Patient Information

(Please Print)

Dermatology & Skin Surgery Center

210 Village Center Pkwy - Stockbridge, GA 30281

Name ____
Last *First* *M.I.*

Mailing Address ____
City *State* *Zip*

Home Phone ______________ Cell ______________ SS# ______________

Date of Birth ______________ Sex ______________

Relationship of patient to the Insured ______________________

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

Primary		**Secondary**	
Insurance Name	______________	Insurance Name	______________
Name of Insured	______________	Name of Insured	______________
Date of Birth	______________	Date of Birth	______________
Insured's ID#	______________	Insured's ID#	______________
Group #	______________	Group #	______________

E-mail ______________ Would you like to receive email notifications? *YES or NO*

In case of Emergency, please notify: ______________ 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 ______________ 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 cash, 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 ______________ Date ______________