GAUGHF
DERMATOLOGY

PATIENT DEMOGRAPHIC SHEET

Please PRINT when filling out this form
All information is kept confidential

First Name_____ Middle Name_____ Last Name_____

Address_____ City_____ State_____ Zip_____

SSN_____ Date of Birth_____ Age_____ Sex_____ Maritial Status_____

Home No._____ Work No._____ Cell No. _____
Would you like to receive text reminders for your appointments? ____ If yes, who is your cell phone carrier/provider?_____

E-mail Address_____
Would you like to receive email reminders about your appointments?_____

How did you hear about us? ☐Phone Book ☐Internet ☐Advertisement ☐Patient ☐Physician

Whom may we thank for referring you? _____

Emergency contact?_____ Relationship _____Phone No. _____

Primary Insurance Company_____ Policy Holder's Name (if not patient)_____

Relationship to the Patient_____ SSN_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Employer_____ Work No._____ Home No._____

*****PLEASE HAVE YOUR PHOTO ID AND INSURANCE CARD AVAILABLE FOR US TO COPY*****

Secondary Insurance Company_____ Policy Holder's Name (if not patient)_____

Relationship to the Patient_____ SSN_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Employer_____ Work No._____ Home No._____

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Test Results

May we leave test results on your answering machine/voice mail? _____ If no, you must call for test results.

Authorization:

I authorize Gaughf Dermatology, P.C. to disclose my healthcare and diagnostic information to the person(s) listed below.

Name_____ Relationship to Patient_____

Name_____ Relationship to Patient_____

I authorize release of any information concerning my (or my child's) health care, consultation and treatment to my referring physician and to others for the purpose of evaluating and administering claims for insurance benefits; this includes information related to psychiatric care, drug abuse and HIV/AIDS confidential information. I also authorize assignment of all medical/surgical benefits to Gaughf Dermatology, P.C. This assignment will remain in effect until I revoke it in writing.
I also authorize any treatment such as skin biopsies or other necessary procedures as necessary for my (or my child's) care.

Signature _____ Date _____

Please complete if the patient is a minor.

Responsible Party:

First Name_____ Middle Name_____ Last Name_____

Relationship to Patient_____

Address_____ City_____ State_____ Zip_____

SSN_____ Date of Birth_____ Sex_____

Home No._____ Work No._____ Cell No._____

Please list any persons who are authorized by you to bring the child into the office for treatment.

Name_____ Relationship to Patient_____

Name_____ Relationship to Patient_____

Signature of Legal Guardian_____ Date_____

OFFICE POLICIES

Thank you for choosing Gaughf Dermatology for your dermatological care. Dr. Gaughf graduated from the Medical College of Georgia, where she also completed her residency in Dermatology. She completed two years of Internal Medicine residency at Mercer University. Dr. Gaughf is Board Certified in Dermatology and is a member in good standing with the American Academy of Dermatology.

The information below is designed to guide you through the rapidly changing world of medicine and managed care. We have developed many of the following policies in response to these changes in the medical delivery system, however we will always remain dedicated to preserving quality of care in medicine.

We will require full payment at the time of service for all self pay patients. Co-pays and deductibles are due at the time of service for those insurance plans with which we are contracted. For those plans we are not contracted with, we will gladly file the insurance claim. Once payment has been received for the carrier a refund well be processed if one is due. Please contact your health insurance company for more information about out-of -network reimbursement. If you're medical problem is of a non-emergency nature and you are unable to remit, we respectfully request that you reschedule.

We accept Cash, Check, VISA, MasterCard, American Express, Discover Cards and Care Credit. Two party checks are not accepted.

Office Hours

Normal office hours are Monday -Thursday from 8:30am to 4:30pm and on Friday from 8:30am -12:30pm.
The after-hours phone number is for established patients that are experiencing an emergency and require immediate attention only.

Physician Assistants

Gaughf Dermatology utilizes physician assistants to provide physician services delegated in accordance with state law. A physician assistant is a skilled healthcare provider who is licensed to a supervising physician and who is qualified by academic and practical training to provide patients services not necessarily within the physical presence but under the personal direction or supervision of the supervising physician.

Office Visits

Due to high patient demand, problems and procedures including skin cancer surgery are limited to one or two per visit. In some cases you may have to schedule an appointment for a procedure.

When the Doctor is away

From time to time the doctor will be away continuing her education so she can provide the best quality care. Another physician will be covering emergencies only.

Appointment Confirmation Calls

As a courtesy to our patients, appointment reminder calls will be made 2 days before a scheduled appointment, to the telephone number provided. If you do not wish to receive a reminder call, please notify the receptionist.

Missed Appointments

Missed appointments causes unnecessary expense and increased overhead for our office. If you can't make your appointment please notify us 24 hours in advance. If you miss 3 consecutive appointments, then we will ask you to seek dermatological care elsewhere. All missed appointments, not canceled 24 hours prior to the appointment time will be charged a $50.00 missed appointment fee which must be paid prior to rescheduling your appointment.

Initial_____

Emergency Appointments
If you have an emergency problem we will work you in to address that emergency problem only. We will be happy to schedule you a follow up appointment for further evaluation of your skin.

Medicaid
We do not participate with Georgia Medicaid. If you have Georgia Medicaid you will be considered as a self-pay patient.

Test Results/Refill Request
Please allow 10-12 days for Pathology results. We will attempt to call every patient with these results. Certain results may require an office visit. If this is the case an appointment is necessary. Request for refills prior to one hour of closing will not be processed until the next business day. Your refill request may require an appointment because we don't authorize refills if you haven't seen the doctor within six months. If your request requires an office visit we will work you in as soon as possible.

Collections
Any account that is past due by 60 days will be charged a $3.00 rebilling fee. Any account that is past due 120 days will be assigned to a collection agency. Any patient requiring co1lections action will be discharged from this practice and must seek their care elsewhere.

I hereby agree that if my bill has to be turned over to a third party collection agency for non-payment, there will be a collection fee added to my bill of 33%. This is pursuant to Georgia Statutory Law "O.C.G.A.-13-1-11"

All return checks, will be assessed a $35 penalty and payment must be made within 10 days.

Patient Confidentiality
It is our policy to adhere to all Health Insurance Portability & Accountability *Act* of 1996 (HIP AA) regulations, including Protected Health Information (PHI). It is not our policy to discuss your healthcare / diagnostic and/or accounting information with anyone other than yourself. If you would like an authorization to be kept on file releasing such information to someone other than yourself, please notify the receptionist.

Minor Children
Minor children (under 18yrs of age) must be accompanied by a Legal Guardian. If the Legal Guardian cannot accompany the minor, the person accompanying (name must be listed on letter) with the child must have a notarized letter from a legal guardian giving permission for Dr. Gaughf to treat the child when they cannot be present.

Cosmetic
Complimentary cosmetic consultations are available with a member of our staff, however if you wish to schedule with Dr. Gaughf there is a $75.00 fee. Insurance companies generally do not pay for cosmetic services. If you desire to have a cosmetic procedure, then you will be expected to pay at time of service.

Insurance
We do accept assignment of benefits from insurance carriers. However many insurance company have restrictive payment rules. I understand that I am financially responsible for all charges, whether or not paid by said insurance company. We are not a provider for Medicaid.

No refunds on products purchased
Gaughf Dermatology will not issue a refund on products purchased.

Initial_____

Laboratory and Pathology Charges
We use outside laboratories for blood work, x-rays, and examination of specimens. We do not bill for their professional services. You may receive a separate bill from these labs. If you have a question regarding the bill, please contact the laboratory directly.

Self Pay Patients
Self pay patients will be asked to provide a $100 deposit before being see by the provider. The total cost of services rendered will be due at check out. There is a $80 pathology fee for every biopsy in addition to the office procedure.

No Show Policy
If you do not show or fail to cancel a scheduled appointment a $50 deposit is required to reschedule the appointment. The deposit will be applied to any copay, deductible or co-insurance charges associated with the visit. Any remainder of the deposit will be refunded after the appointment is completed. If you fail to keep the appointment the deposit is not refundable.

All patients are allowed direct access to a dermatologist without going through a referral by Georgia Open Access Law. If you have any questions or problems with your insurance carrier please contact our billing department at (912) 354-7124 EXT 5004

**** BY SIGNING BELOW I ACKNOWLEDGE THAT I WILL ABIDE BY THE OFFICE POLICIES****

Print Name:_____ Date: _____

Signature: _____ Date: _____

Medicare Patients Only
I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or related Medicare claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignments. Regulations pertaining to Medicare assignment of benefits apply.

Signature: _____ Date: _____

Medigap Patients Only
I request that authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine benefits.

Signature: _____ Date: _____

GAUGHF DERMATOLOGY

Patient Consent for Use and Disclosure of Protected Health Information (HIPPA)

I hereby give my consent for Gaughf Dermatology, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations. (TPO)

Gaughf Dermatology, P.C. Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I acknowledge receipt of Gaughf Dermatology, P.C. Notice of Privacy Practices.

With this consent, Gaughf Dermatology, P.C, may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including but not limited to laboratory results.

With this consent, Gaughf Dermatology, P.C. may mail and or send faxes to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Gaughf Dermatology, P.C may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Gaughf Dermatology, P.C restricts how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Gaughf Dermatology, P.C use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Gaughf Dermatology, P.C may decline to provide treatment to me.

** Gaughf Dermatology
, P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by requesting a copy from the practice.

This Consent was signed by:

Signature of Patient or Legal Guardian _____

Name of Patient (Please Print) _____

Date Signed_____

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Destruction of Lesions

You may have a lesion that requires destruction. Lesions treated with freezing (cryosurgery) or burning (electro-surgery) will take approximately 1 to 2 weeks to heal., however the redness can last longer.

Treatment of Age Barnacles (Seborrheic Keratosis) and/or Age Spots (Lentigo) is considered cosmetic and will not be covered by insurance. Additional fees for these treatments are due at the time of services.

However, if the diagnosis is a pre-cancerous skin condition, treatment is considered medically necessary.

Treatment with Cryosurgery may result in any of the following:

1. Hypopigmentation
2. Hyperpigmentation
3. Scarring

Consent for Cryosurgery and/or Electro-surgery

Patient Name_____

Patient Signature_____

Date Signed_____

Witness_____

GAUGHF DERMATOLOGY

Dermatology Medical History

Patient Name_____ Date of Birth_____/____/_____ Today's Date___/___/___
Reason for today's visit_____
Primary Care Physician _____
Are you allergic to any medications?___ Yes___ No If yes please list:_____
Have you ever had Dental anesthesia (Novacaine)?___ Yes___ NO Any bad reaction?___ Yes___ No
List all medications you are currently taking including prescriptions and over the counter medications ,vitamins and herbals.
1._____ 2._____ 3._____4._____
5._____ 6._____ 7. _____8._____
Do you have now, or have you ever had any diseases or conditions? Please check yes or no.

Lungs:

Bronchitis	___YES___NO
Emphysema	___YES___NO
Asthma	___YES___NO
Chronic Cough	___YES___NO
Morning Cough	___YES___NO
Shortness of Breath	___YES___NO
Wheezing	___YES___NO

Other Systemic:

Diabetes	___YES___NO
Excessive thirst/hunger	___YES___NO
Amputation	___YES___NO
Thyroid	___YES___NO
Kidney	___YES___NO
Dialysis	___YES___NO
Bladder	___YES___NO
Urinary Burning/Frequency	___YES___NO

Cardiovascular:

High Blood Pressure	___YES___NO
Chest Pain	___YES___NO
Heart Attack	___YES___NO
Heart Murmur	___YES___NO
Irregular Heartbeat	___YES___NO
Phlebitis	___YES___NO
Inflammation of Vein	___YES___NO
Blood Clots	___YES___NO
Pacemaker	___YES___NO
Artificial Heart Valve	___YES___NO

Gastrointestinal:

Stomach absorptive Disorder	___YES___NO
Nausea,Vomitting,Diarrhea when taking antibiotics	___YES___NO
Yeast Infection when taking antibiotics	___YES___NO
Arthritis/Joint Deformity	___YES___NO
Arthralgia	___YES___NO
Limited Motion	___YES___NO
Artificial Joint	___YES___NO
Convulsions, Epilepsy Seizures or Fainting	___YES___NO

List any other diseases or conditions._____
List any surgical procedures within the last 6 months._____

Skin Issues:

Have you ever had skin cancer? ___YES___NO Has anyone in your family had skin cancer? ___YES___NO
Do you ever had a skin disease? ___YES___NO Do you have problems with healing? ___YES___NO
Do you develop keloids (scars) after surgery?___YES___NO Do you bleed easily? ___YES___NO
Do you develop skin rashes in reaction to____ Medication ____Food____Environment____Bandages____Neosporin____Other

Social History:

Do you drink alcohol? ____ YES____ NO If YES # _____ Drinks per day/week/month
Do you use IV Drugs? ____YES ____NO If YES, what?_____ How often?_____
Do you smoke? ____YES____NO If YES, how may packs per day?_____
Have you been exposed to HIV or AIDS? ____YES____NO
What is your occupation? _____Hobbies?_____

We recommend that a yearly full body exam is done. This includes the genital area as well. Many Melanoma or other skin cancers can be present without the patient knowing it is there. If you desire a complete skin exam or a sun exposed areas only skin exam please notify the medical assistant. Those at high risk are fair skinned, have moles, family history of melanoma and much sun exposure or are immunosuppressed.

Patient/Guardian Signatue_____ Date_____Provider Signature _____