

To Our Patients:

We appreciate your business and want to thank you for choosing Newnan Dermatology for all your skin care needs. In an effort to provide you with the best service and to keep our costs down, please be aware of the following information:

It is important that you bring your insurance card with you to each visit. Co-pays will be collected at the time of visit. If you do not have insurance or are receiving cosmetic services payment is due at the time of the visit.

Your insurance policy will have its own specific guidelines for your individual benefits. There are inclusions and exclusions which may apply that we would have no way of knowing in advance.

You will receive an additional statement for pathology charges from our office that may have a co-pay or deductible amount due.

A procedure, i.e., an injection, cryotherapy (freezing), a biopsy or surgery, may fall under your insurance deductible instead of your office co-pay.

Please communicate with our office about your account. All returned checks and delinquent accounts will have an assessment fee.

Treatment of minor children (under the age of 18) must be accompanied by their parent or legal guardian to be seen by our providers and treated. If you are unable to attend or the child is brought here by another individual, our office will need you to provide them with the following:

- Written authorization for your child to be seen and treated without you present. Also, include the name of the person you authorized to bring the child and if we are allowed to discuss treatment with them.
- Copy of insurance card.
- Co-pay or fee for services, if self-pay
- Copy of drivers license

It is the endeavor of our staff to provide the best possible service for our community. Please feel free to call us with any of your Dermatological needs or concerns. As always, we appreciate your comments and are eager to be of service.

Notice of our Privacy Practices Policy is located in our waiting room to view. A copy is available upon request.

Confirmation of Receipt:

PATIENT NAME: _____ ACCOUNT NUMBER: _____

I hereby acknowledge that I have received a copy of the Policy and Procedure patient letter which includes Notice of Privacy Practices Policies. A copy is available upon request.

PATIENT SIGNATURE: _____

DATE: _____

WITNESS: _____

DATE: _____