Consent for Treatment/Financial Agreement

Patient Name:______________________________ Account Number:_________________

Consent for Treatment/Financial Agreement: I consent to treatment necessary or desirable to the care of the patient first mentioned above, including but not restricted to, whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray or other studies that may be used by the attending doctor, his nurse or qualified designate. I also acknowledge full responsibility for the payment of all services, and agree to pay all amounts due in full at the time of service. I understand that the patient or responsible party is solely responsible for payment of all services, though the insurance may be filed. If this account becomes delinquent, I agree to pay all costs of collection, including a reasonable attorney's fee. I understand that I will be charged $32.00 for any returned check.

I understand that my insurance may not cover all services. **These plans cover services based on medical necessity. Injections, intralesional injections, hair loss treatment, keloid removal/treatment, wart removal/treatment, skin tags, clavus (corns) removal/treatment and other skin lesions are not always considered medically necessary on many insurance plans.** I understand that if any treatment is rejected by my insurance plan as a non-covered procedure that I will be billed for those services. I also acknowledge as a member of these plans, that this office will submit my insurance and I will be responsible for paying all copays and/or deductibles at the time of visit as well as any cosmetic treatment.

I understand that if my insurance requires a referral from my Primary Care Physician **that it is my responsibility as the patient to confirm that my referral is current and in effect before I arrive for my appointmen**t. If no referral is obtained, I will pay for the visit.

I understand that I will receive a separate bill for any pathology services performed by outside laboratories or by Georgia Skin Cancer & Aesthetic Dermatology.

I understand I will incur a $20.00 billing fee if my copayment is not paid at the time of my visit.

24-hour cancellation policy: I understand I may incur a $50.00 cancellation fee if I do not provide a cancellation notice within 24-hours of my appointment.

I authorize Medicare, MEDIGAP insurer, or my insurance company to remit payment of medical benefits direct to this office for services provided by our physicians.

I hereby authorize the release of all medical records on the patient listed above to the referring and family physicians, as well as all records necessary for the processing of insurance claims.

Patient Signature:______________________________ Date:________________________

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Signature of Parent/Guardian (Child under 19 years old) or Power of Attorney