

FAMILY PRACTICE



Patient Welcome Package

**Dr. Shereen Timani
&
Dr. Zack Charkawi**

Patient Agreement Information

Name: First: _____ Middle Initial _____ Last _____

Home Address: _____

City: _____ State: _____ Zip: _____

Billing Address (if different from above): _____

Guardian (if Patient under the age of 18) Name: _____

Patient DOB: _____ Gender: Male Female

Race: White African American Hispanic Other _____

Ethnicity (Country) _____ First Language: _____

Social Security Number (Adult Patient or Guarantor's SS#) _____ (MANDATORY)

Email Address: _____

Phone Numbers (CELL) : _____ (HOME): _____ (WORK): _____

Marital Status : Married Divorced Single Widowed

Pharmacy Information (telephone number/location): _____

Primary Care Physician: Name: _____ Phone: _____

Referring Physician: _____

Employer: _____ Occupation: _____

Emergency Contact NAME: First _____ Last: _____ Relationship: _____

Emergency Contact PHONE NUMBER: _____

Do we have permission to speak with a family member regarding your medical care? YES NO

Can we leave information regarding your medical care on your voicemail/messaging system? YES NO

How did you hear about us:

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: _____



INSURANCE INFORMATION

* YOU ARE RESPONSIBLE FOR SUPPLYING ALL CURRENT ACTIVE INSURANCE INFORMATION AND NOTIFYING OFFICE OF ANY CHANGES TO YOUR INSURANCE. YOUR ACCOUNT AT JCDFM IS YOUR RESPONSIBILITY.

Name of <u>PRIMARY</u> Insurance Company:	
Insurance ID:	
Insurance Group:	
Name of Insured:	Insured Date of Birth:
Relation to Insured:	

Name of <u>SECONDARY</u> Insurance Company:	
Insurance ID:	
Insurance Group:	
Name of Insured:	Insured Date of Birth:
Relation to Insured:	

Name of <u>TERTIARY</u> Insurance Company:	
Insurance ID:	
Insurance Group:	
Name of Insured:	Insured Date of Birth:
Relation to Insured:	

I consent that I do understand and will abide by the below listed fees which are enforced by Johns Creek Dermatology and Family Medicine.

APPLIED FEES:

- | | |
|---|-----------|
| 1. Appointment cancelled less than 24 hours notice | \$30.00 |
| 2. Patient " NO SHOW" for an appointment | \$40.00 |
| 3. Returned payment for Non -Sufficient Funds | \$35.00 |
| 4. If patient account(s) is unpaid 90 days + a 6.5% interest charge will be applied | % applied |
| 5. Collection Agency administrative charge | \$25.00 |
| 6. To request medical records | Various |

SIGNATURE: _____ DATE: _____



FINANCIAL POLICY – 2011

* PLEASE READ *

Patient co-pay and account balance is required to be paid at time of arrival.

If we have received all of your correct insurance information on the day of the appointment, we will be happy to file your claim for you.

PLEASE NOTE : YOU MUST BE FAMILIAR WITH YOUR INSURANCE BENEFITS, as we will collect from you the estimated amount that insurance is not expected to pay or \$75 towards your visit. The State of Georgia requires payment of each claim within 30 days of receipt. We file all insurance electronically, and your insurance will have received the claim within days of treatment.

YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT AFTER 30 DAYS, WHETHER YOUR INSURANCE HAS PAID OR NOT. Unpaid balance after 30 days will incur additional charges. We will gladly refund any credit on your account (if applicable) after insurance has paid the claim. *We accept Visa, Mastercard, Discover, American Express, Cash, Check.* PATIENT SIGNATURE: _____ DATE: _____

PLEASE ALSO BE AWARE OF THE FOLLOWING:

- **Un-met Insurance deductibles:** \$75.00 charge (inclusive of co-pay) will be charged at check-in. This amount will be applied to today's visit .
- **All Surgical patients:** \$250.00 collected at check-in, day of surgery. This payment will be applied to the surgery and pathology reading fees. Fees not covered by patient's insurance company are the responsibility of the patient. Any credit on patients account after reimbursement from the insurance company will be reimbursed to the patient in the form of a check.
- **Elective Surgical Patients:** Patients choosing elective surgeries with unmet insurance deductibles, will be required to pay full surgery fee on the day of surgery.
- **Surgical Self Pay Patients :** Are required to pay \$250.00 at check- in , with any balance due at check- out, on the day of surgery.
- **Cosmetic procedures and consults:** There will be a \$150.00 consult charge at check-in, this will go to the credit of service received. Balance, if applicable, is due at check-out.

PLEASE UNDERSTAND: We file insurance as a courtesy to our patients. You have a contract with your insurance company of choice. We are not responsible for how your insurance company handles its claims or for the benefits they pay. We do not guarantee what your insurance company will or will not do with each claim. We cannot be responsible for any errors in filing your insurance. This is performed as a courtesy to you.

PATIENT SIGNATURE: _____ LEGAL GUARDIAN (if under 18): _____ DATE: _____

ADMINISTRATIVE FEES

Please be advised as of **January 2012**, An ANNUAL Administrative Fee of \$35.00 will be applied for completion of the following services listed below, each calendar year. You are not required to pay this amount, however, if you elect not to pay the annual administrative fee, you will be charged as indicated below for each requested service:

- Prior Authorizations forms (\$10/each)
- Physical forms (\$50/each)
- Disability forms (\$50/each)
- FMLA forms (\$50/each)
- Life Insurance forms (\$50/each)
- Assisted Living Admission forms (\$50/each)
- Other Miscellaneous administrative forms required by third parties. (\$50/each)

Records will be sent to referring physicians FREE. However patient requested records will incur a separate fee as indicated in our Financial Policy.

All of these activities and services add to the cost of caring for our patients. We are committed to providing the best possible care and thank you for your understanding and cooperation.

_____ I ACCEPT the \$35 calendar year administrative service fee.

*** Multiple requests may result in additional charges ***

_____ I choose NOT to pay the administrative service fee. I understand that if I elect not to pay this fee, I will pay for the services as I need them.

Patient Name: _____

Patient /Guardian Signature _____ Date _____



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 lab 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 Name)**. 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.

Signature: _____ Date: _____



AUTHORIZATION TO REQUEST RECORDS

Patient Name: _____

Patient DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Release Records To: **JOHNS CREEK DERMATOLOGY AND FAMILY MEDICINE**

6300 HOSPITAL PARKWAY, SUITE 100

JOHNS CREEK, GA 30097

FAX: 770-771-6599 PHONE: 770-771-6591

Release Records From : _____

Phone: _____ Fax: _____

I request a copy of the following medical records to be released (please check all that applies):

- Complete medical records
- Biopsy reports
- Consultation report
- Surgical procedures
- X-ray reports
- Hospital records
- Lab results
- Medication records
- Other _____

Patient Signature: _____ Date Signed: _____

Witness Signature: _____ Date signed: _____

*Request expires one year from date completed



Patient Health Questionnaire – Family Medicine

Name _____ Date _____

Date of Birth _____

Personal Profile

1. Are you employed Yes No Have you recently retired? Yes No
If yes, where? _____
2. Are you: (Circle all that apply) **Single** **Married** **Divorced** **Widowed** **Living Together**
3. How many adults live in your home? _____ How many children? _____
4. What is your living situation (check one)
Rent or own your home _____ Rent an Apartment _____ Senior Center _____
Live in someone else's home (friend/relative) _____ Hotel or Rooming House _____
5. Highest Grade in school _____
6. Have you ever served in the Military? _____
7. Religious Preference _____

Hospital/Surgical History

How many times have you stayed overnight in a hospital? _____

List hospitalizations (starting with the most recent)

Year	Operation or Illness	Hospital

Medications

Please list any medications you are taking now. (Include over the counter medicines, vitamins, eye drops, etc.)

Medication	Dose	Medication	Dose
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Are you allergic to any medicine? Yes No

Which ones? _____

What happens when you take them? _____

Past Illnesses Have you ever had any of the following problems? (Circle Yes or No)

Allergies	Yes	No	Bowel Problems	Yes	No
Anemia/Weak Blood	Yes	No	Emotional Problems/Depression/Anxiety	Yes	No
Arthritis/Rheumatism/Gout	Yes	No	Alcohol/Drug Use	Yes	No
Back Injury	Yes	No	Tuberculosis	Yes	No
Bleeding Problems/ Unusual Bruising	Yes	No	Hepatitis/Liver Disease/Cirrhosis	Yes	No
Diabetes/sugar	Yes	No	Stomach Trouble/Ulcers	Yes	No
Epilepsy/Fits/Seizures	Yes	No	Cancer/Tumors	Yes	No
Glaucoma	Yes	No	High Cholesterol	Yes	No
Heart Problems/ Heart Murmur	Yes	No	Gallbladder disease/Gallstones	Yes	No
High Blood Pressure	Yes	No	Rheumatic Fever	Yes	No
Stroke	Yes	No	Thyroid Disease/Goiter	Yes	No

Family History (Please check Yes if anyone in your family has had the following conditions)

History	Relationship to Patient	Age	Living?	Deceased?
Yes Heart Disease				
Yes Heart Attack before they were 50 year old				
Yes High Blood Pressure				
Yes Cancer	What type?			
Yes Diabetes				
Yes High Cholesterol				
Yes Suicide				
Yes Mental Illness				
Yes Alcohol/Drug Abuse				
Yes Osteoporosis (Weak Bones)				

Psychosocial In the **Past year** have you noticed any of the following conditions?

1. Felt depressed, "Blue", or had trouble sleeping or sleeping a lot? Yes No
2. Had difficulty relaxing or calming down, been anxious, worried a lot? Yes No
3. Felt like you (or others) would be better off if you were dead? Yes No
4. Are there concerns about home, family, work, money, or legal issues you would like to speak with someone about? Yes No

The following questions are very personal and you may feel uncomfortable answering them. If you prefer, simply skip those questions.

Sexual History

Age when you had intercourse for the first time _____
 Do you use condoms when you have sex? _____
 Are you sexually active now? _____
 Do you ever fight with your partner about sex? _____
 Have you ever been forced to have sex? _____
 What are you using for birth control? _____
 Are you happy with it? Yes NO

For Women Only

How old were you when you started having periods? _____
 When was your last Pap Smear? _____
 Where? _____
 When was your last Mammogram? _____
 Where? _____
 Do you know how to examine your breasts? _____
 Do you examine your breasts every month? _____
 Have you ever had an abnormal Pap Smear? _____
 Number of Pregnancies? _____ Live Births? _____ Miscarriages _____ Abortions _____ Living Children _____
 Any problems with any of your pregnancies? _____

For Men Only

Do you examine your testicles every month? _____
 Do you ever have problems passing your urine (passing your water)? Yes No
 Have you ever noticed problems achieving or maintaining an erection? Yes No

Domestic risks Please check "yes" if any of the following are true

- ____ Yes 1. Has your partner ever hit or physically hurt you?
- ____ Yes 2. Has your partner ever threatened to hurt you or someone close to you?
- ____ Yes 3. Has your partner ever kept you from doing something important?
- ____ Yes 4. Does your partner frequently put you down, insult you, or blame you for things?
- ____ Yes 5. Does your partner control the money in your house?

Habits

How many cigarettes do you smoke a day? _____ Are you interested in quitting? Yes No

Do you ever smoke cigars or pipes? Yes No Used Chewing Tobacco? Yes No

How much alcohol do you drink each day? _____ Each Week? _____ Each Weekend? _____

(Include Beer, Whiskey, Wine, Shots)

Have you ever used any narcotics, street drugs, or other addictive substances? Yes No

If so, which substance? _____

Have you ever had a blood transfusion Yes No When? _____

In the past ten years, have you ever participated in any "High Risk" behaviors like sharing needles, had more than 5 sexual partners, had sexual activity with someone of the same sex, or with someone who has, multiple partners? Yes No

Risk Assessment

Do you wear a seatbelt? _____

Do you exercise? _____ How often? _____ What type of Exercise? _____

Do you have smoke detectors in your home? _____ A fire extinguisher? _____

Are there guns in your home? _____ Are they kept locked away? _____

Do you think you are overweight? _____ Underweight? _____ Just about right? _____

Do you diet frequently? _____ What types have you tried? _____

Do you salt your food? _____ Are you on a special diet for health reasons? _____

Immunizations

When was your last... Tetanus shot? _____ TB Test _____ Result _____ Hepatitis B Shot _____ Flu Shot _____

Pneumonia Shot _____

Have you traveled outside the country in the past two years? Yes No

Reviewed by: _____ with _____
Provider Signature Patient Signature

Thank you for your time in filling out this form