William E. Freeman, M.D.

DERMATOLOGY • DERMATOLOGIC SURGERY

PATIENT INFORMATION

First Name _____MI _____ Last Name _____

Street _____ Apt # _____ City _____

State _____ Zip _____ Home Phone _____ Cell Phone _____

Birthdate _____ SSN _____ Sex _____ Race _____ Age _____

Occupation _____ Employer _____Work Phone_____

Marital Status _____ Spouse's Name _____

E-mail Address _____ Reason for visit _____

Primary Care Physician _____Referred by _____

RESPONSIBLE PARTY (if other than patient)

Name _____SSN _____ DOB _____

Street _____City _____ State _____

Zip _____ Home Phone _____ Cell Phone _____

INSURANCE INFORMATION

Primary Insurance _____ Insured's DOB _____

Policy Number _____

Secondary Insurance _____ Insured's DOB _____

Policy Number _____

By my signature below, I acknowledge that I have access to Dr. Freeman's Public Notice of Privacy Practices. I also acknowledge that my protected health information (PHI) will be released for the sole purpose of 1) treatment 2) payment and healthcare operations (such as billing and collections) and 3) outside laboratory tissue examination. I understand that I will be billed separately by the pathologist. By refusing to sign, I could forfeit my right to any healthcare services. Unless otherwise noted, payment is due at time of service.

Dr. Freeman uses Physician Assistants and Nurse Practitioners in the office for those levels of practice that have been approved by the Georgia State Board of Medical Examiners. Your signature on this form conveys that you are in agreement with being treated by Dr. Freeman's PAs and NPs, who are acting under his supervision.

Signature _____ Date _____

Notice: Occasionally, Dr. Freeman trains and utilizes students. These students are aware of your rights to confidentiality and have signed a statement acknowledging their compliance to HIPAA standards requiring that your privacy be protected.

If you oppose student involvement in your skin care visit with us, please advise the front desk or nursing staff. Thank you for your cooperation.

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I am a patient of Dr. William Freeman. I hereby acknowledge that I have received an updated notification of Dr. Freeman's HIPAA Patient Policy that is located on this website.

_____

Signature/Date

I am a parent/guardian of the patient. I hereby acknowledge that I have received an updated notification of Dr. Freeman's HIPAA Patient Policy that is located on this website.

_____

Signature/Date