LANE DERMATOLOGY AND DERMATOLOGIC SURGERY
PATIENT INFORMATION

Today's Date	Primary Care Physician	Who Referred You To Our Office?
PATIENT INFORMATION		
LAST NAME	FIRST NAME MIDDLE INITIAL	EMAIL ADDRESS
Mailing Address City	State	Zip
PRIMARY Phone Number	**SECONDARY** Phone Number	**WORK** Phone Number
DATE OF BIRTH	GENDER: ○ MALE ○ FEMALE MARITAL STATUS: ○ SINGLE ○ MARRIED ○ DIVORCED ○ OTHER	SOCIAL SECURITY NUMBER:
EMPLOYER	EMPLOYER'S Street Address	CITY, STATE, ZIP
EMERGENCY CONTACT Name	EMERGENCY CONTACT Primary Phone	EMERGENCY CONTACT Secondary Phone
IF PATIENT IS A MINOR (UNDER 18)		
RESPONSIBLE PARTY	DATE OF BIRTH: RELATIONSHIP TO PT:	ADDRESS (if different)
INSURANCE INFORMATION **Please present insurance card(s) and picture ID to Receptionist**		
PRIMARY Insurance Name		
Policyholder's Name	**Policyholder's** Date of Birth	**Policyholder's** Social Security #:
Policyholder's Address Same as Patient ○		
Patient's Relationship To Policyholder: ○ self ○ spouse ○ child ○ other (specify) ___________________________		
SECONDARY Insurance Name		
Policyholder's Name	**Policyholder's** Date of Birth	**Policyholder's** Social Security #:
Policyholder's Address Same as Patient ○		
Patient's Relationship To Policyholder: ○ self ○ spouse ○ child ○ other (specify) ___________________________		

What **PHARMACY** do you use? ____

The above information is true to the best of my knowledge. I authorize Lane Dermatology & Dermatologic Surgery and their designee(s) to file an insurance claim on my behalf for services rendered. I authorize my insurance benefits to be paid directly to Lane Dermatology & Dermatologic Surgery. I understand that I am financially responsible for any remaining balance(s) on my account. I authorize Lane Dermatology & Dermatologic Surgery to release any information required by my insurance carrier in order to process my claim(s).

X ____ ____

PATIENT SIGNATURE (parent/guardian if minor) **DATE SIGNED**

____ ____

PRINTED NAME (if other than patient) **RELATIONSHIP to patient**

Please carefully read each of the following sections and initial indicating your understanding.

NOTICE OF PRIVACY

_________ Our notice of Privacy Practice provides information about how we may use and disclose protected health information about you. This includes disclosure for the purpose of diagnosing or providing treatment to you, obtaining payment for your health care bills, or to conduct health care operations. By initialing, you acknowledge that you have been informed that there is a privacy notice in our office and consent to use of medical information or disclosure as outlined above.

CANCELLATION POLICY

_________ Our office operates by appointment only. We require a minimum of 24 hours notice of any cancellation of appointment so as to allow other patients to be scheduled. A fee of $50 may be charged without 24 hours notice of cancellation. This is not reimbursable by insurance and will be billed directly to you.

CONSENT FOR ROUTINE TREATMENT

_________ During the course of your care and treatment, various types of treatments, test, and/or procedures may be necessary. These treatments are performed by the Physician, the Physician Assistant, or by an assistant designated by your provider.

While usually performed without incident, there may be potential risks associated with each of the treatments. You will be informed of these risks prior to any treatment being rendered. By initialling, you consent to the treatment deemed reasonably necessary for your care. You may rescind this consent at any time prior to any treatment being performed.

CONSENT FOR MEDICAL TEST RESULTS

_________ In the event that you have lab work or biopsies performed, a member of our staff may contact you regarding the results. By initialling, you consent to information being left in the form of voicemail message. If it is okay for us to talk with another person about your test results or treatment, please provide that person's name: ____
This permission can be revoked at any time.

ASSIGNMENT OF INSURANCE BENEFITS

_________ I hereby assign all applicable insurance benefits to Lane Dermatology & Dermatologic Surgery. I understand that I am financially responsible for any remaining balances in accordance with my insurance contract.

_________ In addition to assigning benefits, should it become necessary to appeal my insurance claim, I authorize Lane Dermatology & Dermatologic Surgery to appeal the claim on my behalf.

____ ______________________________
Printed Name of Person Completing Form Date

____
Signature

LANE
DERMATOLOGY & DERMATOLOGIC SURGERY

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

PLEASE COMPLETE REGARDING **PATIENT:**

Name (Last, First, MI)		
Street Address		Telephone
City	State	Zip
Social Security Number	Date of Birth	

PLEASE **DO NOT** COMPLETE THIS SECTION

Records Released From:

Name (Healthcare Facility/Physician)		
Street Address		
City	State	Zip
Telephone #:	Fax #:	

Records Released To:

Name (Healthcare Facility/Physician) **LANE DERMATOLOGY & DERMATOLOGIC SURGERY**		
Street Address **1210 BROOKSTONE CENTRE PKWY**		
City **COLUMBUS,**	State **GA**	Zip **31904**
Telephone #: **706-322-1717**	Fax #: **706-322-1718**	

Information to be released: (Please check all applicable categories)

- ○ Complete copy of all records
- ○ Laboratory Reports
- ○ Allergy Records
- ○ X-ray Reports/Films
- ○ Telephone Records
- ○ Coding Itemization
- ○ Immunization Records
- ○ Counseling
- ○ Clinic records pertaining to the treatment of: (specify date(s) or condition(s):

____

- ○ Other: (please specify) ____

Purpose or need for disclosure: (please check all that apply)

- ○ Further Medical Care
- ○ Insurance Application
- ○ Legal Investigation
- ○ Payment of Insurance Claim
- ○ Academics
- ○ School Disability
- ○ Personal
- ○ Other: ______________________________________

PLEASE **READ AND SIGN** THIS SECTION

I understand that this authorization will remain in effect until this request is processed unless otherwise specified in the information above. I further understand that my written consent is necessary to revoke this request.

I, the undersigned patient (parent or legal guardian if minor patient) authorize release of my medical records in accordance with the specification listed above. I understand that I have a right to inspect and receive a copy of the disclosed material upon my request. A photocopy of this consent shall be valid as the original. All releases will be processed within 72 hours of receipt.

X____ ________________________________

Patient Signature (parent or legal guardian if minor) Date

Notice to recipient of information: This information has been disclosed to you from confidential medical records which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosure of this information without the specific written consent of the patient or legal representative involved.

Patient Rights and Responsibilities:

PATIENT RIGHTS:

1. All patients will be treated with consideration, compassion, and respect as individuals. Their privacy will be protected and employees will seek to honor their personal and religious beliefs that do not harm or interfere with the planned course of medical/surgical therapy.
2. Each patient, upon request, will receive information regarding his/her insurance benefits and the cost of their care.
3. Patients will be involved in all decisions about their care. Reasonable attempts will be made to communicate in the language or manner primarily used by the patient whenever possible.
4. Patients will be involved in all decisions regarding their care. Discussions with patients will include the necessity, appropriateness, and risks of proposed care, surgery, or procedure as well as discussions of treatment alternatives. If it is medically inadvisable to give such information to the patient, the information will be provided to a person designated by the patient or to a legally authorized person.
5. Patients will be fully informed of the scope of services available at the facility, and will be given clear verbal and written instructions on the postoperative care of their wound and instructions on how to contact the physician on call in the event that they experience a medical problem after hours.
6. Patients will be informed of any human experimentation or other research/educational projects affecting his/her care or treatment and can refuse participation in such programs without compromise to the patient's medical care.
7. Each patient has the right to know the identity and professional status of individuals providing services to them and to know which physician or physician extender is primarily responsible for their care.
8. Patients have the right to refuse treatment to the extent permitted by law and will be informed of the medical consequences of such refusal.
9. Patients may approve or refuse the release of medical records to any individual outside the facility or as required by law or third party payment contract. All individually identifiable health information will be treated as confidential in accordance with HIPAA guidelines.
10. Patients have the right to change providers if other qualified providers are available.
11. Patients have the right to exercise his/her rights without being subjected to discrimination or reprisal.
12. Patients may voice grievances regarding treatment or care that is (or fails to be) furnished.
13. Patients will receive care in a safe setting, and free from all forms of abuse or harassment. Their personal privacy will be respected at all times by all personnel.

If a patient is judged incompetent under applicable State health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf.

If a State court has not judged a patient incompetent, any legal representative designated by the patient in accordance with State laws may exercise the patient's rights to the extent allowed by State law.

PATIENT RESPONSIBILITIES:

1. Be respectful of all healthcare professionals and staff as well as other patients.
2. Respecting that this is a smoke free campus.
3. Respecting the property of others and the facility.
4. Following the treatment plan prescribed by his/her provider.
5. Actively participating in his/her care.
6. Keeping appointments and, when unable to do so for any reason, notifying the practice/facility.
7. Providing care givers with the most accurate and complete information regarding health history, medications including over the counter products, dietary supplements, and any allergies or sensitivities.
8. Observing prescribed rules of the facility during his/her stay and treatment and, if instructions are not followed, forfeiting the right of care at the facility and accepting responsibility for the outcome.
9. Promptly fulfilling his/her financial obligations to the practice/facility.
10. Identifying any patient safety concerns.

ADVANCE DIRECTIVE NOTIFICATION:

In the State of Georgia, all patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers of Attorney that authorize others to make decision on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate their wishes. Lane Dermatologic Surgery Center respects and upholds those rights.

However, unlike in an acute care hospital setting, we do not routinely perform "high risk" procedures. Most procedures performed in this practice/facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery, and care after your surgery.

Therefore, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney-in-fact, that if an adverse event occurs during the course of your treatment at this practice/facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or health care Power of Attorney. Your agreement with the practice/facility's policy will not revoke or invalidate any current healthcare directive or healthcare power of attorney.

At your request, our practice/facility can provide you with the necessary forms to complete your advance directive in accordance with Georgia State Law.

If you do not agree with this practice/facility's policy, we will be pleased to assist you in rescheduling your procedure.

I have provided a copy of my advance directive to be kept on file at this facility. I have read and understand the above policy regarding advance directives.

____________________ ____________
Signature Date

Dr. Joshua E. Lane and Dr. Tanda N. Lane DO have financial interest in this practice/facility.

HOW TO FILE A COMPLAINT OR GRIEVANCE

To report a complaint or grievance, you can contact the Compliance Officer at 706.322.1717, or by mail at:

Lane Dermatology & Dermatologic Surgery
Lane Dermatologic Surgery Center
1210 Brookstone Centre Parkway
Columbus, GA 31904
Compliance Officer

Complaints and grievances may also be filed through the *State of Georgia Office of Investigations* at ***404.657.3700***, or by mail at:

Georgia Department of Community Health
2 Peachtree Street NW
Atlanta, GA 30303-3186
www.dech.georgia.gov

All *Medicare beneficiaries* may also file a complaint or grievance with the *Medicare Beneficiary Ombudsman*. Visit the Ombudsman's webpage on the web at:
www.cms.hhs.gov/center/ombudsman.asp

BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE RECEIVED INFORMATION ABOUT DISCLOSURE OF OWNERSHIP, PATIENT RIGHTS AND RESPONSIBILITIES, ADVANCE DIRECTIVES AND PATIENT COMPLAINT OR GRIEVANCE PROCEDURES:

Patient/Patient's Representative Date

Witness Date