PEACHTREE DERMATOLOGY
MEDICAL · SURGICAL · COSMETIC

FINANCIAL DISCLOSURE STATEMENT

371 E Paces Ferry Rd NE, Ste 900
Atlanta, GA 30305
Tax ID 581089205

Thank you for choosing Peachtree Dermatology (PDA). You can expect to receive the following bills as a result of your visit:

- Physician Fee: Fee to be paid to the physician for performing the service. This bill will be from PDA.
- Lab Fee: If a lab test is ordered, a second bill will come from an outside lab.
- Pathology Fee: When a pathology test is ordered, a second bill will come from an outside pathology lab.

Insurance: Your insurance company will send you an Explanation of Benefits (EOB) that will explain how the insurance company paid your bill. The EOB will also explain any amount for which you may be responsible. Some insurance plans require you to pay different out of pocket amounts based on the where the service is performed. Deductibles, co-insurance and co-payments may also apply according to your insurance plan. By law, you are responsible for these amounts, as well as any non-covered services outlined in your health plan. PDA will submit primary, secondary and tertiary claims of our contracted payers on your behalf as long as the information needed to process the claim is obtained and verified before your visit. If this information is obtained after your visit, the patient or guarantor is responsible for the balance.

Co-payments: PDA collects co-payments at the time of service. Additional payment may be required based on your insurance plan. In the event your account has a credit a refund will be issued in a timely manner.

Refunds: All refunds will be processed within 3-5 weeks after the overpayment is discovered on the patient's account or at the time the refund is requested. Patients who have insurance but made a partial payment or payment in full will not be refunded until payment is received in full from their insurance company. Refunds for prepaid events will be processed within 5-7 business days. For refunded payments a check will be issued to the patient.

Initial below:

_____If we are unable to verify you have active coverage on the date of your appointment you will be required to pay for the visit in full at the time of service. If your insurance later pays for your visit we will issue you a refund.

_____In the event that you are unable to keep your appointment, please reschedule at least 48 hours in advance. A missed office appointment will result in a $40 fee. A missed cosmetic/aesthetic appointment will result in a $75 fee.

_____A $45 fee will be incurred for returned checks.

Additional questions regarding billing or payment arrangements should be directed to our billing department as follows:
Call the office at 404-355-1919 Ext. 342 and 343 and ask to speak to the billing department.

_____In the event we need to contact you regarding a billing matter, we may call you on your cell phone if you have listed this number as your primary or alternate contact number

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Patient's Reassignment and release statement

By signing below, I indicate my understanding of PDA's billing practices and that I may receive multiple bills related to my office visit as explained above. I authorize payment of medical benefits to PDA and authorize them to release any medical information necessary to process claims. I understand that I am financially responsible for any co-payments, deductibles, co-insurance and non-covered services as outlined by my health plan. This agreement applies to all visits that take place one year from the date this is signed, and any bills resulting from those visits.

Patient / Guarantor Signature *_____Date_____
*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.