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 Associates, PC (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 medical 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: It is the responsibility of the patient to verify whether PDA is "in-network" with their insurance plan. You may call your insurance provider and give them our Tax ID number, #58-1089205, to verify your in-network benefits. We are credentialed through Piedmont Healthcare, and we submit claims to most insurance plans with which Piedmont Healthcare participates. You reserve the right to request that PDA not submit a claim to your insurance plan for medical services. However, you must pay for those medical services out-of-pocket, in full. You may revoke this option at any time to begin submitting claims to your insurance plan. To protect against fraud you must present your insurance card at each visit, and we must have a government-issued photo ID on file. PDA will submit primary, secondary and tertiary claims to our contracted payers on your behalf, as long as the information 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 partial payment or payment in full will not be refunded until their claim has been processed and paid. Refunds for prepaid events will be processed within 5-7 business days.

Telehealth: All telehealth visits require a $75 deposit to be scheduled. We will submit telehealth claims to your insurance plan, if this information has been provided. Any credit resulting from this initial deposit will be refunded as outlined above.

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 information is later provided, and the plan pays for your visit after we have submitted your claim, we will issue you a refund as outlined above.

_____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 each returned check.

Additional questions regarding billing or payment arrangements should be directed to our billing department as follows:
Call the office at **404-355-1919**, select option 5 for 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.

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 my 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-payment, co-insurance, deductible and non-covered services amounts as outlined by my health plan. This agreement applies to all visits that take place one year from the date this form 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.

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