Thank you for choosing Georgia Skin Specialists, P.C. for your dermatology needs. We are committed to providing you with the best possible medical care. Your assistance in complying with our policies will help us serve you.

Consent of Treatment

_____ (initials) I hereby authorize the certified providers of Georgia Skin Specialists to provide dermatologic care for me. I give the providers permission to perform any necessary procedures (including the administration of local anesthetic), and I understand that I will be advised of any associated risks.

Labs

_____ (initials) I understand that all pathology specimens and lab work are sent to an outside laboratory for testing. These facilities are a separate entity from Georgia Skin Specialists and therefore will file a separate claim with your insurance and send a separate bill. I understand that Georgia Skin Specialists will forward my insurance information to the lab, and if my insurance does not pay for these services, I will be responsible for the balance. I also understand that if my insurance company requires me to use a certain lab, it is my responsibility to inform a member of Georgia Skin Specialists staff **prior** to the specimen being sent.

Proof and Change of Insurance

_____ (initials) I authorize the release of medical information to my primary care or referring physician and as necessary to process insurance claims, insurance applications, prior authorizations, and prescriptions. I also authorize payment of medical benefits to the physician.

Patients are required to show both proof of insurance and a Government issued photo ID at their initial and subsequent visits. The patient (parent/legal guardian) is responsible for informing our office of any changes in their insurance coverage since their last visit. We will file claims to your insurance carrier and accept payment directly from them. If you are billed for denial of coverage, it is your responsibility to contact your insurance company regarding the denial. Patients are fully responsible for all costs denied by their insurance. If your plan requires a referral or prior authorization, it is your responsibility to obtain this **prior** to your visit.

It is important that you educate yourself about your individual insurance benefits. Some policies have deductibles for surgical procedures. Insurance companies consider procedures like cryosurgery (freezing with liquid nitrogen), removal of moles, or other small procedures to be "surgery." If you have a surgical deductible that has not been met and have one of these procedures, you will be responsible for the payment. We can never guarantee insurance coverage for any service provided. **We cannot submit or resubmit claims with preventative codes.** There are a number of services we provide that are typically considered "cosmetic" by your insurance company. Please note that we do not file insurance claims for cosmetic services, and these services must be paid **in full** at the time these services are rendered. We are unable to offer payment plans on cosmetic services.

Patients Under 18 Years Old

_____ (initials) The patient registration form must be signed and guaranteed by the parent or legal guardian accompanying the minor at the first appointment. The guarantor is legally responsible for payment. We are unable to know the financial arrangements and responsibilities of divorced parents. The adult accompanying the minor is responsible for payment of the patient portion due at the time of service. If the guarantor believes the former spouse is responsible for a balance, the guarantor must forward the statement to him or her.

CONTINUED ON NEXT PAGE/REVERSE – PLEASE REVIEW AND SIGN

Payment, Fees, and Collections

_____ (initials) For your convenience, we accept cash, personal checks, debit cards, Visa, MasterCard and American Express. If you do not have insurance, **or it cannot be verified at the time of your visit**, total payment for your visit is due at the time of service. If you do not have insurance, we offer a self-pay discount of 30% on medical (non-cosmetic, non-product) charges. Payment for self-pay charges is due at the time of service. **Co-payments and outstanding account balances are due at the time of service.** Once insurance has processed a claim, bills are sent for outstanding patient balances. Payment is due within 15 days of statement date.

_____ (initials) I agree that I am personally responsible for payment of all charges for medical and/or surgical services whether not covered, part of my deductible, co-insurance, co-payment or otherwise not paid or payable by my insurance or medical plan. I understand and agree that in the event my account is turned over to a collection agency for non-payment, I will be responsible for collection agency fees in the amount of 10% of the account balance. I further understand and agree that if my account is turned over to an attorney for non-payment, I will be responsible for all court costs and costs of collection including reasonable attorney's fees in the amount of 15% of the account balance.

Collections balances must be paid **in full** before a future appointment can be made. Patients who are sent to collections more than one (1) time will be dismissed from the practice and notified by certified letter.

Returned check fee: A $25 fee will be due for any check returned from the bank for non-payment.

No-Shows or Late Cancellations: We request that appointments be cancelled at least 24 hours prior to appointment time. No-Shows and Late Cancellations will be charged a fee of $25. Patients who No-Show or give Late Cancellation notice more than three (3) times in a calendar year may be dismissed from the practice and notified via certified letter.

Acknowledgement

- I hereby authorize Georgia Skin Specialists, P.C. to release any information requested by the insurance company or companies or respective representatives and act as my agent to secure payment from any and all services rendered.
- I understand that I am financially responsible to Georgia Skin Specialists, P.C. for any and all charges incurred by myself and/or dependents.
- I further acknowledge and understand that I accept the terms outlined in the above policies.
- I understand that no warranty or guarantee has been made to me relative to result in care or medical outcome.

Patient Name (PRINT): _____ DATE OF BIRTH: _____

Patient or Responsible Party Signature: _____ TODAY'S DATE: _____