

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 our 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.

PATIENT REGISTRATION

Acct # _____

Name _____ Today's Date _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Sex: Male Female Employer _____ Retired Student

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

* Primary Phone will be used for Appointment Reminder Calls

Date of Birth ____/____/____ Age ____ SS # ____-____-____ Marital Status: Single Married Other
MM DD YYYY

Race _____ Referring Doctor _____ How did you hear about our practice? _____

Emergency Contact _____ Relationship _____ Phone # _____

Please note that all pathology specimens are sent to Georgia Dermatopathology

PRIMARY INSURANCE INFORMATION

(COMPLETE PRIMARY INSURANCE INFORMATION IF YOU ARE NOT THE PRIMARY CARD HOLDER)

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

(COMPLETE SECONDARY INSURANCE INFORMATION IF YOU ARE NOT THE PRIMARY CARD HOLDER)

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 _____

GENERAL CONSENT FOR TREATMENT

I consent to receive medical treatment, including procedures rendered by Georgia Dermatology & Skin Cancer Center, LLC. Some surgery procedures may require additional consent from you as determined by Georgia Dermatology & Skin Cancer Center, LLC.

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.

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