

**Northwest Georgia Dermatology**  
**Jason L. Smith, MD**  
**103 John Maddox Drive**  
**Rome, Georgia 30165**

Date: _____
Account #: _____
____ New Patient      ____ Existing

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Male or Female Social Security Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

*Indicate by circling the number you would like for us to use as your primary contact number and for leaving messages regarding your appointments.*

*If a number is not indicated as your primary contact number, your home number will be used as your primary contact number.*

Employer: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

**PLEASE INDICATE YOUR PREFERRED PHARMACY:** \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION (if different from above)**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Male or Female Social Security Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**INSURANCE AND MEDICAL RECORD AUTHORIZATION**

I, the undersigned, hereby authorize Northwest Georgia Dermatology to furnish information to my insurance carriers concerning my illness and treatment, and I hereby assign to the physician all payments for medical services rendered. I authorize the release of my medical records to the referring physician and to my insurance company should it be requested.

**PHONE MESSAGE / CALL AUTHORIZATION**

I, the undersigned, hereby authorize Northwest Georgia Dermatology to leave messages on my answering machine regarding my care or for appointment reminders.

**CONSENT FOR TREATMENT / INSURANCE RELEASE**

I, the undersigned, hereby authorize Dr. Jason L. Smith, Dr. Betsy P. Thacker, Christin Smith, PA-C, or Claire Arnett, PA-C, to examine and treat me, including any biopsy or procedure(s), as deemed necessary to provide dermatologic care and aid in the diagnosis of my skin disorder. I understand that any procedure involves risks including, but not limited to, bleeding, infection and scarring. I am aware that scarring can result from any procedure and the type of severity of such scarring cannot always be predicted before the procedure.

I, the undersigned, hereby authorize Northwest Georgia Dermatology to take photographs of me for my medical records and for educational purposes. I understand the photographs may include appropriate portions of the body to demonstrate procedures and that every effort will be made to protect my identity in those materials.

\_\_\_\_ I do \_\_\_\_ I do not give authorization for photographs to be taken of me. \_\_\_\_ (Initials)

**PLEASE SEE REVERSE SIDE – SIGNATURE REQUIRED TWICE**



**Northwest Georgia Dermatology**

**Jason L. Smith, MD**

**103 John Maddox Drive**

**Rome, Georgia 30165**

I, the undersigned, authorize that the payment of insurance benefits be made on my behalf to Northwest Georgia Dermatology for any services rendered to me. I further understand that prior to disbursing payment for services, my insurance company may require documentation from my medical records in order to process claims and approve payments.

I, the undersigned, understand that my insurance may not cover procedures and/or medications. I further understand that I am personally and fully responsible for any non-covered services, services deemed medically unnecessary, denied services, health insurance deductibles and co-insurance payments. I agree to assume full responsibility for the balance not covered.

***We will not bill your insurance for services deemed medically unnecessary and payment is due at time of service.***

I, the undersigned, understand I may be billed by an outside laboratory for work that is performed in this office either because my insurance company does not have a contracted lab or facility, or if services are not covered by my insurance company.

**X**

\_\_\_\_\_  
**Patient Signature** *(may be signed by parent/guardian of minor patient)*

\_\_\_\_\_  
**Date**

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

In compliance with the **Health Insurance Portability and Accountability Act of 1996 (HIPPA)**, Northwest Georgia Dermatology has made available to you, a Notice of Privacy Practices. **You have the right to request a copy of the Notice of Privacy Practices prior to signing this consent.** A current copy of the Notice is posted in our office in a visible location at all times. The terms of the Notice may be revised or amended and you have the right to request a current copy of the Notice at any time.

The Notice provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a section explaining the patient’s rights regarding your PHI. You have the right to request that we restrict or limit how PHI is used or disclosed for treatment, payment, or health care operations.

**By signing this consent, you acknowledge that you have either received or waived your right to receive a current copy of the Notice.** At any time, you have the right to revoke this consent by submitting your request in writing and signed by you, to Northwest Georgia Dermatology.

In an effort to provide you with quality care, please provide the names of individuals you authorize Dr. Jason L. Smith, Dr. Betsy P. Thacker, physician’s assistants, and staff of Northwest Georgia Dermatology to share your patient health information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Names of  
Authorized  
Individuals

**X**

\_\_\_\_\_  
**Patient Signature** *(may be signed by parent/guardian of minor patient)*

\_\_\_\_\_  
**Date**