



## Patient Financial Agreement Form

I consent that I am responsible for (any and all) charges assigned to me by my insurance company including, but not limited to, yearly deductibles, co-insurances, co-pays, non-plan coverage, etc. \_\_\_\_\_(Patient Initials)\*

Certain insurance companies and/or policies (especially Medicare) do not cover preventive care which may include vaccinations, preventive visits and other procedures. These services, if not covered by your insurance plan, will become your financial responsibility. \_\_\_\_\_(Patient Initials)\*

I consent that I do understand and will abide by the below listed administrative fees which are enforced by Johns Creek Dermatology and Family Medicine. I agree to pay for fees accordingly \_\_\_\_\_(Patient Initials)\*

### **Administrative Fees**

- |   |         |
|---|---------|
| 1) Appointment cancelled with less than 24 hour notice =          | \$30.00 |
| 2) Patient "NO SHOWS" for appointment =                           | \$40.00 |
| 3) Returned payment for Non Sufficient Funds =                    | \$35.00 |
| 4) Patient account placed with collection agency =                | \$45.00 |
| 5) Request for release of medical records (paper or electronic) = | \$30.00 |

\*Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Note: \* = Patient understands Financial requirement.