801 | 256-539-2741

John K. Sowell, M.D. Lon F. Raby, Jr., M.D. Patricia L. Wilson, M.D.
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Receipt of Privacy Practices; Consent for Use / Disclosure of Protected Health Information (PHI)

I, _____ (name), _____ (date of birth) was provided a copy of Advanced Dermatology, P.A.'s Privacy Practices Notification. Advanced Dermatology may revise its notification at any time. I understand that a copy is always available at my request. By signing this document, I acknowledge that I have read, understand and agree to the terms of this consent. Further, I hereby consent and authorize Advanced Dermatology to use or disclose my PHI in conjunction with Advanced Dermatology treatment, payment or healthcare operations in accordance with the terms of consent.

Further, I hereby authorize and give my consent to Advanced Dermatology, P.A. to leave messages on my answering machine / voicemail for the following (check all that apply):

_____ Appointment Reminders

_____Medical Information

_____Prescription Refills

_____Test Results

I further authorize and give my consent to Advanced Dermatology, P.A. to communicate any of my PHI to the following persons:

Name	Relationship	Phone Number

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian (if patient is under 14) Date

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Medical History: Please list all medical problems you have had, such as cancers, heart attacks, strokes, infections, skin diseases, etc.

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

Consumption Of The Following:

Aspirin: Amt. Daily _____ Amt. Weekly _____

Alcohol: Amt. Daily _____ Amt. Weekly _____

Tobacco: Amt. Daily _____ Amt. Weekly _____

Review of Systems:

Any medical problems with any of the following (if yes, please explain):

☐ No ☐ Yes Head
☐ No ☐ Yes Eyes
☐ No ☐ Yes Ears, Nose Throat
☐ No ☐ Yes Thyroid
☐ No ☐ Yes Lungs
☐ No ☐ Yes Heart
☐ No ☐ Yes Blood or Blood Vessels
☐ No ☐ Yes Digestive System
☐ No ☐ Yes Liver
☐ No ☐ Yes Muscles, Bones
☐ No ☐ Yes Reproductive Organs
☐ No ☐ Yes Kidneys, Bladder
☐ No ☐ Yes Skin
☐ No ☐ Yes Bleeding Problems
☐ No ☐ Yes Local Anesthesia (Lidocaine or Xylocaine)
☐ No ☐ Yes Pregnant Now? If yes, Due Date _____ Physician _____

Family History: Please list any family history of medical problems.

	Medical Condition	**Family Member(s) Affected**
1.	Skin Cancer	
2.	Skin Disease (please list)	
3.	Other Cancer	
4.	Heart Problems	
5.	Asthma	
6.	Hay Fever	
7.	Other	

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MEDICAL INFORMATION

PATIENT NAME _____ DATE _____

FAMILY DOCTOR _____ REFERRING DOCTOR _____

RACE _____ AGE _____ MARITAL STATUS _____

I. Nursing History (To be filled in by the nurse)

Chief Complaint _____

_____

History of Present Illness: _____

_____

_____

_____

_____

II. Patient History (To be filled in by the patient)

	SURGERY	DATE
Previous surgeries or operations:	1. _____	
	2. _____	
	3. _____	
	4. _____	
	5. _____	

Medications you take now:

	NAME	DOSE	HOW OFTEN
1.	_____		
2.	_____		
3.	_____		
4.	_____		
5.	_____		

Allergies: List any medications you are allergic to:

1. _____ 3. _____

2. _____ 4. _____

List any other allergies (e.g. Hay Fever, Poison Ivy, etc.)

1. _____ 3. _____

2. _____ 4. _____

(Over)

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PATIENT INFORMATION FORM

Patient Name:_____ Date of Birth:_____

Address:_____ City:_____ State:___ Zip:_____

M/F:_____ SS#:_____ Phone:_____ Cell:_____

Person Responsible for Account:_____ Relationship:_____

Address:_____ City:_____ State:___ Zip:_____

Guarantor Email:_____ Guarantor Cell:_____

Employer:_____ Position:_____ Work Phone:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

INSURANCE INFORMATION

Primary Insurance:_____ Insured Name:_____

Relationship to Patient:_____ DOB:_____ Group#_____ Policy#_____

Address (If different):_____ City_____ State_____ Zip_____

Secondary Insurance:_____ Insured Name_____

Relationship to Patient:_____ DOB:_____ Group#_____ Policy#_____

Employer: Primary_____ Secondary:_____

Co-Pay Amount Primary:_____ Secondary:_____

PLEASE READ AND SIGN

I hereby authorize payment of medical benefits directly to physician of due me or my dependents for the services rendered. I further authorize the physician and/or supplier to release any information required to process insurance claims. I understand that I am responsible for any amount not covered by insurance. I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office any changes in my medical status.

Guarantor name (printed):_____ Signature:_____ Date:_____

I acknowledge receipt of the Notice of Privacy Practices form which details how Protected Health Information may be used and disclosed, and how I may access that information.

Guarantor name (printed):_____ Signature:_____ Date:_____

FOR INTERNAL OFFICE USE ONLY

An attempt was made to obtain written acknowledgment of receipt of the Notice of Privacy Practices on:_____

The acknowledgment was/was not obtained because: Patient declined to sign the acknowledgment_____

Other Reason:_____

Name of Patient_____ Staff Member_____ Date_____

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Thank you for choosing Advanced Dermatology, P.A., (John K. Sowell, M.D., Lon F. Raby, M.D., Patricia Wilson, M.D.), as your health care provider. We are committed to your successful treatment and preventive health care.

AUTHORIZATION OF TREATMENT AND TO RELEASE INFORMATION/ASSIGNMENT OF BENEFITS, AGREEMENT AND GUARANTY

I hereby authorize Advanced Dermatology, P.A. to provide me with reasonable and proper medical care in accordance with the standard of care at the time care is provided, including, but not limited to, office visits, surgical procedures and interpretation of pathological biopsies. I also authorize release of my illness and medical treatment by Advanced Dermatology, P.A.

I hereby authorize payment by an insurer directly to Advanced Dermatology, P.A. for all benefits payable under the terms of the insurance policy during the period of services rendered. Advanced Dermatology, P.A. accepts assignment of insurance benefits on some insurance companies. If arbitrary determination of a participating insurance company indicates that charges are cosmetic or not medically necessary, the patient/guarantor will be responsible for the outstanding balance. For insurance companies in which Advanced Dermatology, P.A. does not participate with; payment is due in full at the time of service. Please check with the registration clerk to confirm if your insurance is considered participating or non-participating. However, it is ultimately the responsibility of the patient/guarantor to understand if Advanced Dermatology, P.A. is a participating provider. Advanced Dermatology, P.A. will provide the patient/guarantor upon request, the claim form required to file with the non-participating insurances indicating that payment is due to the guarantor/patient. I understand that the insurance contract may not cover all charges for medical services. Three statements will be generated in the course of an outstanding balance. After which a final notice prior to collections will be mailed. Payment in full is expected on outstanding balances. If a payment plan is absolutely necessary, the terms and conditions will be deemed acceptable by Advanced Dermatology, P.A., not upon the financial plan determined by the client. I further understand that there will be a 55% charge added to the outstanding balance due, plus required postage, if the debt is referred to a collection agency for collection. If legal action is necessary, the associated fees assigned will be added to the fees incurred from medical treatment. Any person signing this agreement as "Guarantor" unconditionally agrees to fully pay charges (and, if appropriate, collection agency fees) owed by the above mentioned patient and remaining unpaid balance over thirty days after rendering service by Advanced Dermatology, P.A.

COPAYS and NON-PARTICIPATING INSURANCE

COPAYS and DEDUCTIBLES are due at the time of services. Those patients with NON-PARTICIPATING insurance companies are responsible to pay the balance accrued each service date after services are rendered.

APPOINTMENTS

Patients are seen on a scheduled appointment basis. Please make an appointment for all offices visits. Unless an appointment is canceled 24 hours in advance, Advanced Dermatology, P.A. may charge up to $200.00 for a missed appointment. This fee is not a billable charge to the insurance company; it is patient/guarantor responsibility.

I have read and understand the above policies.

_____ _____

Patient/Guarantor Date