Main Address
2000 Prince Avenue
Athens, GA 30606

DERMATOLOGY of ATHENS

1220 Langford Drive
Bldg 100, Suite 103
Watkinsville, GA 30677

Name:_____ Date of Birth:_____

FINANCIAL POLICY

It is your responsibility to understand your insurance policy and coverage limits. All co-pays and deductible amounts are the responsibility of the patient. All co-pays are due at the time of service. We accept cash/checks/debit cards (MasterCard and Visa). It is your responsibility to notify us immediately of any change in your insurance, address or phone number.

I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that failure to pay my bill may result in my dismissal from the practice, I understand that I will receive a separate bill for any pathology or laboratory services performed by outside laboratories.

Signature:_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE (HIPPA)

By signing this form, you acknowledge that Dermatology of Athens, P.C. has offered you a copy of its Privacy Notice, which explains how your health information will be handled.

Signature:_____ Date:_____

CONSENT FOR DISCLOSURE OF PERSONAL INFORMATION

As a patient, I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby authorize the physicians and staff of Dermatology of Athens, P.C. to disclose my personal information to the following individual(s) in my presence or when I am not present, including via telephone, fax or mail.

Emergency Contact

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

Signature:_____ Date:_____