Tara Dermatology Center, P.C.
191 Medical Boulevard
Stockbridge, GA 30281
(770)991-1000

NON-COVERED SERVICES

I understand that the following procedure \ services are usually considered as **non-covered services**. If I request medical or surgical treatment for these diagnoses, I will be responsible for the fees if my insurance doesn't pay.

NON-COVERED SERVICES

- Acrochordons (Skin Tags)
- Benign Nevi (Moles)
- Lentigo (Liver Spots, Age Spots)
- Keloid (Injections / Surgery)
- Seborrheic Keratosis
- Spider Veins **(Cosmetic)**
- Injections (Cortisone)
- Chemical Peels **(Cosmetic)**
- Milia
- Split Earlobe Repair **(Cosmetic)**
- Sebacious Herplasis
- Wrinkles / Botox/ Juvaderm **(Cosmetic)**

OUR FINANCIAL POLICY

- All cosmetic surgeries\procedures are to be paid for in full, prior to procedure being done.
- All co-payments will be collected upon completion of the Patient Information Sheet or at sign-in prior to seeing the physician.
- If we are not a provider for your insurance, if you have not met your deductible, or are ineligible for benefits, FULL PAYMENT WILL BE COLLECTED TODAY.
- Deposits for procedures are non-refundable unless at least 24 hour notice is given.
- All billed balances must be paid within 30 days of 1st billed date, after which they are subject to collection efforts.
- All returned checks are subject to a $30 returned check fee
- Tissue specimen will be sent to **Altanta Dermatopathology,** who will bill a separate fee.

CONSENT TO TREATMENT

- I voluntarily consent to receive medical and health care services that may include diagnostic procedure, examination, and treatment
- I hereby assign, transfer, and set over to Tara Dermatology Center all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient or Other Legally Authorized Person: _____ Date _____

Patient Name:_____ Today's Date:_____

Reason for today's visit:

_____

Skin areas involved:

_____

How long has the problem been present?_____

What are your main symptoms: itching, pain, bleeding, other?_____
_____

Was there any previous treatment? No Yes-What?_____

Please list all medications you are currently taking:
_____
_____
_____
_____
Please list any medication allergies:_____

Social History (Circle all that apply):

Drinks alcohol: Never Occasionally Socially Daily
Smoking: Never smoker Former smoker Daily smoker Occasional smoker
What is your occupation? _____

Medical questions:

Yes No Has anyone in your family ever have skin cancer?
If yes, who?_____
If yes, what type of skin cancer(if known)?_____
Yes No Have you ever had skin cancer?
If yes, what type of skin cancer did you have?_____
Yes No Do you have a history of any skin disease?
If yes, which?_____
Yes No Do you have HIV/AIDS?
Yes No Do you have any artificial joints?
Yes No Have you ever had dental anesthesia?
Yes No Do you bleed easily?

Name:_____

(Medical questions continued):

Yes No Do you use illegal drugs?
Yes No Are you pregnant?
Yes No Are you breastfeeding?
Yes No Are you on birth control? If yes, what kind? _____
Yes No Do you have a tendency for Keloid scars?
Yes No Have you had any joints replaced?
If yes, which? _____

Past/Current Medical History (Circle all that apply):

Asthma Allergies(seasonal)

High blood pressure COPD

Thyroid condition Diabetes

Hepatitis HIV/AIDS

Neurological disorder Kidney or bladder condition

Stomach/bowel disease

Past Surgical History (Circle all that apply):

Kidney transplant

Pacemaker

Heart bypass

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

1. With my consent, TARA DERMATOLOGY CENTER, P.C. may use the following methods to communicate with me.
   Call to my home or designated location and leave a message on voicemail or in person, mail to my house or other designated location, **email** to my home or other designated location, or **text** to my mobile device.
2. I authorize the following people to receive information regarding my medical treatment at TARA DERMATOLOGY CENTER, P.C.
   NAME_____ RELATIONSHIP _____
   NAME_____ RELATIONSHIP _____
3. I also understand and consent that my personal health information may be disclosed to other appropriate entities, such as (but not limited to) my insurance company (ies), other physicians or healthcare providers and others as indicated in the Notice of Privacy Practices.
4. I have the right to request that TARA DERMATOLOGY CENTER, P.C. restricts how it uses or discloses my personal health information. I request the following restriction(s):_____
   The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. The above restrictions **ARE**, **ARE NOT** agreed by TARA DERMATOLOGY CENTER, P.C.
   Signed: _____ Title: _____ Date: _____
5. If I do not sign this consent, TARA DERMATOLOGY CENTER, P.C. may decline to provide treatment to me. I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent.

By signing this form I am consenting to TARA DERMATOLOGY CENTER, P.C. use and disclosure of my personal health information (PHI) to carry out treatment, payment, and operations. (TPO) I also authorize assignment of insurance benefits to TARA DERMATOLOGY CENTER, P.C.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Patient Printed Name

TARA DERMATOLOGY CENTER, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Practices may be obtained by forwarding a written request to Ms. Leigh Ann Lapinski, privacy officer at 191 Medical Boulevard Stockbridge, Ga. 30281