

- DAVID J. LEVINE, M.D.
- JUDITH L. SILVERSTEIN, M.D.
- MICHAEL S. FISHER, M.D.
- MARTIN L. WEIL, M.D.
- KENNETH M. ELLNER, M.D.
- KEVIN S. BERMAN, M.D.

ATLANTA CENTER FOR DERMATOLOGIC DISEASES, P.C.

- BARBRA ROSING, PA-C
- MARY LOGGINS, PA-C
- SCARLETT MELTON, PA-C
- ALEXANDRA PALGON, PA-C
- NORMA GORDON, PA-C
- FELICIA DENNIS, PA-C

Date: _____

Mr. _____ Miss _____ Mrs. _____ Minor _____

Name: First _____ M.I. _____ Last _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____

Social Security #: _____

Birthdate: _____ Age: _____ Sex: _____ Spouse's Name: _____

Have you or any of your family members ever been seen by any of our doctors? (please circle) Yes or No

Name of patient seen: _____ By which doctor? _____

In case of emergency, person to notify: _____ Emergency phone #: _____

EMPLOYER OF INSURED: _____ Phone # of company: _____

Address of company: _____

Present Insurance Cards to Receptionist

Referred by physician: Full name: _____ Phone: _____

Address: _____

Referred by (other than physician): Name: _____

ARE YOU OR ANY FAMILY MEMBERS CURRENTLY UNDER TREATMENT FOR:

High blood pressure? _____ Heart or kidney disease? _____ Diabetes? _____ Ulcers? _____
 Cancer? _____ TB? _____ Hepatitis? _____ HIV? _____

ARE YOU ALLERGIC TO ANY MEDICATION? _____

History of heart murmur? _____

PRESENT OR RECENT MEDICATIONS. (if answer to any below is "yes", please list)

Antibiotics? _____ Pain relievers? _____ Birth control pills? _____
 Hormones? _____ Laxatives? _____ High blood pressure pills? _____
 Tranquilizers? _____ Other? _____

CREDIT POLICY: As a general rule, you are expected to pay all charges incurred at the time of your visit. If for some reason you cannot, arrangements should be made at the front desk.

The Atlanta Center for Dermatologic Diseases, P.C. files claims to selected insurance companies as a service to its patients. You are responsible for understanding your policy and any of its requirements pertaining to referrals, co-payments and deductibles.

I authorize release of any information to my insurance company, or the Social Security Administration or its intermediaries or carriers for the appropriate processing of medical claims.

→ SIGNED:

****ALL PATHOLOGICAL SPECIMENS FROM SURGERY AND ALL BLOOD WORK WILL BE SENT TO THE LAB FOR EXAMINATION AND ANALYSIS. YOU WILL BE BILLED SEPARATELY FOR THESE SERVICES.**

→ SIGNED:

I consent to have messages regarding test results/treatment left on the following (list phone numbers):

_____ Home/Cellular Voicemail

_____ Work Voicemail

I consent to have test results/treatment discussed with:

_____ Spouse (Name and Phone)

_____ Other (Name and Phone)

Atlanta Center For Dermatologic Diseases, P.C.

INSURANCE POLICY

In order to accommodate the needs and requests of our patients, we have tried to enroll in numerous managed care insurance programs. While we are pleased to be able to provide this service to you, it is impossible for us to keep track of all the individual requirements of these plans. Each plan has different stipulations regarding its policies.

IT IS YOUR RESPONSIBILITY to contact your insurance company and find out whether or not our doctors are participating physicians within your particular insurance plan. Some insurance carriers have a PPO, HMO, POS, or indemnity status, and it is very possible that our doctors may participate in only one of these areas but not in all.

IT IS YOUR RESPONSIBILITY to give Atlanta Center for Dermatologic Diseases, P.C. correct insurance information to obtain the proper referral (prior to the office visit). If you fail to do so, you are responsible for payment.

IT IS YOUR RESPONSIBILITY to read and understand your own insurance policy. Certain services and procedures may / may not be covered depending on your individual insurance policy.

IT IS YOUR RESPONSIBILITY to be aware of your insurance deductible. Any procedure performed on your body, by a doctor or P.A., is considered to be a surgical procedure by insurance companies. These procedures may go to your insurance deductible and you will be billed for any balance due.

Cosmetic lesions will be sent to the lab for analysis and the lab will bill separately.

- IN THE EVENT THAT:**
- 1) insurance coverage is not in effect because we are not participating physicians in your plan;
 - 2) insurance coverage is not in effect on the date of your visit;
 - 3) a non-covered lab work is ordered / performed;
 - 4) a non-covered service is performed or denied for the reason "not medically necessary".

WE WILL HAVE NO CHOICE BUT TO BILL YOU DIRECTLY FOR ALL CHARGES RELATED TO YOUR OFFICE VISIT.

PAYMENT POLICY - We accept cash, checks, Visa and Mastercard. Payment is expected at the conclusion of each visit. If you need to set up a payment plan, please contact our office in advance and a member of our business office staff will be glad to help you; however, all cosmetic procedures must be paid in full at the time of service.