Atlanta Dermatology
Hailey, Brody, Casey, Wray & Alexander, M.D.
DERMATOLOGY AND DERMATOLOGIC SURGERY

LAST NAME _____ FIRST _____ M.I. _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

CELL PHONE _____ EMAIL _____

DATE OF BIRTH _____ SEX _____ MARITAL STATUS: S M P W D

PATIENT S.S. NO. _____ RACIAL OR ETHNIC GROUP _____ PRIMARY LANGUAGE _____

PATIENT'S EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMPLOYER PHONE _____ EXT. _____

SPOUSE/PARTNER/PARENT NAME _____ S.S. NO. _____ DATE OF BIRTH _____

SPOUSE/PARTNER/PARENT EMPLOYER _____ OCCUPATION _____

SPOUSE/PARTNER/PARENT EMPLOYER PHONE _____

NAME OF PERSON RESPONSIBLE FOR PAYMENT (IF OTHER THAN PATIENT)

RESPONSIBLE PARTY LAST NAME _____ FIRST NAME & INITIAL _____

RELATIONSHIP (SPOUSE/PARTNER/PARENT) _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ RESPONSIBLE PARTY S.S. NO. _____

RESPONSIBLE PARTY EMPLOYER _____

EMPLOYER ADDRESS _____ EMPLOYER PHONE _____

REFERRED BY:

NAME: _____

RELATIONSHIP TO PATIENT: _____ PHONE #: _____

EMERGENCY CONTACT:

NAME: _____

RELATIONSHIP TO PATIENT: _____ PHONE #: _____

EMERGENCY CONTACT:

NAME: _____

RELATIONSHIP TO PATIENT: _____ PHONE #: _____

PHARMACY INFORMATION:

PHARMACY NAME: _____

PHARMACY PHONE: _____

ADDRESS: _____

_____

(PLEASE PROVIDE AT LEAST CROSS STREETS)

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described, realizing I am responsible to pay non-covered services.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_____ _____

SIGNATURE (Patient or Parent if Minor) DATE

Hailey, Brody, Casey & Wray, M.D., P.C.
DERMATOLOGY AND DERMATOLOGIC SURGERY

CHENAULT W. HAILEY, M.D.
HAROLD J. BRODY, M.D.
DARREN L. CASEY, M.D.
G. WILLIAMSON WRAY III, M.D.
HERBERT D. ALEXANDER, JR, M.D.

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SUITE 200
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Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES

Hailey, Brody, Casey & Wray, M.D., P.C.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we share do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to ''opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in his notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. lf we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of discourses of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.
We are required by law to maintain the privacy of your PHI and to provide you the not1ce of our legal duties and our privacy practice with respect to PHI.
This notice is effective as of and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.
You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.
Feel free to contact the Practice Compliance Officer (insert name and telephone number) for more information, in person or in writing.

Receipt of Notice of Privacy Practices
Written Acknowledgement For
HAILEY, BRODY, CASEY, & WRAY, M.D., P.C.

I am a patient of **HAILEY, BRODY, CASEY, & WRAY, M.D., P.C.** I hereby acknowledge receipt of **HAILEY, BRODY, CASEY, & WRAY, M.D., P.C.** Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ (patient name). I hereby acknowledge receipt of **HAILEY, BRODY, CASEY, & WRAY, M.D., P.C.** Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

HIPAA Authorization Form:

I authorize the following individuals to have full access to my health information:

Print Name	Relationship	Date
_____	_____	_____
_____	_____	_____

I, _____ give my permission for you to leave any medical/lab information for me at the following places:

Email	
Mobile #	
Work #	

Hailey, Brody, Casey & Wray, M.D., P.C.

Financial Policy:

To provide care to as many patients as possible without excessive financial burdens to our patients, Hailey, Brody, Casey & Wray, M.D., P.C. makes an effort to accept a large number of health insurance policies. To further assist you, we usually file insurance claims on your behalf. For a variety of reasons, many insurance carriers have placed restrictions on covered benefits and covered medications. When medically essential, we will attempt to overcome these restrictions, but the ultimate decision rests with your insurance carrier.

There are a variety of conditions which are routinely **NOT** covered by health insurance. These include all treatment for cosmetic problems, including removal of benign lesions, such as skin tags, seborrheic keratosis and normal moles, revisions of scars, and evaluation and treatment of many types of hair loss. If you undergo a treatment or a procedure which is deemed medically unnecessary, you will be responsible for payment at the time of service.

In some instances, your insurance carrier may determine that a procedure is considered to be a surgical procedure. If this occurs, the surgical procedure could be applied to your surgical deductible and you would be responsible for payment.

Our staff will make every effort to pre-certify medically essential medications. Please understand that even with letters of medical necessity from your doctor, certain plans do not cover specific medications or require failures of other treatment options. If your health insurance carrier denies coverage, you are still able to obtain these medications, but you will have to pay out-of-pocket. In addition, although most vitamin-A derived creams, such as Retin-A, Renova and Tazorac are covered during adolescence and acne-prone years, because these creams are also used for anti-aging, they are often NOT covered in adult patients. We do not pre-certify coverage of these creams.

We appreciate the opportunity to care for you and will work with you and your insurance carrier to obtain the best possible treatment for you and your family. If you have any questions regarding billing or covered procedures, our office staff will be happy to assist you.

I agree that I am personally responsible for payment of all charges for medical and/or surgical services whether not covered, part of my deductible, co-insurance, co-payment or otherwise not paid or payable by my insurance or medical plan. I understand and agree that in the event my account is turned over to a collection agency for non-payment, I will be responsible for collection agency fees in the amount of 10% of the account balance. I further understand and agree that if my account is turned over to an attorney for non-payment, I will be responsible for all court costs and costs of collection including reasonable attorney's fees in the amount of 15% of the account balance.

I have read and understand the policies as stated above.

_____ _____

Signature Date

Hailey, Brody, Casey & Wray MD PC

HISTORY AND INTAKE FORM

Name:_____ Date of Birth:_____

EMAIL:_____

Past Medical History: (Please check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplantation
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐Hepatitis
- ☐Hypertension
- ☐HIV/AIDS
- ☐Hypercholesterolemia
- ☐Hyperthyroidism
- ☐Hypothyroidism
- ☐Leukemia
- ☐Lung Cancer
- ☐Lymphoma
- ☐Prostate Cancer
- ☐Radiation Treatment
- ☐Seizures
- ☐Stroke
- ☐None
- ☐Other_____

Have you received the following:

Influenza Vaccine ☐Yes ☐No Pneumococcal Vaccine ☐Yes ☐No

Primary Care Provider:_____

Past Surgical History: (Please check all that apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy(☐ Right, ☐ Left, ☐ Bilateral)
- ☐ Lumpectomy (☐ Right, ☐ Left, ☐ Bilateral)
- ☐ Breast Biopsy (☐ Right, ☐ Left, ☐ Bilateral)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ PTCA
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Testicles Removed(☐Right, ☐Left, ☐ Bilateral)
- ☐ Joint Replacement, Knee (☐Right, ☐Left, ☐ Bilateral)
- ☐ Joint Replacement, Hip (☐ Right, ☐ Left, ☐ Bilateral)
- ☐ Joint Replacement within last 2 years
- ☐ Other_____
- ☐Kidney Biopsy
- ☐Kidney Removed (☐Right, ☐Left)
- ☐Kidney Stone Removal
- ☐Kidney Transplant
- ☐Ovaries Removed: Endometriosis
- ☐Ovaries Removed: Cyst
- ☐Ovaries Removed: Ovarian Cancer
- ☐Prostate Removed: Prostate Cancer
- ☐Prostate Biopsy
- ☐TURP
- ☐Skin Biopsy
- ☐Basal Cell Cancer Carcinoma Surgery
- ☐Squamous Cell Carcinoma Surgery
- ☐Melanoma Surgery
- ☐Spleen Removed
- ☐Heart Transplant
- ☐Hysterectomy: Fibroids
- ☐Hysterectomy: Uterine Cancer
- ☐None

Turn Over

Hailey, Brody, Casey & Wray MD PC

HISTORY AND INTAKE FORM

NAME: _____ EMAIL: _____

Skin Disease History: (please check all that apply)

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ **None**
- ☐ Other _____

Do you wear Sunscreen? ☐ Yes ☐ No

If yes, what SPF? _____

Do you tan in a tanning salon? ☐ Yes ☐ No

Medications: (Please enter all current medications – include ***dose, frequency***, and ***route***)

_____

_____

_____

Allergies: (Please enter all medication allergies)

_____

_____

Social History:

Alcohol Use:

- ☐ None
- ☐ 1 – 2 drinks per day
- ☐ Less than one drink per day
- ☐ 3 or more drinks per day

Cigarette Smoking:

- ☐ Never Smoked
- ☐ Smokes less than daily
- ☐ Quit: former smoker
- ☐ Smokes daily

Do you feel safe at home:

- ☐Yes
- ☐ No

Do you have a living will? ☐ yes ☐no

Family Skin Disease History:

Do you have a ***family*** history of Melanoma? ☐Yes ☐ No

If Yes, which relative(s)? _____

Any additional skin diseases:

- ☐ Mother _____
- ☐ Father _____
- ☐ Siblings _____
- ☐ Child(ren) _____
- ☐ **None**

Turn Over

Hailey, Brody, Casey & Wray, M.D., P.C.

DERMATOLOGY AND DERMATOLOGIC SURGERY

Please fill this these forms out, print them, and bring them with you to your appointment.