Leslie S. Gaskill, M.D. LLC

Patient Registration Sheet

Name: _____ _____ _____
Last First M.I.

Address: _____ **Apt #** _____
Street

_____ _____ _____
City State Zip

Home Ph#: _____ **Cell Ph#** _____ **Work Ph#:** _____

Employer: _____ **Address:** _____

Email Address _____

SSN#: _____ **Birth Date:** _____ **Age:** _____ **Sex** _____

Race/Ethnicity: _____

Emergency Contact Name: _____ Relationship: _____
(Not living with you)

Emergency Contact Tele#: _____ City, State _____

Marital status (circle one): Married Single Widow Divorced Spouse's Name: _____

HOW DID YOU HEAR ABOUT DR. GASKILL'S PRACTICE? _____

INSURANCE INFORMATION

Name of **Policy Holder:** _____ Policy holder's **Date of Birth** _____
(If different from Patient)

Relationship to Patient: _____ Policy Holder's SSN#: _____

Policy Holder's Employer _____ Employer Tele#: _____

Insurance Carrier: _____ **Policy# :** _____ **Grp#** _____

PLEASE READ THE FOLLOWING VERY CAREFULLY:

***Note**: It is our responsibility to process insurance claims in a timely manner. It is your responsibility to know your individual plan benefits. Eligibility is NOT a guarantee of payment. If your claim is denied or if certain services are not covered by your plan, YOU are responsible for payment. If your insurance requires you to have a primary care physician; it is your responsibility to ensure that Dr. Gaskill is listed as your PCP. If your insurance later recoups payment for services after paying for any reason, you are responsible for the balance. Our office reserves the right to charge for appointments missed or cancelled. If you cancel or reschedule anytime the day before your appointment, there is a cancellation fee. Monday appointments cancelled on Friday will acquire a cancellation fee. ($49.00 Reg office visit. $120 Physical and Women's Wellness;$150.00 Pellet or shot Procedure; $120.00 for IV therapy.) An ultrasound scan must be cancelled 3 days in advance to avoid a cancellation fee of $210.00 per ultrasound scheduled- ABI, DOC, AAA, and CIMT. The ONLY time a cancellation fee is waived is for death of first degree relative and we require obituary notice. A late fee of $35.00 will be charged for past due balances over 30 days, and again at 60 days. If sent to collections, we also charge the collections fee of 50%. Any credit card charges exceeding $200.00 will have an additional charge of 4%. Any checks that return due to insufficient funds, closed account, etc will incur a $49.00 check return fee. The balance after insurance pays or denies is what you owe. It is your responsibility to call the office if you have not received a bill within 15 days of your office visit. It is your responsibility to ensure we have the correct address on file. If you have any changes in your contact information, please email us* at info@drlesliegaskill.com. *(Email information at own risk. We do not recommend confidential information to be sent through email. Fax or bring in hand confidential and private information.) No restrictive check endorsement or other unilateral offer to compromise any amount to due to the practice shall be binding on the practice, without an independent, corroborating agreement between patient and practice with regard to such outstanding balance.*

I authorize and consent to examination and treatment, including procedures, by Dr. Leslie S. Gaskill. I authorize the release of medical information to my insurance company necessary to process claims or to any physician who is currently involved with my medical care. I understand that I am financially responsible for charges not covered by my insurance company. I hereby authorize photocopies of this form to be as valid as the original. I have received a copy of the Consent for Filing Insurance, dated 10/28/2008 and will comply.

_____ _____
Signature Date

Name_____ D.O.B. _____ AGE_____ DATE_____

PATIENT INFORMATION

Do you exercise? Yes____ No___
Do you smoke? Yes____ No___
Do you drink alcohol? Yes____ No___
- If "Yes", number of drinks per week:____
Marital Status: Single_____
Married_____ Widowed _____
Divorced _____ Separated _____
How many children do you have? _____
Education_____ Yrs. Elementary_____ Yrs. High School _____ Yrs. College_____Yrs.
What is your occupation? _____
Have you ever been exposed to any occupational/environmental hazards? Yes___ No___
What are your hobbies? _____

Do you use illicit drugs? Yes___ No___
Are you on a special diet? Yes___ No___
Do you wear a seat belt? Yes___ No___
Do you have a living will? Yes___ No___
Do you have your tonsils? Yes___ No___
Do you have your appendix? Yes___ No___

PAST MEDICAL HISTORY/PROBLEMS

Illnesses/Problems	Hospitalizations/Surgeries
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Has any blood relative ever had cancer? Yes___ No___

If yes, what kind of cancer? _____ Who? _____ Who? _____
_____ Who? _____ Who? _____
_____ Who? _____ Who? _____

HAS ANY BLOOD RELATIVE HAD/HAVE:

Diabetes?	Yes___ No___	Relative(s) _____
Heart trouble?	Yes___ No___	Relative(s) _____
Heart Attack?	Yes___ No___	Relative(s) _____
High Blood Pressure?	Yes___ No___	Relative(s) _____
Stroke?	Yes___ No___	Relative(s) _____
Asthma?	Yes___ No___	Relative(s) _____
Tuberculosis?	Yes___ No___	Relative(s) _____
Epilepsy/seizures?	Yes___ No___	Relative(s) _____
Bleeding Disorders?	Yes___ No___	Relative(s) _____
Kidney Disease?	Yes___ No___	Relative(s) _____
Stomach Disease?	Yes___ No___	Relative(s) _____
Osteoporosis?	Yes___ No___	Relative(s) _____

* Please complete the back side →→→

Emphysema?	Yes___ No___	Relative(s)	_____
Depression or Suicide?	Yes___ No___	Relative(s)	_____
Other Mental Illness?	Yes___ No___	Relative(s)	_____
Alcoholism?	Yes___ No___	Relative(s)	_____
Drug Dependency?	Yes___ No___	Relative(s)	_____
Lupus?	Yes___ No___	Relative(s)	_____
Arthritis?	Yes___ No___	Relative(s)	_____
Birth defects?	Yes___ No___	Relative(s)	_____
Migraines?	Yes___ No___	Relative(s)	_____
Liver Disease?	Yes___ No___	Relative(s)	_____
Obesity?	Yes___ No___	Relative(s)	_____
Thyroid Disorder?	Yes___ No___	Relative(s)	_____

Other illness/problem not listed here? _____

Relative	Age	Living	Deceased	Cause of Death
MOTHER	_____	_____	_____	_____
FATHER	_____	_____	_____	_____
PAT. GR. FATHER	_____	_____	_____	_____
MAT. GR. FATHER	_____	_____	_____	_____
PAT. GR. MOTHER	_____	_____	_____	_____
MAT. GR. MOTHER	_____	_____	_____	_____
BROTHER/SISTER	_____	_____	_____	_____
BROTHER/SISTER	_____	_____	_____	_____
BROTHER/SISTER	_____	_____	_____	_____
BROTHER/SISTER	_____	_____	_____	_____
MAT. AUNT	_____	_____	_____	_____
MAT. UNCLE	_____	_____	_____	_____
PAT. AUNT	_____	_____	_____	_____
PAT. UNCLE	_____	_____	_____	_____

To the best of your knowledge, when was your last: If not applicable, put "N/A". If you don't know, put "?".

Chest X-ray	_____	Pap Smear	_____	INJECTIONS:	
Pulmonary Function Test	_____	Mammogram	_____	Tetanus	_____
EKG	_____			Flu shot	_____
		Ultrasound of	_____	Pneumonia	_____
Echocardiogram	_____	CT Scan of	_____	MMR (measles)	_____
Treadmill stress test	_____	MRI of	_____		
Cardiac Catheterization	_____				
Flexible Sigmoidoscopy	_____	Eye exam	_____		
Colonoscopy	_____				
Barium enema	_____				
GI series	_____				
Upper endoscopy	_____				

Patient Consent Form

Leslie Gaskill, M.D., L.L.C.
Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Leslie Gaskill, M.D., L.L.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The notice of Privacy Practices provided by Leslie Gaskill, M.D. L.L.C. describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Leslie Gaskill, M.D., L.L.C., reserves the right to revise its Notice of Privacy Practices at any time. A revised notice of Privacy Practices may be obtained by forwarding a written request to the office manager at 6290 Abbotts Bridge Rd, Bld. 200, Suite 201, Duluth, GA 30097.

With this consent, Leslie Gaskill, M.D., L.L.C. may call my home or other alternative 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 calls pertaining to any clinical care, including laboratory test results, among others.

With this consent, Leslie Gaskill, M.D., L.L.C. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

With this consent, Leslie Gaskill, M.D., L.L.C. may e-mail to my home or other alternative 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 Leslie Gaskill, M.D., L.L.C., restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Leslie Gaskill, M.D., L.L.C. to use and disclose 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 this consent, or later revoke it, Leslie Gaskill, M.D., L.L.C. may decline to provide treatment to me.

Signed by:_____Date_____Relationship to patient_____
Signature of patient or legal guardian

_____ _____
Print patient's name Print name of legal guardian, if applicable

Dear Patients,

Please note:

Our practice adheres to the Centers for Disease Control (CDC):

"Indoor Environmental Quality Guidelines"

That are enforced for hospitals, medical offices and most workplaces.

Fragrances of any sort; ***colognes, after shaves, lip glosses, dryer sheets, lotions, body washes, shampoos, as well as cigarette smoke*** are actually hazardous to many patients, doctors, staff and sensitive individuals.

We offer treatment/testing laser acupuncture services and fragrances interfere with these services.

These products may cause severe medical difficulties in individuals who are sensitive to them. Such difficulties may include migraine headaches, nausea, chest tightness, coughing, loss of voice, scratchy throat, and rhinitis. Some of the reactions may be life threatening.

Please Refrain from wearing these when you come to the phycian's office to avoid being asked to reschedule your appointment with a cancellation fee.

Thank you for your flexibility and your good faith efforts to meet this accommodation, as exposure to these products negatively impacts approximately 16% of our U.S. population.

Print Name	Sign	Date
_____	_____	_____

Contact Consent Form

Patient Name _____ D.O.B. _____ Date _____

Please list any personal numbers you have that we can leave detailed messages to you about appointments, test results, etc.

Phone number _____ cell _____ home _____ office _____

Phone number _____ cell _____ home _____ office _____

Please indicate anyone who has authorization to receive private/personal information concerning your care, test results, medical history, etc.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Signature _____ Date _____