INTAKE AND HISTORY FORM

Last name:_____ First Name:_____ M.I_____ Date:_____

Address: _____ Apt/Suite:_____ City:_____ Zip:_____

Primary Phone#:_____ Secondary Phone#:_____

DOB: _____ Sex: M F N/A Marital Status: S M D W

Email Address:_____

Emergency Contact and Number:_____

Allow Emergency Contact Person access to medical information: Yes No

Primary Care Physician:_____

Phone#:_____

Location:_____

Pharmacy Name:_____

Phone#:_____

City or Zip Code:_____

Current
Medications:_____
_____
_____
_____

List any allergies and reactions if
known:_____
_____

Past Medical History (please circle any of the following conditions you currently have)

AF- Atrial Fibrillation	ESRD- End Stage Renal Disease	Radiation Treatment
Anxiety	Thyroid Disorder	Renal Failure
Arthritis	Hypertension	COPD
Autoimmune Disease	Heart Murmur	HIV
Bronchitis	Hepatitis	COVID-19
Diabetes	High Cholesterol	Keloid
Organ Transplant	Epilepsy	Cancer:_____
	NONE	

Skin Disease History (please circle)

AK-Actinic Keratoses	Mask of Pregnancy	Psoriasis
Acne	Rosacea	Itchy Scalp
Allerigic Contact Dermatitis	Seborrheic Dermatitis	Eczema
Atypical Nevus	Squamous Cell Carcinoma	Basal Cell Carcinoma
Malignant Melanoma	Wart Virus	Other:_____

Do you have a family history of melanoma?: Y N Relative:_____

Any previous dermatologists? Y N Dermatologist's name:_____

(Women) Are you currently pregnant or breastfeeding? Y N

Smoking (please circle): Current Smoker	Non-Smoker	Prior Smoker
Alcohol use (please circle): Non-drinker	Occasional	Daily

Patient Name: _____ DOB: _____

PLEASE READ/INITIAL EACH ITEM BELOW on the blank line on the left to acknowledge that you have read and understand our office policy regarding payments that are the responsibility of the patient.

_____For patients with no insurance coverage, payment is due at the time of service. We accept cash, checks, Visa/Mastercard/Discover/American Express, and Care Credit.

_____We will bill your insurance carrier for all medical services if you are covered by a plan that we are in network with. You are required to pay for all co-payments and deductibles at the time of your visit.

_____For amounts due after your insurance has processed your claim (such as for your deductibles not yet met for the year), our billing company, MODERNIZING MEDICINE, will mail you two consecutive statements at 30 day intervals. Please ensure you have given us the name and address of the person responsible for your bills.

_____You have 30 days after the second statement/bill is sent to pay the full balance as indicated on the statement itself. If no payment is received, you will then receive a phone call from MODERNIZING MEDICINE (800-300-7819). If no payment is then received, your account may be forwarded to our local collection agency and credit bureau for further action.

_____I have provided all the necessary billing information: updated/active insurance card(s), billing address, and best contact/working telephone number.

_____I understand that as the patient, it is my responsibility to notify the office of Dr. Joy Chastain of any changes to my contact information such as mailing address (for billing purposes), and contact information (best/working telephone numbers).

_____I understand that the office of Dr. Joy Chastain does not set up payment plans for patients with outstanding balances. For patients who wish to pay off their balances over several months, we accept Visa/Mastercard/Discover/American Express, and Care Credit.

Your signature below signifies that you have read and initialed each line, and that you understand your financial responsibilities.

_____ _____

Signature of Patient/Guardian Date

Financial Policy

Insurance

We cannot file your insurance unless all of your insurance information is given at the time of your visit. It is therefore necessary for us to have a **current copy** of your insurance card for accurate billing. It is recommended that you educate yourself about your individual benefits by contacting your insurance company before being seen. Knowing if you have a deductible for procedures and medications is most helpful to you and your provider. You will be responsible for your portion of the charges, including those for copays, and cosmetic fees at the time of service. If your insurance company has not paid a claim within 60 days, you may receive notification in the mail requesting your assistance in determining if there is a problem, or if additional information is required in processing the claim. It is therefore also essential that we have the correct/updated address for the person responsible for your bill. Remember, if you have a deductible you are responsible for all procedures until that specific medical deductible amount is met.

Authorization of Payment and Release of Information

I request payment of authorized insurance benefits be paid to Joy B. Chastain, M.D., PC, and authorize release of medical information to determine payable benefits for services rendered.

Non-Covered Services

There are a number of services we provide that are considered cosmetic by your insurance company. These are policies enforced by the insurance companies and are out of our control. For example, removal of some benign growths such as skin tags and blackhead/whitehead/oil gland removal are not medically necessary. Full payment for all non-covered services must be made at the time of your visit.

Referrals

Since we are a dermatology office in the state of Georgia, referrals are not usually required. If your insurance company does require a referral, it is solely your responsibility to obtain a current referral for office visits. A valid referral must be received at 48 hours prior to your appointment, or you may be asked to reschedule.

Labs

If you are aware that your insurance carrier requires you to utilize certain labs for bloodwork or wound cultures, or biopsies you must inform your nurse. There are charges related to the laboratory itself, and these charges are separate from our office charges. Our office sends a copy of your insurance cared with the specimen to the outside facility. You will receive an explanation of benefits (EOB) from your insurance carrier.

Unless otherwise notified, your biopsy specimen will be processed by the Dermatopathology department of Skin Cancer Specialists, PC. Each biopsy specimen will be examined in a full service laboratory by one of two Board Certified Dermatopathologists. Your wound cultures and bloodwork will be processed by
either Labcorp, Quest, or Piedmont Athens Regional. As a result, you will receive two statements – one for your office visit from us and one for laboratory services.

No Shows/Same Day Cancellation

As a courtesy, we use outside service in attempts to contact every patient to remind them of their appointment. This is done by phone, text, or email. It is therefore important that you give us your updated and correct contact information. However, it is your responsibility to arrive for your appointment on time. Cancellations must be received greater than 24 hours in advance. Patients who no-show or cancel his or her appointments with less than a 24 hour notice are documented in our system. If we notice this has occurred more than once, we may not reschedule you or may require that you pay a refundable deposit of $50 in order to schedule any future appointments. Patients who repeatedly no show appointments may be terminated from the practice. This charge cannot be billed to your insurance company. This charge will be held until the claim for services rendered is paid in full by your insurance company, and any amount left over will be refunded to you. The $50 will not be refunded for no-shows or same day cancellations.

Cosmetic Deposits

A non-refundable cosmetic deposit may be required for certain services that require multiple appointment times. (These include permanent makeup, Sclerotherapy for leg veins, and laser hair removal on extensive areas on the body). Cancellations must be received no less than 48 hours in advance. Patients who no-show or cancel his or her appointment with less than a 48 hour notice may forfeit their deposit.

Accepted Forms of Payment

For your convenience, we accept checks, cash, Visa/Mastercard/American Express/Discover, and Care Credit. You must be given a printed receipt for all cash payments.

Signature: X _____ Date: _____

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes

- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations

- Disclosures that constitute a sale of PHI under HIPAA

- Other uses and disclosures not described in this notice

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.

The right to inspect and copy your PHI.

The right to amend your PHI.

The right to receive an accounting of disclosures of your PHI.

The right to obtain a paper copy of this notice from us upon request.

The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of September 1, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer Katie Smith (706-543-1335) for more information, in person or in writing.

Your Signature Below Signifies That You Have Read And Understand The Notice of Privacy Practices of Joy B. Chastain, M.D., P.C.

Patient Name:_____

Parent/Guardian/Other:_____

Signature:_____

Date:_____