Athens Dermatology Group, P.C. & The Vein Clinic

1050 Thomas Avenue
Watkinsville, Georgia 30677

Karen Maffei, M.D.
Vincent Maffei, M.D
Morgan Rains, PA-C

Phone: 706-769-1550
Fax: 706-769-1514

Name: _____ Today's Date: _____ Date of Birth: ____/____/_____
Last First Middle

Age: _____ Sex: __ Male__ Female __ Transgender SSN: _____ Marital Status: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMAIL: _____

INSURANCE INFORMATION: Do you have health insurance? ___ Yes ___NO (if yes, please complete below) this is the actual policy holder; we need ALL of the information in order for your office visit to be processed properly.)

Primary Insurance- Name of Insured (Guarantor): _____Insured's Date of Birth: _____

Secondary Insurance -Name of Insured (Guarantor): _____Insured's Date of Birth: _____

PATIENT RECORD OF DISCLOSURES / HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing the 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 or 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, if you revoke this Consent it shall not affect any disclosure we have already made in reliance on your prior Consent.

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands 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.

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER
(CHECK ALL THAT APPLY)

Home Telephone: (_____)_____-_____

[] Ok to leave message with detailed information
[] Leave message with call-back number only

Written Communication:

[] Ok to mail to my home address
[] Ok to mail to my work address

Work Telephone: (_____)_____-_____

[] Ok to leave message with detailed information
[] Leave message with call-back number only

Cell Phone: (_____)_____-_____

[] Ok to leave message with detailed information
[] Leave message with call-back number only

Other: _____

DO YOU GIVE OUR OFFICE PERMISSION TO DISCUSS YOUR MEDICAL INFORMATION WITH ANYONE OTHER THAN YOURSELF?

Name: _____ Relationship: _____Telephone #: _____

Name: _____ Relationship: _____Telephone #: _____

EMERGENCY CONTACT INFORMATION: In case of emergency, whom should we notify?

_____ Relationship to patient: _____ Phone: ( ) _____

IMPORTANT! PLEASE PRESENT YOUR INSURANCE CARD(S) AND DRIVERS LICENSE TO THE RECEPTIONIST. THE RECEPTIONIST WILL MAKE A COPY AND RETURN THEM TO YOU PROMPTLY.

_____ _____

Patient Signature Date

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Thank you for choosing us for your dermatological or vein care. Dr Karen and Vince Maffei both trained at Emory University and are Board Certified. In order for everyone to understand our payment policy, a set of guidelines has been written for your review prior to your visit. We require full payment at the time of service if you are not covered under an insurance plan. Co-pays and deductibles are due at the time of service for those insurance policies in which we are contracted. For those policies we are not contracted with, we will gladly file an insurance claim however; payment will be requested at the time of service. Please contact your health insurance company for more information about out-of-network reimbursement. If your medical problem is of a non-emergency nature and you are unable to remit, we respectfully request that you reschedule. We accept cash, check, Visa, MasterCard, and Discover. No 2 party checks are accepted. Certain procedures such as cosmetic removal of unsightly lesions are not covered by your insurance. If you still desire to have the procedure then you will be expected to pay at the time of service.

Medicare

We participate with the Medicare program. This means that we charge only the fees allowable by Medicare. Medicare will reimburse 80% of the allowable charges once the annual deductible has been met; the patient is responsible for this deductible and 20% balance. This 20% portion is collected at the time of service if the patient does not have a secondary policy. Medicare does not pay for services considered medically unnecessary; these must be paid for by the patient. Examples are removal of any lesions considered cosmetically unattractive, cosmetic removal of veins, removal of cyst, treatment of warts not interfering with vision and others. We participate with most Medicare HMO's PSO, and POS plans.

Laboratory & Pathology Charges

We use outside laboratories for blood work, x-rays, cultures and pathology. We have no relationship with these labs as far as their fees are concerned. A copy of your insurance card will be sent to the lab, if you are a self pay patient you will be billed by the lab. You will receive a separate bill from these labs. If you have a question regarding the bill, please contact them.

ATTENTION PATIENTS, IMPORTANT INSURANCE INFORMATION:

DUE TO THE RAPID CHANGES & VOLUME IN HEALTHCARE POLICIES, WE ARE UNABLE TO VERIFY YOUR INDIVIDUAL COVERAGE. THEREFORE, PLEASE TAKE PERSONAL RESPONSIBILITY FOR CALLING THE NUMBER ON YOUR INSURANCE CARD TO VERIFY THAT DR. MAFFEI IS LISTED AS A PROVIDER **PRIOR** TO YOUR INITIAL APPOINTMENT, OR IMMEDIATELY AFTER AN INSURANCE POLICY CHANGE. IF DR. MAFFEI IS NOT LISTED, WE HAVE A SELF PAY OPTION AT A **REDUCED RATE**.

ASSIGNMENT OF INSURANCE & FINANCIAL RESPONSIBILITY: I do, hereby, authorize payment of all insurance benefits, basic & major medical, for the services I receive, to be made directly to Athens Dermatology Group. I understand that I am ultimately responsible for any unpaid balance or non-covered service. I agree to pay all costs of collecting, securing, or attempting to collect or secure payment, including reasonable attorney fees or collection agency fees.

STATEMENT AUTHORIZING PAYMENT BY DICARE & OTHER INSURANCES: I request that payment of authorized Medicare or other applicable private insurance benefits be paid directly to Athens Dermatology Group for services provided under their care. I also authorize Athens Dermatology Group to release necessary medical information to my insurance company, its agents, or any third party in order to determine payable benefits for the services rendered.

MEDICAID: We do not participate with Medicaid. If you have an emergency then we will see you for this exception only, however, payment will be expected at the time of service.

APPOINTMENT CONFIRMATION CALLS: As a courtesy to our patients, every effort will be made to do appointment reminder calls two days prior to a scheduled appointment, to the telephone number provided. If you are unavailable, a message will be left. If you do not wish to receive a reminder call, please let us know.

PAYMENT POLICY: We will require full payment at the time of service. Co-Pays and deductibles are due at the time of services for those insurance policies we are contracted with. For those policies we are not contracted with, we will gladly file an insurance claim; however, payment will be requested at the time of service. Please contact your health insurance company for more information about out-of-network reimbursement.

NO-SHOW / MISSED APPOINTMENTS: Due to the increased volume of no-show and missed appointments, our office has implemented a **$50.00** fee for all scheduled office visit appointments not cancelled or rescheduled with proper notification of at least **24 hours.** However, at the physician's discretion, emergency cancellations will be handled on a case-by-case basis.

NO-SHOW / MISSED SURGERY APPOINTMENTS: Due to the increased volume of no-show and missed appointments, our office has implemented **a $75.00** fee for all scheduled surgery appointments not cancelled or rescheduled with proper notification of at least **48 hours**. However, at the physician's discretion, emergency cancellations will be handled on a case-by-case basis.

COLLECTIONS: Any account that is past due by 60 days will be relinquished to a collection agency. Every patient will be notified by mail of this action. Payment plans are available if necessary. Any patient requiring collection actions will be discharged from this clinic and must seek their care elsewhere. Fraudulent checks will be assessed a $25.00 penalty and the payment must be paid in cash. All future payments must be in cash. At the physician's discretion, reduced services shall be offered. These services will be evaluated on a case-by-case basis.

HOLIDAYS/VACATIONS: Dr. Karen and Dr Vince Maffei will be out of the office from time to time. If He/She is unavailable, you may see her Physician Assistant, or rarely, there may be a Locum Tenens Physician fill in. If the office is closed or if you have an urgent need or medical emergency which cannot wait until business hours, please go to an emergency room of your choice.

PATIENT CONFIDENTIALITY: It is our policy to adhere to all Health Insurance Portability & Accountability Act of 1996 (HIPAA) regulations, including Protected Health Information (PHI). It is not our policy to discuss your healthcare, diagnostic, and / or accounting information with anyone other than yourself. If you would like an authorization to be kept on file releasing such information to someone other that yourself, please notify the receptionist.

PHYSICIAN ASSISTANT: I understand that on some appointments, I will see the Physician Assistant.

By signing below, you have been informed of the $50.00 appointment fee for any missed appointment and the $75.00 appointment fee for any missed surgical appointments after this day and agree that you have read all of the above information and understand.

I understand that I am financially responsible for all charges, whether or not paid by said insurance.

Patient Signature _____ Date_____

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PATIENT NAME: _____ DOB: _____ DATE: _____

PAST MEDICAL HISTORY/ALERTS: (PLEASE CIRCLE ALL THAT APPLY)

ALERTS:

Bleeding Disorders
Pacemaker/Defibrillator
Hearing Loss
HIV/Hepatitis A B C
Pregnant/Nursing
Due Date: _____
Shunts
Tuberculosis History

ALLERGIC TO:

Tape
Lidocaine
Epinephrine
Betadine

Anxiety/Depression
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplant
BHP/ Enlarged Prostate
COPD
Coronary Artery Disease
Diabetes
Dialysis
Heart Attack or Heart Failure

Heart Valve
HIV / AIDS
High Cholesterol
High Blood Pressure
Hyper / Hypothyroidism
Kidney Disease
Leukemia
Blood Clots
Radiation/Chemo
Stroke

ANY TYPE OF CANCER OR OTHER PROBLEMS: _____
_____
_____
_____
_____
_____
_____
_____

PAST SURGICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

Squamous Cell cancer
Basal Cell Carcinoma
Melanoma
Leg injury/Trauma

OTHER SURGICAL PROCEDURES: _____
_____
Vein Treatments_____
_____

Acne
Leg ulcers
Phlebitis
Eczema
Psoriasis

SKIN DISEASE HISTORY/SUN DAMAGE: (PLEASE CIRCLE ALL THAT APPLY)

Family history of non-melanoma skin cancer? **No/Yes**
Family history of melanoma? **No/Yes**

SOCIAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

Currently Smokes Have Smoked In The Past Never Smoked
Any Drug Usage? YES / NO Pneumonia Vaccine? YES/NO
Alcohol Consumption? YES / NO If yes, how many drinks per day? _____
Occupation: _____
Primary Care Doctor: _____
Pharmacy Name / Location: _____

ALL PATIENTS PLEASE READ AND SIGN:

- I authorize the release of any medical information needed to process Medicare and / or other insurance.
- I authorize Athens Dermatology Group, P.C. to treat the above-named patient (including minors) as necessary.
- I authorize the release or acquisition of any medical information to / from any physician or physician's office, laboratory, pharmacy, hospital or surgical facility involved in my care.
- I have read the HIPAA privacy policy of Athens Dermatology Group, P.C.

Completed by: _____ Patient _____Parent / Guardian (initials: _____) _____ Medical Assistant (Initials ____)

_____ _____ _____

Signature of Patient / Parent / Guardian Reviewer's Signature Date