DERMATOLOGY AND SKIN SURGERY CENTER
210 Village Center Parkway
Stockbridge, GA 30281Phone: 770-474-5952

Dr. Juan A. Mujica
Dr. Neville G. Pereyo
Dr. Maria R. Pico
Grace Bogert, PA-C
Matthew Brunner, PA-C

Martha Sikes, PA-C
Christopher Golden, PA-C
Dr. Mark Baucom
Dr. David Pharis

Patient Information ***Please Print*** **Today's Date** _____/______/______

Last Name ____________________ First Name ____________________ Middle Initial __________

Social Security Number ____

Address No PO Boxes ____

City ____________________ State and Zip ____________________

(   )   - ____________ (   )   - ____________ (   )   - ____________

Home Phone Work Phone Cell Phone

Date of Birth MM / DD / YY ____________ Current Age ____________

Sex MALE OR FEMALE ____________ Martial Status ____________

Patient or Responsible Party (If different from patient)

Last Name ____________________ First Name ____________________ Middle Initial __________

Address ____

City ____________________ State and Zip ____________________

(   )   - ____________ (   )   - ____________ (   )   - ____________

Home Phone Work Phone Cell Phone

Date of Birth MM / DD / YY ____________ ____________

Sex MALE OR FEMALE ____________

Relationship of patient to the Insured ____

INSURANCE INFORMATION (Please present insurance card at time of check in)

Primary Insurance Name	______________________	Secondary Insurance Name	______________________
Name of Insured	______________________	Name of Insured	______________________
Insured's ID #	______________________	Insured's ID #	______________________
Group #	______________________	Group #	______________________
Pharmacy of Choice	______________________	Phone	______________________
In case of Emergency, who should be notified?	______________________	Phone	______________________

Referred by: ____

Primary Care Physician: ____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature ______________________________________ Today's Date ___/____/____

In order to establish optimal relations with our patients and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected. We accept payment in the form of ash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be preverified and you will be asked to pay any unmet deductibles, non-covered services and copayments.

In the event you must cancel a surgical or cosmetic appointment, we must be notified at least 48 hours prior to your appointment time. If not, you will be charged a $50 cancellation fee for a surgical appointment and your cosmetic deposit will be forfeited. All unpaid balances over 90 days will be charged a $2.00 per month finance charge. After 120 days of non-payment, an additional $10.00 charge will be added and your account will be forwarded to an outside collection agency.

Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature ______________________________________ Today's Date ___/____/____

☐ **Copy of insurance card (both sides) attached.** ☐ **Updated by:** ______________________