By law, this form must be completed in its entirety! If the question does not apply, please indicate so, by placing an "NA" in the space provided.

PATIENT REGISTRATION

Patient Name: Last_____ First_____ Middle _____
Sex: Male/Female Date of Birth_____ Age_____ Marital Status: S M W SE D
Height:_____ Weight _____ SSN_____
Mailing Address:_____ City _____ State_____Zip _____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
Email:_____
Pharmacy:_____

Employer Name:_____ Occupation: _____
Employer Address: _____City, State & Zip: _____

Spouse's Name: _____ Date of Birth_____
Spouse's Employer: _____Occupation: _____
Phone:_____

Emergency Contact: _____Relation to Patient: _____Phone #: _____

INSURANCE COVERAGE

Primary Insurance: _____
Policyholder: _____DOB_____
SSN: _____ Relation to patient: _____

Secondary Insurance: _____
Policyholder: _____DOB_____
SSN: _____ Relation to patient: _____

RESPONSIBLE PARTY INFORMATION
(If under age 18)

Name of Person bringing in Patient: _____Relation to Patient: _____
Fathers Name: _____SSN_____DOB_____
Mothers Name: _____SSN_____DOB_____
Address (if different from pt): _____
Employer Name: _____Employer Phone: _____
Daytime Phone: _____ Evening Phone: _____ Cell Phone: _____

PERSONAL HISTORY

Primary Care Doctor: _____ Phone Number: _____
Referring Physician: _____ Phone Number: _____
Referring Physician Address: _____
Date of last physical exam: _____
Purpose for this consultation: _____
Pregnant? Y or N – If so, how far along? _____
Please list any medications or substances you are allergic to:
_____
Please list any medications you are currently taking:
_____
_____

Medications (check those that you take)
Bufferin _____ Insulin _____ Motrin _____ Blood Thinners _____ Aspirin/Anacin _____ Antibiotics _____
Ibuprofen _____ Birth Control _____ Arthritis Medication _____
*****Aspirin & Aspirin type products can cause excessive bleeding during surgery!!!*****

MEDICAL HISTORY

(Check those conditions that you have had problems with)

Thyroid _____ Blood Pressure _____ Heart _____ Asthma _____ Lungs _____ Stroke _____ Kidneys _____
Cancer _____ Bladder _____ Hepatitis _____ Gall Bladder_____ Nerves_____ Stomach_____
Bleeding_____ Diabetes_____ Arthritis_____ Irregular Menses_____ Heavy Bleeding_____

- ♦ Have you ever tested POSITIVE for HIV? Y/N
- ♦ Do you wear a Pacemaker? Y/N
- ♦ Do you smoke? Y/N Packs per day? ____
- ♦ Do you drink over three cups of coffee per day? Y/N
- ♦ Do you regularly drink alcohol or beer? Y/N

Please list any serious illnesses or injuries and dates:
Illness/Injury: _____ Date: _____
Illness/Injury: _____ Date: _____
Illness/Injury: _____ Date: _____
Please list any operations you have had, and give the year:
Operation: _____ Year: _____
Operation: _____ Year: _____
Operation: _____ Year: _____

FAMILY HISTORY

Please give the relation of any family member who has any of the following conditions:
Diabetes: _____Arthritis: _____Asthma: _____
Bleeding Disorder: _____Cancer: _____ Stroke: _____

DISCLOSURES

Please read the following disclosures carefully!

All professional services rendered are charged to the patient. In the case of minor children, the ***services are charged to the parent or guardian bringing the child in for treatment.*** We will assist you with insurance reimbursement; however the patient is responsible for all fees, regardless of insurance coverage. It is our policy to request payment at the time of service, unless arrangements have been made in advance with the administrator. If you have a question about fees, please check with the receptionist before being seen.

I authorize Thomas H. Lamb, MD, PC to furnish information to insurance carriers, physicians or hospitals concerning my/my dependents illness and treatment. I authorize any physician, hospitals or medical care facility to provide all information on medical history and treatment to Thomas H. Lamb, MD, PC. I assign to Thomas H. Lamb MD, PC all payments for medical services including major medical benefits, rendered to me/my dependents. I understand that I am responsible for any amount not covered by assigned insurance. I permit a copy of this authorization to be used in place of the original. I have read all of the above and give Thomas H. Lamb, MD, PC permission to treat me/my dependent.

Many insurance plans currently have a Multiple Surgical Procedure policy. These plans will make a 50% reduction in claim payment when more than one surgical procedure is performed on the same date of service. However, it is the belief of this facility that this provision of your policy is only a policy provision, and not a contractual obligation. Therefore, many insurance companies will show this 50% reduction as a provider write-off, when in actuality this reduction does not appear to be written in the contract. Under these circumstances, this facility does not take additional write-offs.

At this time, the staff will be more than willing to accommodate your medical needs any way that we can, however, if you desire that all surgical procedures be performed at the same time, then please sign below that you understand that any 50% reductions in these procedures are not the responsibility of this facility, and that you will assume all responsibility for the unpaid portion of your claim (even if these reductions appear on your insurance explanation of benefits as a provider write-off).

I hereby declare that I have read and understand the above statement in regards to the Multiple Surgical Procedure Reduction. I also understand that I may elect to have all surgical procedures performed at the same time, and I assume responsibility for all unpaid balances if my insurance company applies a 50% reduction provision. I also understand that in the event that I have any concerns with regards to this provision in my policy, that this insurance problem, must be addressed directly to my insurance carrier, and not to this facility.

Payment in full, co-payments and/or deductibles, which ever applies, is due at the time services are rendered;

In certain cases payment plans are available, however, the plan must have advanced approval before treatment, by the Office Administrator.

Insurance claims are filed as a courtesy, or as an obligation based on a signed contract with your insurance carrier, however:
Your percentage is due at time services are rendered
Your deductible must be covered at time of services, unless previously met with another Medical facility

If your insurance company does not pay for their portion after **60 days,** you are responsible for the balance, and you will receive a bill for the balance. In the event that your insurance company does not pay in 60 days, and you receive a bill from this facility, you will need to contact your insurance carrier to correct the problem.

For cases involving divorce: The parent that brings the child in for medical treatment is responsible for payment. **We do not bill the other parent or party involved!**

This facility does use the services of Collection Agencies; therefore, if payment is not made on a monthly basis, or no payment is made at all, then your account will be placed with a national agency. In the event legal action becomes necessary, you, (the patient or responsible party) will be responsible for all legal fees associated with your account. In the event checks written for services are returned to our office, there will be a **$35.00** service charge.

Please do not hesitate to speak with the front office staff, or the Office Administrator, if you should have any questions in regards to this policy or charges that may be incurred at this facility.

Please sign below to indicate that you have read and understand all the above statements. I also have completed the requested information to the best of my ability. Your signature below shall serve for the contents of this entire three-page registration package.

Your signature is required on this form before treatment can be rendered by this facility.

_____
Printed Name – Patient or Representative

_____ ___/___/___
Signature Date

Relationship to Patient (if other than patient):_____

Carrollton Dermatology Associates
Thomas H. Lamb, M.D., P.C.

Dr. Thomas H. Lamb, M.D.
Dr. Jason Clark, M.D.

HIPAA PATIENT 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 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 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, such a revocation shall not affect any disclosures 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.

This Consent was signed by:

_____
Printed Name – Patient or Representative

_____ ___/___/___
Signature Date

Relationship to Patient (if other than patient):
_____

100 Professional Park, Suite 110
Carrollton, GA 30117
Tel: 770/834-0818
Fax: 770/834-5098