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: _____ _
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
Wheezing	YES	NO
Morning Cough	YES	NO

OTHER SYSTEMIC

Diabetes	YES	NO
Urinary Burning/Frequency	YES	NO
Amputation	YES	NO
Thyroid	YES	NO
Kidney	YES	NO
Dialysis	YES	NO
Bladder	YES	NO

CARDIOVASCULAR

High Blood Pressure	YES	NO
Artificial Heart Valve	YES	NO
Heart Attack	YES	NO
Heart Murmur	YES	NO
Irregular Heartbeat	YES	NO
Phlebitis	YES	NO
Inflammation at Vein	YES	NO
Blood Clots	YES	NO
Pacemaker	YES	NO

GASTROINTESTINAL

Stomach absorptive disorder	YES	NO
Nausea, Vomiting, 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. _____

OTHER SOCIAL HISTORY:

Do you drink alcohol? ___YES ___NO If YES# _____Drinks per day/week/momh
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? _____

If you desire a complete skin exam or a sun exposed areas only, please notify the medical assistant Those at high risk are fair skinned, have moles, family history of melanoma and much sun exposure or are immmiosuppressed.

Patient/Guardian Signature _____ Date _____

Physician/Provider Signature _____

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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_____ Marital Status _____

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

E-mail Address _____

Emergency contact? _____ Relationship _____ Phone No._____

Please complete if the patient is a minor (Guarantor Information)

First Name _____ Middle Name_____ Last Name _____

Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

SSN _____ Date of Birth _____ Age_____ Sex_____ Marital Status _____

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 _____

NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature _____ Date _____

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

___ An emergency existed and a signature was not possible at the time.
___ The individual refused to sign.
___ A copy was mailed with a request for a signature by return mail.
___ Unable to communicate with the patient for the following reason _____
___ Other: _____

Prepared by _____ Signature _____ Date _____

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

Communications between Patients and their Family, Friends, or Caregivers

This form allows **Gaughf Dermatology** to communicate information about your care (e.g., appointments, labs, medication, treatment plans, billing information) to you and those you list on this form. Signing this form is optional, is not required to receive treatment, and does not expire until you end it in writing.

Patient Name: _____

Date of Birth: _____ Main Contact Number: (___) _____

Mailing Address: _____

_____

COMMUNICATING WITH YOU

PHONE Mobile (____) _____ Home (____) _____

Work (____) _____

EMAIL _____

☐ All information from this practice ☐ Billing/insurance information

☐ Appointment information only (request/confirm/cancel)

COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS

☐ This practice may communicate to the family members, friends, or caregivers listed below.

Spouse/Partner: _____

Phone: (_____) _____

Email:* _____

Other: _____

Phone: (_____) _____

Email:* _____

Relationship: _____

Check the box next to each type of information this practice may share.

☐ All information ¨ Prescriptions ¨ Appointments (request/confirm/cancel) ¨ Billing/Insurance ¨ Results

☐ Other: _____

Do not include:

☐ Mental health records ☐ Communicable diseases (e.g., HIV/AIDS) ☐ Alcohol/drug abuse treatment

*I understand that emails and texts are not always secure ways to communicate and could be intercepted and read by a third party. I am willing to accept this risk.
This practice is not responsible for the privacy or security of your health information once it is sent to you, or the recipient(s) listed above.

☐ Photos are used internally for diagnostic and treatment purposes

Signature _____

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CONSENT TO CLINICAL PROCEDURES

Patient Name _____ **Date of Birth** _____

I hereby consent to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. This may include but is not limited to laboratory procedures (including diagnostic testing such as lab draws and skin biopsies), medical and surgical treatment or procedure (including cryosurgery (freezing), curettage (scraping), electrodesication (cautery), shave removals or biopsies, or other services rendered during my visit with Gaughf Dermatology, or its affiliated practices ("Gaughf Dermatology").

In order to ensure that you understand all aspects of your visit, you are encouraged to ask any questions or clarify any procedures prior to them being performed. Our dermatology providers will answer any questions and discuss any procedures, concerns and goals with you in regard to the following:

- Benefits of the proposed procedure.
- The way the treatment or procedure is to be performed.
- Alternative treatment options.
- Probable consequences of not receiving the treatment.
- The right to withdraw informed consent at any time, in writing.
- Risk and side effects involved with the procedure.
- Potential for additional incurred charges.

Should a biopsy be performed, or any other procedure in which a section of your skin is removed, the specimen will be sent to a pathology lab for an accurate diagnosis. You will receive a separate bill from the laboratory or from our office.

I acknowledge that some medlcal diagnoses (such as warts) will require multiple treatments with one or more methods that may change throughout the course of treatment and each office visit and procedure will be billed accordlngly.

With any procedure, there are risks involved which include, but are not limited to the following:

- Scar - Scarring is possible with any procedure of the skin. We will do everything we can to provide you with the best cosmetic result possible, but the final cosmetic outcome is not guaranteed. This includes also a chance of hypopigmentation, hyperpigmentatlon.
- Infection - The entire procedure wlll be done in a sterile and/or clean fashion. Still, a small number of people will get a wound infection.
- Bleeding - Some procedure may create some bleeding. Rarely will someone have significant bleeding after they leave such that they would have to come back to have us treat it.
- Nerve damage - Numbness or parasthesias can occur with biopsies, excisions, cryosurgery, or electrodessication.

Cryosurgery (freezing) or **Electrodessication** (cautery) may be used for destruction of lesions. These areas usually heal within 1-2 weeks but the redness or pigmentation may last longer. This may be used to treat actinic keratoses (precancers) or seborrheic keratoses (age barnacles) or other age spots and other lesions. Treatment with cryosurgery or electrodessication may result in

- Scar
- Hypopigmentation or hyperpigmentation
- Nerve damage or parasthesias

I acknowledge the risk of becoming infected with Covid 19 or other virus before, during, or after my visit or treatment. This may lead to extended quarantine (self isolation), hospitalization, and risk of other health complications.

I have read the consent form in its entirety. I understand the risks associated with procedures that may occur during my visits at Gaughf Dermatology. I do not impose any limitations on Gaughf Dermatology and its staff. I understand that I should discuss any questions or concerns with my dermatology provider prior to any procedure and therefore, with my signature, agree to have any necessary procedures performed.

Patient Signature _____ **Date** _____

The undersigned hereby provides consent as the parent or guardian of the above referenced minor patient

Parent or Legal Representative Signature/Date _____

Relationship to Patient _____

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Have you ever been seen by a dermatologist? (please circle). YES NO

If YES, please complete this form to give us permission to obtain your records.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

By signing this form I authorize the release of confidential health information about me or my dependent, by releasing a copy of the patient medical records, or a summary or narrative of the patients protected health information.

I authorize the information to be released **FROM**:

Name of Organization _____

Address _____

Phone _____ Fax: _____

THIS INFORMATION WILL BE RELEASED TO:

Gaughf Dermatology

639 Stephenson Avenue

Savannah, GA 31405

Phone: 912-354-7124 Fax: 912-353-8944

The information you may release subject to this signed release form is as follows:

___Entire Record ___ Pathology report ___Visit Notes

I understand that I have a right to cancel or revoke this authorization at any time. I understand that if I cancel or revoke this authorization, I must do so in writing and present my written cancellation or revocation to the Health Information Services Department (Medical Records). I understand that the cancellation or revocation will not apply to information, which has already been released in response to this authorization as stated in the Notice of Privacy Practice. Unless otherwise cancelled or revoked this authorization with expire/ end 90 days from this date.

I understand that a reasonable, cost-based fee for copies of protected health information and postage fees will be charged. I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment I understand I may review and or copy the information to be disclosed. I understand that any disclosure of information carries with it the possibility of unauthorized disclose by the person or organization receiving the information. If I have questions about the disclosure or use of my protected health information, I may contact the HIPAA coordinator.

Printed Name of Patient or Legal Guardian _____ Date of Birth _____

Date _____ Signature _____

Medical Records Charge _____

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FINANCIAL POLICIES

The following are internal policies set in place by Gaughf Dermatology, and its affiliated practices ("Gaughf Dermatology"). Signature is required before services can be provided. Gaughf Dermatology is unable to accept any revisions to this form and any attempted changes shall be null and void.

Insurance Filing: As a courtesy we will bill your insurance company for charges incurred at our clinic. Please remember your health insurance is a contract between you and your insurance company. Our office will make two attempts to settle any outstanding bill with your insurance company. If your insurance deems a service to be not covered by your insurance plan you agree to be responsible for the balance of this service. Claims not paid by your insurance carrier within 90 days will be considered a non-covered service. We will furnish information required by the insurance company to receive payment. Benefits should be paid directly to the Practice from your insurance company. If your insurance company reimburses you directly for any outstanding amounts due to us, payment will be expected by us within 10 days. I hereby assign to Gaughf Dermatology all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits. I understand it is my responsibility to know my dermatological benefits provided by my insurance company.

Bad Debt Account Status: I realize that if my account is in bad debt, I will be required to pay the full balance prior to being seen or scheduled.

Financial Responsibility: A $ 50.00 charge will be added for any non-sufficient funds notice from the bank. I understand and agree that I will be responsible for all legal fees and other costs of collection if my account is turned over to an attorney or agency for collection in which case your visit/s with our office may become a matter of public record.

Missed Appointments: If you can't make your appointment, please notify us 24 hours in advance. All appointments not cancelled 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.

Medicaid: We do not participate with Medicaid.

Non-Insured Patients: Non-insured patients will be required to pay in full at time of service.

Co-payments, Co-Insurance, Deductible, & Cosmetic Procedures: All copayments and deductibles are due on the date of service. These are estimates and additional charges may be billed. If you have a deductible and are having a procedure you may ask what the approximate fee is before having the procedure done. Payment for a cosmetic procedure is due in full on the day of service. There are no returns on cosmetic products sold unless such products are defective or, in the opinion of your provider, caused an adverse reaction. Insurance companies do not pay for cosmetic procedures. There is a $75.00 consultation fee for our providers to discuss cosmetic procedures. A deposit is required to schedule with the esthetician for spa services. These fees will be applied to any services or products purchased.

Parent or Legal Representative Signature/Date _____

Date of Birth _____ Relationship to Patient _____

Date _____ until revoked