DERMATOLOGISTS of BIRMINGHAM

PATIENT DEMOGRAPHICS

First Name: _____ MI: _____ Last Name: _____ Suffix: _____ Nickname: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

PHONE: Home: _____ Cell: _____

Email: _____

DOB: _____/_____/_____ Soc. Sec. Number: _____ Gender: _____ Marital Status: _____

PCP or Referring Physician: _____ Employer: _____

RESPONSIBLE PARTY | GUARDIAN INFORMATION

If same as above check here: ☐

Person Responsible for Account: _____ DOB: ____/____/____ Relationship: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

PHONE Home: _____ Cell: _____

INSURANCE POLICY INFORMATION

1st Insurance: _____ Contract #: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____/_____/_____ Relationship of patient to policy holder: _____

2nd Insurance: _____ Contract #: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____/_____/_____ Relationship of patient to policy holder: _____

3rd Insurance: _____ Contract #: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____/_____/_____ Relationship of patient to policy holder: _____

CONTACT INFORMATION

Preference for receiving lab/biopsy results and clinical information: **TEXT** or **PHONE CALL**

May we include personal information including lab/biopsy results on your Voicemail or in a secure Text Message? **Y N**

List your emergency contacts. May we discuss appointments or clinical information including results with them? **Y N**

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

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of BIRMINGHAM

PHARMACY

Name: _____ Location: _____

DRUG ALLERGIES | MEDICATIONS

DRUG allergies?

- ❑ Lidocaine
- ❑ Other

_____

_____

_____

_____

Current oral and topical Medications?

- ❑ See Attached List

_____

_____

_____

_____

PATIENT POLICIES AND NOTICES

Guarantee of Payment
In consideration of medical services rendered, the undersigned accepts all fees charged as lawful debt and agrees to pay Dermatologists of Birmingham, insurance notwithstanding, for all said charges. Furthermore, undersigned agrees to pay the costs of collection including reasonable attorney's fees, and court costs if such be necessary, waiving now and forever the right of accept insurance assignment as a guarantee of full payment.

_____ **(PLEASE INITIAL)**

Assignment of Insurance Benefits and Release of Information
My signature below authorizes my insurance company to mail payment of authorized benefits for any medical services rendered directly to Dermatologists of Birmingham. Furthermore, my signature below authorizes Dermatologists of Birmingham to release to my insurance company medical information regarding his treatment for the purposes of determining eligibility for and payment of charges for services rendered in connection with care.

_____ **(PLEASE INITIAL)**

Dermatologists of Birmingham reserves the right to change the privacy practices that are described in the Notice. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment**.**

_____ **(PLEASE INITIAL)**

ePrescribing
Dermatologists of Birmingham has implemented ePrescribing. ePrescribing sends your prescriptions over the internet to your pharmacy; keeping your personal information protected. ePrescribing also lets your doctor see important information- like drug interactions and your prescription history. I authorize, with the signature below, that Aesthetic Dermatology | Shelby Dermatology may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes through ePrescribing software.

_____ **(PLEASE INITIAL)**

Notice of Privacy Practices and Patient Consent for Use and Disclosure of Protected Health Information
I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information. I understand that Dermatologists of Birmingham may use or disclose my protected health information for treatment, payment or health care operations – which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization. Dermatologists of Birmingham have a detailed document called the '*Notice of Privacy Practices'*. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information. I understand that I have the right to read the 'Notice' before signing this agreement. If I ask, Dermatologists of Birmingham will provide me with the most current *Notice of Privacy Practices.* My signature below indicates that I have been given the chance to review such a copy of the *Notice of Privacy Practices.* My signature means that I agree to allow Dermatologists of Birmingham to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Dermatologists of Birmingham has taken relying on this consent.

_____ **(PLEASE INITIAL)**

Patient or Responsible Party Signature: _____ Date: _____/_____/_____

DERMATOLOGISTS of BIRMINGHAM

Media and Photography Release Form

Patient Name: _____ Date: _____

I am: ☐ The individual named above

☐ The individual's parent/guardian/ legally authorized personal representative

I consent for medical photographs or videos to be taken of me/my child/the person for whom I am legally authorized to represent. I understand that the information may be used in my personal medical record, for purposes of medical teaching, or for informative medical media purposes via website or in office telecommunications and publications. By consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact:

Erin Fisher, Practice Administrator
Phone: (205) 621-9500
Email: efisher@shelbydermatology.com

By signing this form below, I confirm that this consent form has been explained to me in terms which I understand.

I HAVE READ THE ABOVE WAIVER AND RELEASE, UNDERSTAND THAT I HAVE GIVEN UP RIGHTS BY SIGNING IT, HAVE NOT CHANGED IT ORALLY, AND SIGN IT VOLUNTARILY.

_____
Patient or Responsible Party Signature

**Any photographs or videos taken by Dermatologists of Birmingham will be obtained by the use of a camera or video recording device dedicated specifically for the above explained purposes. It will be maintained in a secure location and cleared of its memory after images are uploaded. At NO time will personal devices, such as cell phones, be used to obtain photographs or videos for use by Dermatologists of Birmingham.*

Tell Us About Your Skin!

We want to better understand your skin concerns and current routine so we can provide the best care for you. Please take a moment to answer the questions below.

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1. What are your primary skin concerns? (Check all that apply)
☐ Facial Skin Health
☐ Skin Cancer Screenings
☐ Moles or Skin Growths
☐ Eczema, Psoriasis, or Rosacea
☐ Acne or Blemishes
☐ Scars or Stretchmarks
☐ Wrinkles or Fine Lines
☐ Uneven Skin Tone or Texture
☐ Stubborn Areas of Fat
☐ Sagging Skin
☐ Redness or Veins
☐ Dark Spots
☐ Unwanted Hair

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2. What does your current skincare routine look like? (Check all that apply)
☐ Cleanser
☐ Moisturizer
☐ Sunscreen
☐ Anti-Aging Products
☐ Prescription Treatments (e.g., acne, rosacea)
☐ Other: _____

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3. Do you wear sunscreen regularly to help prevent skin cancers?
☐ Yes ☐ No

As part of your care, we include an annual VISIA Skin Analysis.