Babcock Dermatology
Patient Information

PLEASE PRINT

Name: _____ _____ _____
Last First M.I.

Date of Birth: _____ Age: _____ Social Security #: _____ Sex: ☐M ☐ F

Mailing Address:_____
Street/PO Box Apt# City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Please circle the best daytime number

Occupation: _____ Email Address**:** _____

1. Status
__Single
__Married
__Divorced
__Widowed
__Separated
__Domestic Partner

2. Race
__American Indian or Alaskan Native
__Asian
__Native Hawaiian/Other Pacific Islander
__Black or African American
__White
__Hispanic
__Other Race
__Refuse to Report

3. Ethnicity
__Hispanic or Latino
__Not Hispanic or Latino
__Refused to Report

4. Primary Language
__English
__Spanish
Other_____

Pharmacy: _____
Name Address Phone

☐**Yes** ☐**No Please notify me of specials on Cosmetic Procedures and Skincare Products**.

Responsible Party (if different from patient i.e.: parent, spouse)

Name: _____ _____ ___Relationship:_____
Last First M.I.

Date of Birth: _____ Age: _____ Social Security #: _____ Sex: ☐M ☐ F

Mailing Address:(if different from above))_____
City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Referral Information

How did you hear about us? _____

Primary Care Physician_____
Address Phone

Payment Policy:

Babcock Dermatology will accept assignment on all insurance claims when we are a participating provider with the insurance company. If our physician is not a participating provider, the entire unpaid balance, will be billed to you regardless of the benefits of your plan. All patients are responsible for paying copayments and annual deductibles, as well as, paying for any non-covered or cosmetic services at the time services are rendered. We do file with secondary/supplemental carriers. However, in the event that the secondary insurance does not pay within 60 days, patients will be balance billed. We do our best to use an in network lab based on your insurance coverage. We are not responsible if the lab is not an in network provider. If there is a specific lab you want used please let our staff know.

I have read and understand the payment policy.

Patient or Responsible Party Signature _____Date _____

Babcock Dermatology
Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Babcock Dermatology to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Babcock Dermatology describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Babcock Dermatology reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Babcock Dermatology 4890 Roswell Road, Suite B-10, Atlanta, GA 30342.

With this consent, Babcock Dermatology may call my home or other alternative location and leave a message on voice mail 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 laboratory test results, among others.

With this consent, Babcock Dermatology may mail 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 as long as they are marked "Personal and Confidential."

With this consent, Babcock Dermatology may e-mail 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. I have the right to request that Babcock Dermatology restrict how it uses or discloses my PHI to carry out TPO. 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 allow Babcock Dermatology to use and disclose 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, Babcock Dermatology may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Print Patient's Name **Date**

_____

Print Name of Parent or Legal Guardian, if applicable