Cahaba Dermatology
skin health center
Vlada Groysman, MD, FAAD

New Patient Visit Intake Packet
Medical, Patient, & Family History

Patient Name: _____ Birth Date: _____ Patient ID#_____

Referring Physician: _____ Primary Care Physician: _____

+++++ Make corrections on form and alert staff for any pre-filled information that is incorrect +++++

Patient Information

PLEASE PROVIDE FULL LEGAL NAME. PLEASE NOTE: PRESCRIPTIONS WILL BE CALLED IN UNDER YOUR LEGAL NAME

Full Mailing Address :				
Date of Birth:	Age:	Gender:		Email:
Home #:		Work #:		Cell #:
Occupation:		Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed		
Primary Language:			Race:	

Patient Medical Insurance

Primary Insurance (Complete or Review Insurance information)

Primary Insurance (if blank complete below):		
Insurance Address (see back of card):		
Insured ID#	Insured Group#	
Relationship to Policy Holder: ☐Self ☐Spouse ☐Child/Dependent ☐Other_____		
Complete Policy Holder Info below if **not** Self		
Name:	DOB:	SSN:

Secondary Insurance (Complete or Review Insurance information)

Secondary Insurance (if blank complete below):		
Insurance Address (see back of card):		
Insured ID#	Insured Group#	
Relationship to Policy Holder: ☐Self ☐Spouse ☐Child/Dependent ☐Other_____		
Complete Policy Holder Info below if **not** Self		
Name:	DOB:	SSN:

Appointment No-Show, Change & Cancellation Policy

Cahaba Dermatology strives to provide the highest level of patient care and respect patient's time in our office. Overscheduling is a practice in medicine to limit cost of no-show and cancellations, but leads to longer wait times. Our office does not overschedule our clinic and therefore will require **24 hrs** notice to change or cancel an appointment. Patients arriving more than 30 min after appointment start time may not be admitted to clinic and considered no-show. This policy allows our office to function with efficiency and provide the best care to all of our patients.

Following conditions will result in a $35 fee charged to patient account. Fee will be $100 for surgery appointments, $250 for vulvar clinic appointments:

- Patient fails to show for an appointment
- Patient arrives more than 30 min late and not admitted to clinic
- Patient cancels or changes appointment with less than 24-hrs notice and appointment slot cannot be filled

Please Initial to communicate acceptance of this policy Patient Initials _____

Pharmacy Information

Provide as much information as possible to ensure prescriptions are sent to correct pharmacy

Pharmacy Name: _____

Pharmacy Address/Location: _____

Phone number: _____ Fax number: _____

Reason for Today's Visit

To provide our patients with excellent care we request you limit visit concerns to one chief complaint. Alert staff immediately if you need to have records sent to our office from another physician.

Cosmetic consults will require a separate cosmetic consult appointment.

Concern: _____ Location: _____

Prior Treatments: _____ Complications: _____

Additional Information: _____

_____

_____

_____

Current Medications

Medication Name _____ Medication Name_____

Medication Name _____ Medication Name_____

Medication Name _____ Medication Name_____

Do you have any medication allergies? □ yes □ no If yes List_____

Past Medical History

Latex Allergy	□ yes	□ no	Bleeding Disorders	□ yes	□ no	Poor Wound Healing	□ yes	□ no
Lupus	□ yes	□ no	Adhesive Tape Allergy	□ yes	□ no	Heart Disease	□ yes	□ no
Arthritis	□ yes	□ no	Anticoagulant Treatment	□ yes	□ no	Kidney Disease	□ yes	□ no
Psoriasis	□ yes	□ no	Bacitracin Allergy	□ yes	□ no	Thyroid Disease	□ yes	□ no
Hepatitis	□ yes	□ no	Artificial Heart Valves	□ yes	□ no	Hypertension	□ yes	□ no
MRSA	□ yes	□ no	Pacemaker / Defibrillator	□ yes	□ no	High Cholesterol	□ yes	□ no
Diabetes	□ yes	□ no	Mitral Valve Prolapse	□ yes	□ no	Pre-Dental Antibiotics	□ yes	□ no
Eczema	□ yes	□ no	Immunosuppressed	□ yes	□ no	Epinephrine Allergy	□ yes	□ no
Asthma	□ yes	□ no	Organ Transplant	□ yes	□ no	Neosporin Allergy	□ yes	□ no
HIV Positive	□ yes	□ no	CCL Chronic Leukemia	□ yes	□ no	Artificial Joint	□ yes	□ no
HSV / Cold Sore	□ yes	□ no	Memory Problems	□ yes	□ no	Pre-op Antibiotics	□ yes	□ no
Hay Fever	□ yes	□ no	Fainting / Syncope	□ yes	□ no	Abnormal Scars	□ yes	□ no
			Local Anesthetic Allergy	□ yes	□ no			

Skin Cancer History

Do you have a history of melanoma? □ yes □ no

Do you have a history of other skin cancer(s)? □ yes □ no If so, what types?_____

Do you have a **family history** melanoma? □ yes □ no If so, list relation _____

Do you have a **family history** of other cancer(s)? □ yes □ no If so, what types?_____

Social History

Do you use tobacco? □ yes □ no If yes, list all types:_____

Recreational Drug Use □ Yes □ No If Yes, Specify:_____

Alcohol consumption? □ None □ Socially □ Moderate □ Heavy

Do you use sunscreen? □ None □ Daily □ Occasionally □ Never

Tanning Bed Usage? □ Never □ Currently Using □ Previously Used

Additional Symptoms

Easy Bruising □ yes □ no Shortness of breath □ yes □ no Fever □ yes □ no

Weight Loss □ yes □ no Nausea/Vomiting □ yes □ no Anxiety □ yes □ no

Headache(s) □ yes □ no Abdominal Pain □ yes □ no Fatigue □ yes □ no

Blood Clots □ yes □ no Swollen lymph nodes □ yes □ no Joint Pain □ yes □ no

Eye Irritation □ yes □ no Constipation □ yes □ no Rash/Itch □ yes □ no

Chronic Cough □ yes □ no

Women' s Only History

Are you pregnant? □ yes □ no Are you breastfeeding? □ yes □ no

Are you on birth control? □ yes □ no

Do you have regular menstrual cycles? □ yes □ no

Skin Care Regimen

Tell us about your skincare regimen...

AM Routine:

Cleanser: _____

Prescription Products: _____

Facial Day Cream/Serum: _____

Sunscreen: _____

Other: _____

PM Routine:

Cleanser: _____

Prescription Products: _____

Facial Night Cream/Serum: _____

Other: _____

Let us know if you're interested...

Spa/Skin Care	Cosmetic Dermatology	Laser & Energy
☐ Acne Blue Light	☐ Broken Blood Vessels	☐ GentleMax® Laser Hair Removal
☐ Facial / HydraFacial MD®	☐ Botox® Injectable Cosmetic	☐ PicoWay® Laser Tattoo Removal
☐ Sunscreen Advice	☐ Injectable Filler Cosmetics	☐ miraDry® Problem Sweat Treatment
☐ Chemical Peels	☐ Age Spots/Brown Spots/Rosacea	☐ $C0^2$ Laser Rejuvenation
☐ Latisse	☐ Vein Treatment	☐ Photo facial/IPL Laser Treatment
☐ MicroNeedling	☐ Sculptra® Cosmetics	☐ Ematrix® Sublative Resurfacing
☐ Platelet Rich Plasma	☐ Cosmetic Consultation	☐ Photo facial/IPL Laser Treatment
☐ Skin Care Products	☐ Excessive Sweating	
Other Spa: _____	Other Cosmetic:_____	Other Laser: _____

How did you hear about our office? _____

Primary Care Physician: _____

What would you like to Improve?_____

_____

_____

HIPPA Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice (copy available upon request) before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used and disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have made on reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understand that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

Do you give us permission to discuss your medical record with anyone? (specify name, DOB, and relationship):

Name:_____DOB:___/___/___Relationship:_____

Name:_____DOB:___/___/___Relationship:_____

Name:_____DOB:___/___/___Relationship:_____

Signature:_____Date:_____

Relationship to the patient (if other than patient):_____

Patient Consent to Treatment & Financial Responsibility

I am at least 18 years of age or, if not, I am accompanied by a legal guardian. I hereby consent to and authorize an examination by my doctor and such assistant or staff as may be assigned by the physician. I authorize Cahaba Dermatology & Skin Health Center, LLC to fax my records to any physician or pharmacy for the purpose of coordinating or managing my healthcare. We have contracts with many insurance companies to accept assignment of benefits for our services. In order to do this we must have a valid insurance card and a driver's license or other legal form of identification at the time of the visit or you will be charged as a private pay patient and charges for your visit will be your complete responsibility. You are responsible for knowing your insurance coverage and benefits. Insurance coverage varies from plan to plan. Cahaba Dermatology will not waive your financial responsibly if your insurance provider denies payment. Your co-pay and any deductible are expected at the time of service. We accept Cash, Check, Credit Card and Care Credit.

As a service to you, we will file your insurance claim. You will be billed for any amount not covered by the insurance company, including deductibles, surgical/pathology deductibles and co-insurance. Payment is due upon receipt of your statement. For cosmetic services not covered by health insurance, charges are payable on or before the day service. Photography is at times a necessary part of planning and evaluating treatment. Patient or responsible party authorize the taking of photographs at the direction of the physician and/or delegate, solely for documentation purposes and recognize they will be kept confidential unless otherwise disclosed. Cahaba Dermatology shall be entitled to recover any losses or damages it may suffer by reason of a failure of the patient and/or responsible party to pay charges when they become due, including, but not limited to, reasonable attorney fees, plus costs of enforcing this agreement. Any amounts overdue for more than thirty (30) days shall accrue interest at the rate of 1.5% per month. Balances delinquent more than 90 days are subject to collection efforts and associated reporting to collection agencies. Patient will be responsible to pay Cahaba Dermatology for fee's charged by assigned collection agency.

I authorize that payment of Medicare or other commercial insurance company benefits be made to Cahaba Dermatology & Skin Health Center, LLC for services provided.
I authorize the release of any information needed for processing of this or any related claim/s. I will permit a copy of the authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment.

I understand that all outside laboratory testing will be billed from the specific laboratories to me and/or my insurance company. I accept payment responsibilities if my insurance denies payment. A copy of this authorization shall be considered as valid as the original. I acknowledge I have read this information thoroughly and understand this patient financial responsibility form.

If it becomes necessary to cancel or change your appointment, we require at least 24 hours advanced notice. This is important so that we may offer appointment time to another patient in need of seeing the doctor. If an appointment is cancelled or changed with less than 24 hours' notice, there will be a $35 cancellation fee applied to account. Fee is $100 fee for surgical appointment. These fees will also be applied to patients account for any appointment no-show. These fees will be the responsibility of patient or party financially responsible for patient.

Your signature below conveys your understanding of terms and acceptance of financial responsibilities outlined.

Signature:_____ Date: _____

Relationship to the patient (If other than patient)_____