



DERMATOLOGY



Patient Welcome Package

**Dr. Sheereen Timani
&
Dr. Zack Charkawi**

Patient Agreement Information

Name: _____

DOB: _____

Age: _____

Social Security Number: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Phone Numbers (Please list at least 2): _____

Marital Status (circle one): Married Divorced Single Widowed

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Emergency Contact Number: _____

Patient email address: _____

Pharmacy Information (telephone number/location): _____

How did you hear about us? / Name of Physician that referred you? _____

I consent for treatment by the Physicians of Johns Creek Dermatology & Family Medicine, as well as, I agree to allow the Physician to diagnose and treat my condition based on their extensive knowledge and recommendation pertaining to my medical condition.
_____ (Patient Initials)

I acknowledge that all information supplied by myself to Johns Creek Dermatology & Family Medicine is true and correct.
_____ (Patient Initials)

Signature

Date

Patient Financial Agreement Form

I consent that I am responsible for (any and all) charges assigned to me by my insurance company including, but not limited to, yearly deductibles, co-insurances, co-pays, non-plan coverage, etc. _____(Patient Initials)*

Certain insurance companies and/or policies (especially Medicare) do not cover preventive care which may include vaccinations, preventive visits and other procedures. These services, if not covered by your insurance plan, will become your financial responsibility. _____(Patient Initials)*

I consent that I do understand and will abide by the below listed administrative fees which are enforced by Johns Creek Dermatology and Family Medicine. I agree to pay for fees accordingly_____ (Patient Initials)*

Administrative Fees

- | | |
|---|-----------|
| 1) Appointment cancelled with less than 24 hour notice = | \$30.00 |
| 2) Patient "NO SHOWS" for appointment = | \$40.00 |
| 3) Returned payment for Non Sufficient Funds = | \$35.00 |
| 4) If patient account(s) is unpaid for greater than 90 days, a
6.5% interest charge will be applied to unpaid claim/total(s) owed. | % of Bill |
| 5) Patient account placed with collection agency = | \$45.00 |
| 6) Request for release of medical records (paper or electronic) = | \$30.00 |

*Signature: _____ Date: _____

Note: * = Patient understands Financial requirement.



HIPAA – Privacy Policy

It is the policy of our practice that all physicians and staff members preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our entire practice have the necessary medical and PHI to provide our patients the highest quality medical care possible patients should not be afraid to provide information to our practice, physicians, staff members for purposes of treatment, payment, and healthcare procedures. Our HIPPA policy in its entirety can be obtained through our office at any time. Let us know if you would like to receive a copy prior to signing this consent.

Office Policy on managed Care Insurers

We are pleased to meet the needs of our patients and referring physicians by enrolling with various managed care insurance programs. While we are able to provide you with this service, it is extremely difficult to keep track of all the individual requirements of each plan. Even with the same insurance company, plans often may differ. Providing quality medical care for our patients is our primary concern, and we are more than willing to provide that care based on your insurance contract guidelines. We request at each visit that you advise us of your guideline requirements.

Unfortunately, if you do not inform us of any special requirements in your contract and we subsequently provide services, or order services such as label work or hospitalization that are not covered, we or the medical facility will have no choice but to bill you directly for all said charges. All fees submitted and denied by your insurance carrier will become your responsibility.

Our practice will file insurance claims as a courtesy for you, however, office visit co-pays and deductibles are payable on the day of your visit. Remember that you are responsible for all fees, regardless of your insurance coverage. Some insurance plans require prior authorization and/or referral documentation. This is your responsibility. If we do not receive the authorization and/or referral documentation in advance, payment is due at the time of service.

With your cooperation, you should be able to receive all benefits offered by your insurance plan, and we will be able to concentrate on caring for your medical needs.

Authorization

Please initial and sign below:

_____ I understand HIPAA and its policies.

_____ I have read and understand the office policy stated above and agree to accept responsibility as described.

_____ I authorize the release of medical information necessary to process a claim, to health care professionals requesting consultation, and third party payers responsible for payment of medical and surgical benefits to Johns Creek Dermatology and Family Medicine.

Patient Name: _____ **Date:** _____

Signature of Patient or Personal Representative: _____ **Date:** _____

If Personal Representative, give relationship to patient: _____



MUTUAL AGREEMENT

Johns Creek Dermatology and Family Medicine, PC (collectively labeled “Practice”) agree to provide treatment to: _____ (“Patient”). The Practice takes pride in being able to extend a greater degree of privacy than is required by law.

Nothing in the form prevents Patient from speaking privately about his or her care to another physician, a family member, or a friend. Indeed, the patient can speak to any third party; however, should the information intended to be released into the public domain, written pre-authorization is required from our office. That’s it. The language, then balances the legitimate rights of Patient with Practice.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Our Practice believes this is improper and may not be in the patients’ best interest. Accordingly, our Practice agrees not to provide medical information for the purpose of marketing directly to Patient. Regardless of legal privacy loopholes, our Practice will never attempt to leverage its relationship with Patient by seeking Patient’s consent for marketing products for others.

In consideration for treatment and the above noted patient protection, Patient agrees to refrain from directly or indirectly publishing or airing commentary about our Practice, expertise-and/or treatment-the sole exceptions being communication to the confidential medical-peer review body; to another healthcare provider; to a licensed attorney; to a governmental agency; in the context of a legal proceeding; or unless mandated by law. Publishing is intended to include attribution by name, by pseudonym, or anonymously. If patient does prepare commentary for publication about Practice, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to our Practice for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary. Practice has invested significant financial and marketing resources in developing our practice. Published comments on web pages, blogs, and/or mass correspondence, however well intended, could severely damage Practice’s office.

Our Practice feels strongly about the offices’ right to control its public image. Both Practice and Patient will work to prevent the publishing or airing of commentary about the other party from being accessed via Internet, blogs, or other electronic, print, or broadcast media without prior written consent. Patient will use all reasonable efforts to prevent any member of their immediate family or acquaintance from engaging in any such activity. Finally, this Agreement shall be in force and enforceable for a period of five years from Practice’s last date of service to Patient. As a matter of office policy, our Practice is requiring all patients in its office to sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Practice’s patients. Furthermore, this Agreement will survive for a minimum of three years beyond any termination of Practice-Patient relationship.

Patient and Practice acknowledge that breach of this Agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, Patient and Practice agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of the Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable cost, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

SO AGREED THIS ____ DAY OF _____, 201____. _____ (PATIENT)



Medical Records Release Policy

All record(s) requests that come into the office either written or verbal will initially be directed to our Medical Records Coordinator and Office Manager. From that point, requesting information will be forwarded to Dr. Timani or Dr. Charkawi for approval and signature. No records are to be released without Dr.(s) approval.

This office chooses to follow the OIG Records Release Guidelines and therefore we charge all requestors for the process of copying the records. Please see charge chart below:

Pursuant to O.C.G.A. 31-33-3, effective July 1 of each year, the costs related to medical records retrieval, certification, and copying may be adjusted in accordance with the medical component of the consumer price index. **The Office of Planning and Budget (OPB)** is responsible for calculating this annual inflation adjustment and publishing the revised rates. However, in response to consumer and provider concerns over existing medical records costs, OPB has opted to freeze rates for the upcoming year and in the interim will review this issue to determine the appropriate methodology for rates.

Administrative Costs:	\$24.86 (e.g. search, retrieval, and other labor costs)
Costs of Postage:	Set by Post Master Annually
Pages 1-20:	\$.93 per page
Pages 21-100:	\$.80 per page
Pages 101 and up:	\$.63 per page

No records will be released until a payment is received in full to the billing department. Upon collection of required fees the Manager will process the records and assure that they are sent where they need to go.

Please note that there are some agencies that are not required to pay for copies of records. SSI, Health Insurance Companies. But those requests will be sent directly to our office with required Federal and State documentation.

Patient Name: _____

Date Of Birth: ____/____/____

Reason For Records Request: Relocation Insurance Change Patient Discontent
 Second Opinion Employment Request

Patient Signature Of Release: _____ Date: ____/____/____

Address To Send Records To: _____

_____ Date Completed

 **Patient Health Questionnaire – Dermatology**

Patient Name: _____

Chief complaint (reason being seen please be as detailed possible): _____

Current Medications (doses required): _____

Medical History (any chronic illnesses): _____

Allergies (specify reaction type): _____

Surgical and Hospital history: _____

Family History (circle appropriate and specify which relative):

- | | | | |
|----------------|-----------|---------------|------------------|
| Epilepsy | Thyroid | Osteoporosis | High Cholesterol |
| Migraine | Hay fever | Arthritis | Alcoholism |
| Mental Illness | Asthma | Heart Disease | Cancer |
| Glaucoma | Anemia | Stroke | Hypertension |
| Bleeds Easily | Diabetes | Other: | |

Social History: Smoker = YES/NO, If yes, how long and how much per day? _____

Alcohol = YES/NO, If yes, how much per day/week? _____

Special Diet = YES/NO, If yes, specify: _____

Occupation: _____

Who is your Primary Care Physician? _____