

Patient Name: _____
Last First MI

Please read each statement below then sign at the bottom:

- I authorize the release of medical information to my primary care or referring physician if needed as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician.
- In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office.
- We cannot accept assignment of your insurance visits unless all of your insurance information is given at the time of your visit. **It is imperative that a copy of your insurance card is provided for accurate billing.**
- **It is important that you educate yourself about your individual insurance benefits. Some policies have deductibles for surgical procedures. The insurance companies consider procedures like cryosurgery (freezing with liquid nitrogen), removal of moles, or other small procedures "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.
- **Every patient's insurance policy is different and it is beyond the ability of our staff to know the benefits of every plan. Our office can NEVER guarantee coverage for any service provided by our office. If you are unsure of your coverage benefits, call the customer service number on your insurance card.**
- In the event that your account must be turned over to collections, a \$25 collection fee will be added to your account.
- There is a \$25 fee for returned checks.
- *I have received a copy of Georgia Skin Specialists' Notice of Privacy Practices.*

ALL PAYMENTS, CO-PAYMENTS, AND DEDUCTIBLES ARE DUE AT THE TIME SERVICES ARE RENDERED

*****For your convenience, we accept Cash, Checks, Visa, MasterCard, and American Express*****

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

Patient or Responsible party signature: _____ Date: ____/____/____

Please complete the following medical history

Name: _____ Date: _____

Age: _____ Sex: _____ Referred by: _____

Medication Allergies: _____

Current Medications (List all medications including over the counter, aspirin and birth control):

Past and Current Medical Illness (Including bleeding disorders): _____

Surgical History: _____

Previous Skin Cancer: _____

Family History of Skin Cancer, Psoriasis, Eczema, Acne or other skin disease: _____

Occupation: _____

Smoking and/or Alcohol consumption: _____

Reason(s) for today's visit: _____

Location (skin area involved): _____

Duration (how long has the problem been present?): _____

Previous Treatment (was there any previous treatment, list treatment and if it helped): _____

Associated symptoms (pain, bleeding, itching, or other?): _____

I have completed this form to the best of my ability.

Please sign here

Date