Southern Skies
Dermatology & Surgery
The Skin Cancer Experts

St. Vincent's East Campus
48 Medical Park Dr E #458
Birmingham, AL 35235

Phone: (205) 900-2000

St. Vincent's St. Clair
Outpatient Clinic
7063 Veterans Pkwy
Pell City, AL 35125
Fax: (205) 838-4525

Gadsden Regional Medical Center
300 Medical Center Dr #402
Gadsden, AL 35903

www.SouthernSkiesDermatology.com

RMC Oxford Mediplex
1400 Highway Dr Ste C
Oxford, AL 36203

info@ssdspc.com

05/17/2023 -->L3-3-3R<--

Hello,

Thank you for choosing Southern Skies Dermatology & Surgery for your dermatology needs!

In an effort to expedite the check-in experience, we ask that you complete the enclosed paperwork and bring it with you on the day of your appointment. Please bring your driver's license and insurance card as well. We will need to copy those at the time of check-in.

Bring the following with you to your appointment:

- ☐ **Driver's License (or other government issued photo ID)**
- ☐ **Insurance card**
- ☐ **Completed Payment Information Form (in this packet)**
- ☐ **Completed Medical History Form (in this packet)**
- ☐ **Signed HIPAA Consent Form (in this packet)**

Don't hesitate to call our office at **205-900-2000** if you have any questions beforehand. Otherwise, we will see you at your scheduled appointment.

We look forward to meeting you soon!

Sincerely,
The Physicians & Staff at Southern Skies Dermatology & Surgery

Appointment Date & Time: _____

Provider:

☐ Dr. Maruthur ☐ Dr. Kennedy ☐ Chelsi Davis, PA
☐ Adrienne Keely, NP ☐ Lauren Miller, PA

Location:

☐ **Birmingham/Trussville**
St. Vincent's East Campus, 48 Medical Park Dr E #458, Birmingham, AL 35235

☐ **Gadsden**
Gadsden Regional Medical Center, 300 Medical Center Dr #402, Gadsden, AL 35903

☐ **Pell City**
St. Vincent's St. Clair, Outpatient Clinic, 7063 Veterans Pkwy, Pell City, AL 35125

☐ **Oxford**
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Patient Payment Information

PATIENT AND INSURED (SUBSCRIBER) INFORMATION									
PATIENT'S FULL NAME	SOC. SEC. NO.	SEX M	SEX F	DATE OF BIRTH / /	AGE				
MAILING ADDRESS	CITY, STATE, ZIP CODE	HOME PHONE	CELL PHONE						
PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT) ☐ PART TIME ☐ FULL TIME	MARITAL STATUS S	M	W	D	SEP			
EMPLOYER'S STREET ADDRESS	CITY, STATE, ZIP CODE	BUSINESS PHONE							
SPOUSE'S OR PARENT'S NAME	SOC. SEC.NO.	DATE OF BIRTH / /	CELL PHONE						
SPOUSE'S OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT) ☐ PART TIME ☐ FULL TIME	BUSINESS PHONE							
PATIENT EMAIL ADDRESS									

RESPONSIBLE PARTY INFORMATION				
NAME OF RESPONSIBLE PARTY	SOC. SEC. NO.	DATE OF BIRTH	HOME PHONE	CELL/WORK PHONE
MAILING ADDRESS	CITY, STATE, ZIP CODE	RELATIONSHIP TO PATIENT		
RESPONSIBLE PARTY'S EMPLOYER	CITY, STATE OF EMPLOYER	BUSINESS PHONE		

INSURANCE INFORMATION						
NAME OF PRIMARY INSURANCE CO.	CO-PAY	CONTRACT NO.	GROUP NO.	NAME OF INSURED (AS IT APPEARS ON YOUR INS. CARD) DATE OF BIRTH		
NAME OF SECONDARY INSURANCE CO.	CO-PAY	CONTRACT NO.	GROUP NO.	NAME OF INSURED (AS IT APPEARS ON YOUR INS. CARD) DATE OF BIRTH		
ARE YOU INSURED UNDER YOUR SPOUSE'S INSURANCE?	YES	NO	IF YES: NAME OF INSURANCE CO.	CONTRACT NO.	GROUP NO.	

IN CASE OF EMERGENCY NOTIFY (OTHER THAN RESPONSIBLE PARTY)			
NAME	HOME PHONE	CELL/WORK PHONE	RELATIONSHIP
MAILING ADDRESS	CITY, STATE, ZIP CODE		

EXPLANATION OF PAYMENT POLICY, INSURANCE FILING PROCEDURES, AND FINANCIAL RESPONSIBILITY AGREEMENT

I hereby authorize Southern Skies Dermatology and Surgery to release any and all information acquired in my examination and treatment to my insurer listed above. If I am covered by Blue Cross, Medicare and/or Medicaid, I will furnish my insurance card and signature. If I am covered by other insurance, I will furnish the necessary forms to this office.

I hereby assign and authorize payment directly to Southern Skies Dermatology and Surgery any medical and surgical benefits otherwise payable to me. Should an insurance payment be received that is less than the physician's usual charge for the services provided, I will be responsible for the difference.

I understand that payment is due at the time of service. I agree to pay collection fees of 33 1/3 % of the unpaid balance at such time that my account is placed with a collection agency. I further agree that I am responsible for all costs associated with the collection of my account, including but not limited to postage costs, and all credit card processing costs. In the event my account is referred to an attorney for collection, I agree to be liable for attorney's fees of 33 1/3% of the unpaid balance, and all costs of court. I also authorize my employment location and status to be verified for the purpose of processing my bill for payment.

I authorize the use of the phone numbers and other contact information I provide, including my cellular number and any future number assigned to me, for calls, texts, emails, to include automated dialers to contact me regarding my care and my account by this medical provider and this medical provider's business associates.

I authorize treatment by Southern Skies Dermatology and Surgery Physicians and personnel.

Patient/Guardian _____ Signature Date _____

I certify that all information on this form is correct to the best of my knowledge. Recertify.

Signature:_____ Date:_____

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Personal & Family Medical History

DATE	PATIENT NAME	CHART NO.

ALERTS (PLEASE CIRCLE ALL THAT APPLY)

Hepatitis C Positive
HIV Positive
Allergy to adhesive
Allergy to lidocaine
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to surgical procedure

MEDICATION ALLERGIES (PLEASE CIRCLE ALL THAT APPLY)

Aspirin
Penicillin
Codeine
Morphine
None
Sulfa Drugs
Erythromycin
Tetracycline
Keflex (Cephalosporin)
Other_____

ALLERGIC/ IMMUNOLOGIC (CIRCLE)
Food, Insect, Jewelry
Ointments, Creams, Lotions, Cosmetics
Hay Fever, Asthma, Sinus, Eyes
Other_____
_____

DO YOU CURRENTLY HAVE OR HAVE YOU HAD ANY FORM OF CANCER? (CIRCLE)
Skin Cancer
Melanoma
Other_____
_____

HAVE YOU BEEN HOSPITALIZED DURING THE PAST 3 YEARS? YES NO
For What Condition?_____

CARDIOVASCULAR (CIRCLE)
Blood Pressure
Heart Attack
Irregular Heartbeat
Enlarged Heart (Heart Failure)
Chest Pain
Easy Bleeding
Are You Presently Taking Blood Thinners?
If Yes, What Type?
( ) Coumadin ( ) Aspirin ( ) Plavix
( ) Ticlid ( )Persantine [Dipyridamole]
( ) Other_____

RESPIRATORY (CIRCLE)
Asthma
Emphysema

GASTROINTESTINAL (CIRCLE)
Ulcer Disease
Colitis or Inflammatory Bowel Disease
Signature_____

GENITOURINARY
Kidney Failure

FEMALE ISSUES (CIRCLE)
Miscarriage
Pregnancy
Are You Currently Using Birth Control Pills?

MUSCULOSKELETAL
Arthritis

NEUROLOGICAL (CIRCLE)
Seizure
Stroke or Paralysis
Tendency to Faint

MENTAL STATUS (CIRCLE)
Tendency Toward Nerves
Tendency Toward Depression

ENDOCRINE (CIRCLE)
Thyroid Disease
Diabetes

HEMATOLOGICAL (CIRCLE)
Anemia
Bleeding or Clotting Disorder

SOCIAL HISTORY
Do You Smoke Presently? Yes No How much?_____
Do You Consume Alcoholic Beverages? Yes No How Much?_____

FAMILY HISTORY (CIRCLE)
Do Any Immediate (blood) Relatives Have Any Of The Following? Do Not Consider Yourself.

Hay Fever
Drug Allergy
Diabetes
Heart Disease
Psoriasis
Eczema
Skin Problems
Skin Cancer

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Date_____ Bleeding Disorders Skin Melanoma

List all medicines, even if you only take them occasionally: Please include laxatives, tranquilizers, sleeping pills, antihistamines, vitamins, aspirin, pain pills, blood thinners, birth control pills, blood pressure pills, fluid pills, etc.

DATE	MEDICATION	DISCONTINUED

PRIMARY CARE PROVIDER:_____ PHONE #:_____

PREFERRED PHARMACY:_____ PHONE #:_____

At the time of each visit, the medical information was reviewed and corrected where appropriate.

DATE	PAT. INIT.	STAFF INIT.	M.D. INIT.	DATE	PAT. INIT.	STAFF INIT.	M.D. INIT.

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HIPAA Consent

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Southern Skies Dermatology and Surgery may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Please refer to Southern Skies Dermatology and Surgery Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Southern Skies Dermatology and Surgery reserves the right to revise its Notices of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by request to Southern Skies Dermatology and Surgery.

With my consent, Southern Skies Dermatology and Surgery may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including but not limited to laboratory results.

With my consent, Southern Skies Dermatology and Surgery may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as laboratory and pathology results, appointment reminder cards and patient statements.
With my consent, Southern Skies Dermatology and Surgery may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Southern Skies Dermatology and Surgery restrict how it uses or discloses my PHI to carry out its clinical care. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

During the course of your medical treatment, we strive to communicate with you, the patient, in a timely and professional manner. There are certain occasions when family members, friends, or others might be involved in your care and you will want our office to be able to communicate directly with them. In order to protect the privacy of your personal health information, please indicate below the names of any other people with whom we can discuss your care and personal health information:

Name:_____ DOB_____Relationship_____

Name:_____ DOB_____Relationship_____

Name:_____ DOB_____Relationship_____

By signing this form, I am consenting to Southern Skies Dermatology and Surgery's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign his consent, Southern Skies Dermatology and Surgery may decline to provide treatment to me.

Signature of Patient/Legal Guardian:_____Date:_____

Relationship to Patient if Legal Guardian:_____