Harmonie Medical

Dermatology, Skin Cancer & Reconstruction Specialists
902 Ponder Place Ct., Suite 3
Evans, GA 30809
Phone: (706) 364-3223 Fax: (706) 364-4918
www.harmoniemedical.com

Referring Physician:_____

Name:_____**SSN:**_____**D.O.B.:**___/___/_____

Address:_____**City:**_____**State:**____**Zip:**_____

Home Phone:_____**Work Phone:**_____**Mobile Phone:**_____

Email:_____ **Sex:** ☐ Male ☐ Female

Need Interpreter? ☐ Yes ☐ No **Language:** English or Other **Marital Status:** Single/ Married/ Divorced
Ethnicity (circle one): Non-Hispanic Hispanic/Latino **Race:**_____ Widowed/ Separated

Emergency Contact:_____**Relationship:**_____**Phone:**_____

Employment Status: Full Time Part Time Retired Unemployed

Employer:_____

Guarantor of Account: ☐ Self ☐ Other:_____**Relationship:**_____

D.O.B. (if not self):_____**SSN:**_____

Primary Insurance:_____**ID#**_____**Grp#:**_____

Subscriber: ☐ Self ☐ Other:_____**Relationship:**_____

D.O.B. (if not self):_____**SSN:**_____**Phone:**_____

Secondary Insurance:_____**ID#**_____**Grp#:**_____

Subscriber: ☐ Self ☐ Other:_____**Relationship:**_____

D.O.B. (if not self):_____**SSN:**_____**Phone:**_____

If you have Medicare, please circle YES or NO:

Are you receiving Black Lung Benefits? YES or NO If yes, Date benefits began:_____
Are the services to be paid by a government research program? YES or NO
Are you entitled to benefits through the Department of Veterans Affairs? YES or NO
Was the illness/injury due to a work-related accident? YES or NO
Was the illness/injury due to a non-work-related accident? YES or NO
Are you entitled to Medicare based on Age? YES or NO
Are you entitled to Medicare based on disability? YES or NO
Are you entitled to Medicare based on End-Stage Renal Disease? YES or NO
Are you currently employed? YES or NO If applicable, date of retirement?_____
Do you have a spouse who is currently employed? YES or NO If applicable, date of retirement?_____

ALLERGIES AND SENSITIVITIES

Do you have any allergies to medications? YES or NO
List the medications that you are allergic to:_____

MEDICAL INFORMATION

Pharmacy:_____

Address:_____Phone:_____

List any medications you are taking:_____
_____

FAMILY HISTORY
Please list any known diseases or disorders in your family: (i.e., Heart disease, Cancer, High blood pressure, diabetes, etc.)
_____Relationship:_____

_____Relationship:_____

_____Relationship:_____

_____Relationship:_____

Tobacco Use: Have you ever used tobacco? YES or NO
Previously used tobacco products – Quit in:_____(year)
Use tobacco now: YES or NO Type:_____Amount:_____

Alcohol Use: Have you ever drank alcohol? YES or NO
Previously drank alcohol – Quit in:_____(year)
Drink Alcohol now: YES or NO Type:_____Amount:_____

Illegal Drug Use: Have you ever used/abused drugs: YES or NO

Previously use/abused: YES or NO

Use drugs now: YES or NO Type:_____Amount:_____

Have you ever had skin cancer? YES or NO

If yes, what type? Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma Unknown type

Where was the skin cancer located?_____What year were you diagnosed?_____ Were you treated? YES or NO

If yes, what type of treatment? (circle one) Excision MOHS Surgery Medication Scraping Freezing Chemotherapy Radiation Laser

Have you ever had pre-skin cancer? YES or NO

Type:_____ Location:_____

Have you ever had abnormally pigmented lesions or moles? YES or NO

FOR FEMALES ONLY:

Are you pregnant? YES or NO

If yes, what is your due date?_____ Are you breastfeeding? YES or NO

General Questions

Do you or have you had any of the following?

( ) Tendency to bleed	( ) Hay fever	( ) Bleeding Problem after dental work or surgery
( ) Glaucoma	( ) Heart Murmur	( ) Radiation Therapy
( ) Mitral Valve Prolapse	( ) Bacterial endocarditic	( ) Cancer (where)_____
( ) Diabetes	( ) Heart disease	( ) Low thyroid ( ) High thyroid
( ) Heart attack	( ) Seizures	( ) Rheumatic fever
( ) Kidney disease	( ) High blood pressure	( ) Hepatitis
( ) Fainting	( ) Lupus	( ) Depression
( ) Rheumatoid arthritis	( ) Blood clot in lung	( ) Sexually transmitted disease
( ) Blood clot in leg	( ) HIV/AIDS	( ) Phlebitis
( ) Pacemaker	( ) Heart Valve replacement	( ) Internal defibrillator
( ) Tuberculosis	( ) Heart bypass surgery	( ) Asthma
( ) Stroke	( ) Blood Transfusion	( ) Joint replacement: What joint?_____

Any other major conditions:_____

Other surgeries/dates:_____

Have you recently had any of these complaints? (unchecked responses are considered a "no")

( ) Fever	( ) Headaches	( ) Excessive tearing	( ) Weight loss
( ) Visual changes	( ) Sensitivity to bright light	( ) Changing skin lesions	( ) New cough
( ) Enlarged glands	( ) Enlarged glands	( ) Numbness of skin	

( ) Other:_____

Please tell us about the problem(s) you are having today. Some of the things we want to know are the size, color, shape, and any type of lesion. We also want to know where it is, how long you've had it and has it changed. When and what was the change? Is it tender? Does it drain or bleed? Has it previously been treated? What was the treatment?

Problem#1:

_____

_____

Problem #2:

_____

_____

TEST RESULTS POLICY

If unable to reach me by phone, I give permission to the physicians or staff of Harmonie Medical to release my test results to my (initial all that apply):

Spouse_____Parent_____Child_____Answering machine_____Other_____

MISSED APPOINTMENT POLICY

Your appointment time has been reserved especially for you. If you cannot keep your appointment, please call at least 24 hours in advance to cancel or reschedule. This is particularly important for patients who are having a procedure done, especially a MOHS procedure. **Your account will be charged a $25 surcharge for all missed appointments without notification to our office of cancellation or rescheduling**. We also reserve the right to reschedule your appointment if you are more than 15 minutes late.

MEDICAL RECORDS POLICY

Your medical record is the property of Harmonie Medical Dermatology. We will send all pertinent information to any doctor we refer you to at no charge to you. If you move out of the area and transfer care to another dermatologist, we will also forward necessary records at no charge. However, there will be a charge for any other request for medical records as allowed by Georgia Law.

INSURANCE POLICY

PLEASE REMEMBER THAT YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. YOU (THE PATIENT) ARE ULTIMATELY RESPONSIBLE FOR PAYMENT OF YOUR MEDICAL BILLS. WE CAN ONLY ASSIST YOU IN OBTAINING YOUR SPECIFIED CONTRACT BENEFITS. FILING INSURANCE IS A SERVICE THAT WE PROVIDE AS A COURTESY TO YOU.

1. **Co-pays:** Co-pays are a way insurance companies have of sharing the cost of your healthcare with you, the patient. Every time you come to our office for a medical visit, you will be expected to pay a co-pay. No exceptions will be made. If you have a condition requiring frequent visits to our office, expect a co-pay for each visit.

   _____(Please Initial)

2. **Deductibles:** Most insurance plans have a deductible. A deductible is an amount of money your insurance company wants you to pay for your healthcare before they will "kick-in" and pay the rest. Almost every procedure (major or minor) that doctors perform will be applied to a deductible. This means that if you have a yearly $1000 deductible that you have not met, any non-cosmetic procedures we do such as freezing a wart, removing a cancer, etc will go towards your deductible. This means you will receive a statement from our office for these charges and are expected to pay them in a timely manner. We reserve the right to collect deductibles up from prior to certain procedures.

   _____(Please initial)

Our staff is required to check your insurance card at the time of your visit, so please have it ready at the time of checkin.

If your insurance changes or is no longer in effect, you should advise the staff at the time of check-in.

We participate with most major carriers and will bill those plans with which we have an agreement. All co-payments or deductibles are due at the time of service. In the event your health plan determines a service to be "not covered," you will be responsible for the charge(s).

Acknowledgement Form

I acknowledge the Notice of Privacy Rights provided by Harmonie Medical Dermatology and give my permission to Harmonie Medical Dermatology to use and disclose my health information in accordance with it.

_____	_____
Signature of Patient or Guarantor	**Signature of Harmonie Medical Representative**
_____	_____
Name of Patient (print)	**Name of Harmonie Medical Representative (print)**
_____	_____
Date	**Date**

OUR PRACTICE FINANCIAL POLICY

We are dedicated to providing our patients with the best possible care and service, and regard your understanding of our financial policy as an essential element of your care and treatment. If you have any questions, please feel free to discuss them with our staff.

- Unless other arrangements have been made in advance, co-payments are due at the time of service. If you fail to pay your co-payment at the time of your visit, we reserve the right to reschedule your appointment.
- For your convenience, we accept personal checks, VISA, MasterCard, DISCOVER, and American Express. We also accept cash; however, we are unable to provide change for bills larger than $20. A $30.00 fee will be charged for returned checks. If your account is assessed a returned check, only cash and credit cards will be accepted.
- If you do not have active insurance coverage or do not have documentation of your coverage, you are required to pay for services at the time of your visit.
- In the event your health insurance plan determines a service to be "not covered," you will be responsible at the time of service.
- If you have insurance coverage through a plan with which we do not have an agreement, we will prepare and send the claim for you as a courtesy; however, payment is still your responsibility at the time of service.
- Our office typically uses Labcorp, Cutaneous Pathology, DermPath Diagnostics, SouthPath, Clinical Pathology, and SkinPath unless otherwise specified by you. If your insurance carrier requires another laboratory, please let us know so that you will not be responsible for the charge.
- We use the services of an outside collection agency for past due accounts.
- Patients with account in bad debt will not be allowed to schedule further appointments at our office until the balance is paid in full. Patients with accounts having a history of nonpayment are subject to being dismissed from the practice.

MINORS: All services rendered to minor patients will be the financial responsibility of the adult accompanying the minor.

I have read and understand the financial policy of the practice and I agree to be bound by its terms.

_____ _____ **Signature of Patient or Responsible Party** **Date**

_____
Please Print the Name of the Patient

_____
Witness