CLEAVER MEDICAL GROUP
THE CENTER FOR DERMATOLOGY
& SKIN CANCER SURGERY

NATHAN CLEAVER D.O.
FAOCD, FAAD

PATIENT INFORMATION

Date of Birth: _____ Today's Date: _____
First Name: _____ Middle Name: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home #: _____ Work #: _____
Email Address: _____
Primary Doctor: _____ Primary Doctor's #: _____
Referred by: Doctor _____ ☐Family ☐Friend ☐Internet ☐Newspaper ☐Ad
Pharmacy Name: _____ Preferred Language: _____

Race (cirlce one): African American☐ American Indian or Alaskan Native☐ Asian☐
White☐ Native Hawaiian or other Pacific Islander☐ Other☐

Ethnic Group (cirlce one): Hispanic or Latino☐ Not Hispanic or Latino☐
Unknown☐ Unspecified☐

Patient Occupation: _____ Employer: _____
Employer Name: _____ Employer #: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Student: ☐Part Time d☐Full Time Name of School: _____

EMERGENCY CONTACT OR PARENT/LEGAL GUARDIAN (IF MINOR)

Name: _____ Phone #: _____
Relationship to Patient: _____
Parent or Legal Guardian Financially Responsible for Minor: _____
Address: _____ Date of Birth: _____

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PLEASE PRESENT INSURANCE CARD SO THAT A COPIED CAN BE MADE

Primary Insurance: _____
Policy Holder: _____
Relation: _____
Phone #: _____
DOB: _____
SSN: _____

Secondary Insurance: _____
Policy Holder: _____
Relation: _____
Phone #: _____
DOB: _____
SSN: _____

WE REQUIRE 1/2 OF PAYMENT FOR ALL COSMETIC PROCEDURES AT THE TIME THEY ARE SCHEDULED. YOU WILL BE ASKED TO SIGN A WAIVER OF LIABILITY FORM IN THE EVENT THAT A SERVICE IS PROVIDED WHICH WE KNOW IS NOT COVERED BY MEDICARE.

Patient Name (Please Print): _____

I hereby acknowledge that I have been presented with a copy of Cleaver Medical Group's Notice of Privacy Practices

Signature of Patient/Guardian/Parent: _____

IF PATIENT IS A MINOR: (Patient Name) HAS MY PERMISSION TO BE SEEN AND TREATED WITHOUT BEING ACCOMPANIED BY GUARDIAN OR OTHER ADULT (THIS VISIT AND FUTURE VISITS) I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR THE BILL SHOULD INSURANCE NOT PAY, EVEN IF I AM NOT PRESENT AT THE TIME OF PATIENT'S VISIT

Signature of Legal Guardian/Parent: _____ Date: _____

If you have MEDICARE, please answer the questions below by placing a check in the appropriate box:

☐ Yes ☐ No Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?

☐ Yes ☐ No Are you covered by a HMO/PPO which makes Medicare secondary?

☐ Yes ☐ No Is this illness covered by the VA Veteran's Administration?

☐ Yes ☐ No Is this illness covered by the Federal Black Lung or End Stage Renal Disease Program?

☑ Yes ☐ No Is this illnes due to an automobile accident?

☐ Yes ☑ No Is this illnes due to an injury at work?

☐ Yes ☐ No Are you receiving Medicaid?

PLEASE PRESENT INSURANCE CARD SO THAT A COPIED CAN BE MADE

This office is required to keep your signature on file authorizing us to file claims for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me be released to the Social Security Administration and Health Care Financing Administration or it intermediaries or carrier or any health insurance carrier that I have a policy with any information needed for this claim or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignments of benefits apply.

Signature as it appears on Medicare Card or Insurance Card: _____
Date: _____

If you have a supplement policy or a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a signature on file.

Name of Supplement/Secondary Insurance/Medigap Carrier: _____

Insured's Name: _____

Signature as it appears on Supplement/Secondary Insurance/Medigap Card: _____

Date: _____

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Patient Name: Date of Birth:

Please list the Name(s) and Phone Number(s) of the person(s) with whom you give up permission to discuss your medical condition as well as their relationship to you (I.E. friend, neighbor, child, etc.)

Name: Relationship: Phone Number:

☐ Check here if you do not wish for us to discuss your condition with anyone other than yourself.

May we leave a message on your answering machine? ☐ Yes ☐ No ☐ N/A

May we call you at work? ☐ Yes ■ No ☐ N/A

Patient Signature: _____ Date: _____

* You may change any of this information at any time. Please check with a receptionist or nurse and they will supply a new form for you. Thank you.

PAST MEDICAL HISTORY: (Cirlce any of the following conditions that you currently have or have had)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign Prostatic Hypertrophy
- ☐ Blindness
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPT
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes (Type 1 or Type 2)
- ☐ End Stage Renal Disease
- ☐ GERI
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heaving Loss
- ☐ Hepatitis (A, B, or C)
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hypothyroidism (Low)
- ☐ Hyperthyroidism (High)
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Seizures
- ☐ Stroke

Other _____

Other _____

PAST SURGICAL HISTORY: (Please circle all that apply)

- ☐ Basal Cell Carcinoma Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma Surgery
- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy or Lumpectomy (Right, Left, or Both)
- ☐ Breast Reduction or Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis or IBS
- ☐ Colostomy
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ Heart Stents

Other: _____

- ☐ Heart Transplant
- ☐ Heart Valve Replacement (biological or mechanical)

Joint Replacement within last 2 years: (location) _____

- ☐ Kidney Removed (Right or Left)
- ☐ Kidney Transplant (Right or Left)
- ☐ Pacemaker/Defibrillator Implant

Radiation Treatment: (reason) _____

- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Bilateral)

Hysterectomy: (reason) _____

Ovaries Removed: (reason) _____

SKIN DISEASE HISTORY: (Please circle all that apply)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin / Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Seasonal Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Skin Cancer

Do you have a family history of Melanoma? ☐ Yes ☐ No
If yes, which relative(s)? _____
Do you tan in a tanning salon? ☐ Yes ☐ No

Do you wear sunscreen? ☐ Yes ☐ No
If yes, what SPF? _____

MEDICAL HISTORY

Medications: (Please list all current medications including over-the-counter products and herbals)

_____

_____

_____

Allergies: (Please list all drug and enviromental allergies)

_____

_____

_____

SOCIAL HISTORY: (Please circle all that apply)

☐ Currently smoke	☐ Chew tobacco	☐ No alcohol intake
☐ Have smoked in the past	☐ Have chewed tobacco	☐ Less than 1 drink per day
☐ Have never smoked	☐ Have never chewed	☐ 1-2 drinks per day
☐ Drug use	☐ Other	☐ +3 drinks daily

FAMILY HISTORY: (Please list major health problems with parents, siblings, or children)

_____

_____

_____

Please circle ALL that apply to YOU:

■ Yes	■ No	Do you have a DPOA who currently makes your medical decisions for you?
■ Yes	☐ No	Do you or did you have Hepatitis A, B, or C?
☐ Yes	☐ No	Do you have HIV or AIDS?
☐ Yes	■ No	Any contact with someone from West Africa?
☐ Yes	☐ No	Insurance dictates that labs be sent to an outside lab such as Quest or LabCorp?
☐ Yes	☐ No	Do you have a metal implant and cannot have an MRI?
☐ Yes	☐ No	Pacemaker or Defibrillator Implant?
☐ Yes	☐ No	Have you ever had an organ transplant?
☐ Yes	☐ No	Artificial joint replacement within the last six months?
☐ Yes	☐ No	Artificial heart value? (Includes mechanical or biological)
☐ Yes	☐ No	Rapid heartbeat with epinephrine (often mixed with numbing medicine)?
☐ Yes	☐ No	Mitral valve prolapse or heart murmur?
☐ Yes	☐ No	Currently on blood thinners including regular use of aspirin or NSAID's?
☐ Yes	☐ No	Antibiotics needed prior to dental work or other surgical procedures?
☐ Yes	☐ No	Allergy to adhesives such as Band-Aids or tapes?
☐ Yes	☐ No	Allery to Novocaine?
☐ Yes	☐ No	Allery to Betadine or Iodine?
☐ Yes	☐ No	Allery to Lidocaine?
☐ Yes	☐ No	Allery to IV dye/contrast solutions used in diagnostic procedures?
☐ Yes	☐ No	Allery to Bactroban or mupirocin antibiotic ointment?
☐ Yes	☐ No	Currently pregnant or sexually active without use of prevention?
☐ Yes	☐ No	History of fainting or getting lightheaded during shots or procedures?
☐ Yes	☐ No	Difficulty getting numb with local anesthetics such as at the dentist?
☐ Yes	☐ No	Yeast infections with oral antibiotics?
☐ Yes	☐ No	Upset stomach with oral antibiotics?
☐ Yes	☐ No	Any history of seizures?

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we describe them in this notice.

Ways in Which We May Disclose Your Protected Health Information

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your protected health information fall within one of these five categories.

Treatment - We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your protected health information to other physicians who may be treating you. Additionally, we may from time to time disclose your protected health information to another physician who has requested to be involved in your care. For example: we may disclose your protected health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

Payment - We may use and disclose your protected health information to obtain payment for the health care services we provide you. For example: We may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations - We may use and disclose your protected health information to support the business activities of our practice. For example: We may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription services for our practice.

Other Ways We May Use and Disclose Your Protected Health Information:

Appointment Reminders - We may use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment.

Treatment Alternatives - We may use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to you.

Others Involved in Your Care - When necessary, we will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.

Research - We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

As Required by Law - We may use and disclose your protected health information when required to by federal, state, or local law. You may request an accounting of such disclosures at any time (refer to Accounting Disclosures paragraph on the next page for details).

To Avert a Serious Threat to Public Health or Safety - We will use and disclose your protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability; and with parental permission, proof of immunization to a school where required by law. If directed by a health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Worker's Compensation - We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work related injuries or illness in accordance with state law.

Inmates - We will use and disclose your protected health information to a correctional institutional or law enforcement official if you are an inmate of that correctional institution or under custody of the law enforcement official. This information would be necessary for the institution to provide with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

YOUR HEALTH INFORMATION RIGHTS

Although health record is the physical property of this health care practitioner the information belongs to you. You have the right to:

A Paper Copy of This Notice - You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

Inspect and Copy - You have the right to inspect and obtain a copy of the protected health information that we maintain about you in our desigdated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. You may request an electronic copy of your information in a form you specify; however, if we are not able to provide the information in the form requested, we must contact you to determine a suitable alternative. Any psychotherapy notes that may have been included in records that we received about you are not available for your inspection or copying by law. We may charge you a fee for the cost of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy you medical information, you must submit your request in writing to our Practice Manager at Cleaver Medical Group, 105 Professional Park Drive, Cumming, GA 30040. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed an additional 30 days to respond but must inform you of this delay in writing.

Request Amendment - You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and your reasoning that supports your request.

We are permitted to deny your request if it is not in writing or does not include a reason to support the request, we may also deny your request if:

- the information is not created by us, or the person who created it is no longer available to make the amendment;
- the information is not part of the record which you are permitted to inspect and copy;
- the information is not part of the designated record set kept by this practice; or if it is the opinion of the health care provider that the information is accurate and complete.

Request Restrictions - You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operations. For example: you could request that we not disclose your information to your insurance carrier about a treatment you paid for in full out of pocket. Your request must be made in writing to our practice manager. Other than as in the example above, we are not required to agree with your request unless that information is needed for emergency treatment.

An Accounting of Disclosures - You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for the purposes of treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may request the information about disclosures for any dates within the six years prior to the date of your request (our legal obligation to retain information), your first request for a list of disclosures within a 12-month period will be free. If you request an addition list within 12-months of the first request, we may charge you a reasonable cost-based fee for providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any cost are incurred.

Request Confidential Communications - You have the right to request how we communicate with you to preserve your privacy. For example: you may request that we call you only at your work number, or contact you by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

File a Complaint - If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice manager or directly to the Secretary of Health and Human Services. To file a complaint with our practice manager, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it attention to Privacy Officer, Cleaver Medical Group, 105 Professional Park Drive, Cumming, GA 30040, 770-800-3455. You should know that there would be no retaliation for your filing a complaint.

Uses or Disclosures Not Covered

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

For More Information

If you have questions or would like addtional information, you may contact our Practice Manager at 770-800-3455.