Georgia Dermatology & Skin Cancer Center, LLC

To our new patients:

Welcome to our dermatology practice and thank you for placing your confidence in us by choosing to be treated in our office.

In order to expedite your check-in process, please complete and sign the enclosed **Patient Registration, Dermatology Medical History** and **Acknowledgment of Patient Privacy** forms. **Upon arrival, please present these forms along with your insurance card and a photo ID to the receptionist.** If your paperwork is not complete upon arrival, your appointment time may be delayed.

We have enclosed a copy of our financial policy. Our practice is committed to providing you high quality care at a reasonable cost. Diligent efforts are made to control internal costs. As a courtesy to you, we submit insurance claims directly to the insurance companies on your behalf. Prior to your appointment, you may desire to contact your insurance company, to verify information regarding your co-payment, deductible, and percentages they will pay. Insurance plans can require referral forms, pre-certifications, and use of "in-network" facilities and providers. We ask that you also be familiar with your insurance plan.

Copays & Patient Balances are payable at the time of service. For your convenience, VISA, MasterCard, Discover and American Express are accepted, along with cash or check.

Minor patients (children under the age of 18) must be accompanied by a parent or legal guardian for the initial visit.

Due to limitations in office space and out of courtesy to other patients, please limit the number of visitors accompanying you to one.

This office utilizes the services of Physician's Assistants and Nurse Practitioners.

Directions to out offices can be found on our website, ***GaDerm.com***.

If you are unable to keep your appointment, please contact our office at least 24 hours in advance. We look forward to seeing you soon.

Sincerely,

Georgia Dermatology & Skin Cancer Center, LLC

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FINANCIAL POLICY

Thank you for placing your confidence in us by choosing to be treated in our office. Our practice is committed to providing high quality care at a reasonable cost. Diligent efforts are made to control internal costs and maintain a fair and accurate fee schedule.

INSURANCE: As a courtesy to you, we submit insurance claims directly to the insurance companies on your behalf. However, you are responsible for insurance plan requirements, such as referral forms, pre-certifications, and the use of "in-network" providers.

All types of insurance plans designate a portion of the bill for which the patient is responsible. You as the patient are directly responsible for one or more of the following:

- **Co-payment**: This is a "flat" dollar amount that is set by your insurance plan. You will be expected to pay your co-pay at each visit. Your plan may call for separate co-payments for specific types of services meaning that you may have two or more co-payments to make for one visit to the office.

- **Deductible:** This is a dollar amount designated by your insurance company that you will pay "off the top" of an allowable amount for a covered service. Deductibles typically start over on January 1 of each year.

- **Coinsurance:** This amount is based on a designated coverage formula. For instance, if your insurance is an "80/20" plan, then the insurance pays 80% of the allowable charge and you will pay the remaining 20% called coinsurance.

- **Excluded or Non-Covered Services:** Each insurance plan determines which medical services it will or will not cover. You will be responsible for paying for those services not allowed for benefits/payment under your plan.

NON INSURED (SELF PAY): All fees are payable at the time of service.

Copays & Patient Responsible Balances are payable at the time of service. For your convenience, VISA, MasterCard, Discover and American Express are accepted, along with cash or check.

If you have any questions, please let us know immediately. We want to work together with you to achieve the most cost-effective, high quality patient care.

Thank you for choosing Georgia Dermatology & Skin Cancer Center, LLC, your premier dermatology provider.

Rev 12/1/2010

Georgia Dermatology & Skin Cancer Center, LLC

Office _____

MINOR PATIENT REGISTRATION

Note: We do not bill absent parents, the adult presenting the minor for care is the responsible party.

Name _____ Today's Date _____

Address _____Apt #_____City_____State_____Zip _____

Sex: ☐ Male ☐ Female Student: ☐ Full Time ☐ Part Time

Primary Phone (_____)_____ Secondary Phone (_____)_____ Email _____

* Primary Phone will be used for Appointment Reminder Calls

Date of Birth _____/_____/_____ Age _____ SS # _____-_____-_____
MM DD YYYY

Race_____ Referring Doctor _____ How did you hear about this practice?_____

Emergency Contact_____ Relationship _____ Phone # (_____)_____

Please note that all pathology specimens are sent to Georgia Dermatopathology

PRIMARY INSURANCE INFORMATION

Insurance _____ Policy # _____ Group # _____

Policy Holder Name _____ SS # _____-_____-_____ Relationship _____

Policy Holder's Date of Birth _____/____/_____ Employer of Policy Holder _____ Work # (____)_____
MM DD YYYY

SECONDARY INSURANCE INFORMATION

Insurance _____ Policy # _____ Group # _____

Policy Holder Name _____ SS # _____-_____-_____ Relationship _____

Policy Holder's Date of Birth _____/____/_____ Employer of Policy Holder _____ Work # (____)_____
MM DD YYYY

Do you have a Third Insurance or a Cancer Policy? ☐Yes ☐ No If yes, Insurance _____

RESPONSIBLE PARTY INFORMATION

Name _____

Address _____Apt #_____City_____State_____Zip _____

Work #(_____)_____ SS # _____-_____-_____ Date of Birth _____/_____/_____ Relationship _____
MM DD YYYY

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I authorize my insurance company, Medicare, Medicaid, or any Medigap policy to pay benefits on my behalf directly to Georgia Dermatology & Skin Cancer Center, LLC, and/or its affiliated companies. I authorize these companies to provide to my insurance company, the Centers for Medicare and Medicaid Services, its agents or my Medigap insurer any information necessary including my signature to process claims for services rendered to me. I understand I am financially responsible for all charges not covered by my insurance assignment.

_____ _____
Signature Date

AUTHORIZATION FOR TREATMENT OF A MINOR

Parents often find it difficult to accompany their minor children to their appointments. This authorization has been created to give you the opportunity to authorize treatment, including procedures rendered by Georgia Dermatology & Skin Cancer Center, LLC, when you are not accompanying your minor children. Some surgery procedures may require additional consent from you as determined by Georgia Dermatology & Skin Cancer Center, LLC. I authorize Georgia Dermatology & Skin Cancer Center, LLC and/or its affiliated companies to render treatment, including procedures, to my minor child without my presence in the office.

_____ _____
Signature Date

Georgia Dermatology & Skin Cancer Center, LLC

ACKNOWLEDGEMENT OF PATIENT PRIVACY PRACTICES

I understand that Georgia Dermatology & Skin Cancer Center, LLC has a responsibility to protect patient privacy. To do that, the practice strives to keep patient information confidential and to safeguard the privacy of patient information.

I understand that Georgia Dermatology & Skin Cancer Center, LLC has the authority to use and disclose private health information to carry out treatment, payment and healthcare operations.

By signing this form, I acknowledge that I have been provided with the right to review Georgia Dermatology & Skin Cancer Center, LLC's Notice of Privacy Practices and have been informed that I may obtain a copy upon request.

I further understand that Georgia Dermatology & Skin Cancer Center, LLC reserves the right to change their Notice of Privacy Practices. I understand that I may obtain a revised copy by contacting the office.

_____ _____

Print Name Signature

_____

Date

Rev 12/1/2010