

**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.

1218 WEST PACES FERRY ROAD NW  
SUITE 200  
ATLANTA, GEORGIA 30327  
PHONE: 404/525-7409  
FAX: 404/522-0608

## Notice of Privacy Practices

### NOTICE OF PRIVACY PRACTICES

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

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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. If 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 disclosures 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 notice 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.

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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

_____	_____	_____
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 have read and understand the policies as stated above.

## CANCELLATION AND NO SHOW POLICY

When you make an appointment, the scheduled time is reserved for your exclusive use. Please be aware when scheduling an appointment there will be a \$75.00 no-show fee and for excisions there will be a \$150.00 fee. This fee will be applied to the amount due on the day of your surgery. If you miss or cancel an appointment without a 48 hour notice, the full appointment fee will be charged to you.

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Signature

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Date

HISTORY AND INTAKE FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

EMAIL: \_\_\_\_\_

Past Medical History: (Please check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Anxiety                     | <input type="checkbox"/> Hepatitis            |
| <input type="checkbox"/> Arthritis                   | <input type="checkbox"/> Hypertension         |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> HIV/AIDS             |
| <input type="checkbox"/> Atrial Fibrillation         | <input type="checkbox"/> Hypercholesterolemia |
| <input type="checkbox"/> Bone Marrow Transplantation | <input type="checkbox"/> Hyperthyroidism      |
| <input type="checkbox"/> BPH                         | <input type="checkbox"/> Hypothyroidism       |
| <input type="checkbox"/> Breast Cancer               | <input type="checkbox"/> Leukemia             |
| <input type="checkbox"/> Colon Cancer                | <input type="checkbox"/> Lung Cancer          |
| <input type="checkbox"/> COPD                        | <input type="checkbox"/> Lymphoma             |
| <input type="checkbox"/> Coronary Artery Disease     | <input type="checkbox"/> Prostate Cancer      |
| <input type="checkbox"/> Depression                  | <input type="checkbox"/> Radiation Treatment  |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> End Stage Renal Disease     | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> GERD                        | <input type="checkbox"/> None                 |
| <input type="checkbox"/> Hearing Loss                | <input type="checkbox"/> 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)

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

Turn Over





# Hailey, Brody, Casey & Wray MD PC

## HISTORY AND INTAKE FORM

NAME: \_\_\_\_\_ EMAIL: \_\_\_\_\_

### Skin Disease History: (please check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Acne                   | <input type="checkbox"/> Hay Fever / Allergies     |
| <input type="checkbox"/> Actinic Keratosis      | <input type="checkbox"/> Melanoma                  |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Poison Ivy                |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Precancerous Moles        |
| <input type="checkbox"/> Blistering Sunburns    | <input type="checkbox"/> Psoriasis                 |
| <input type="checkbox"/> Dry Skin               | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <input type="checkbox"/> Eczema                 | <input type="checkbox"/> None                      |
| <input type="checkbox"/> Flaking or Itchy Scalp |  |
| <input type="checkbox"/> 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:

- |   |  |
|---|--|
| <input type="checkbox"/> None                 | <input type="checkbox"/> Less than one drink per day |
| <input type="checkbox"/> 1 – 2 drinks per day | <input type="checkbox"/> 3 or more drinks per day    |

#### Cigarette Smoking:

- |   |  |
|---|--|
| <input type="checkbox"/> Never Smoked           | <input type="checkbox"/> Quit: former smoker |
| <input type="checkbox"/> Smokes less than daily | <input type="checkbox"/> 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.**