WEST GEORGIA DERMATOLOGY, P.C.
SKIN CANCER & COSMETIC LASER CENTER

AUTHORIZATION TO RELEASE INFORMATION, TO OBTAIN RECORDS AND TO ASSIGN BENEFITS

I hereby assign to and authorize payment directly to West Georgia Dermatology, P.C. of all benefits payable under the terms of any insurance policy to which I may be entitled to benefits. I realize the insurance, workers' compensation, and/or liability claims may not pay the entire bill. I understand the PPO/Managed Care plan that I am insured with may deny/reduce payment or claim out of network status for services rendered by providers of West Georgia Dermatology, P.C. **I understand it is my responsibility to know my insurance coverage/policy and do not hold West Georgia Dermatology, P.C. responsible for failures of my insurance contract.** I agree to pay the difference or the entire bill if necessary. I also agree to pay all charges above what insurance companies claim to be reasonable and customary if my insurance plan has no contract with West Georgia Dermatology, P.C.

I hereby authorize West Georgia Dermatology, P.C. to release any information acquired in my examination or treatment to any insurer, government agency providing benefits, or to any other physician or medical facility in the event of my referral or request. I also authorize the release of my medical records or copies of such from other physicians or medical facilities to be sent to West Georgia Dermatology, P.C. to the attention of Garin D. Barth, M.D. and his staff.

MEDICARE/MEDICAID RELEASE AUTHORIZATION AND ASSIGNMENT

If applicable, I authorize any holder of medical or other information about me to release to any State or Federal Agency (or any carrier) information needed for this or a related Medicare or Medicaid claim. I permit a copy of this authorization to be used in place of the original. I further request that payment of all Medicare and/or Medicaid benefits be assigned and made to West Georgia Dermatology, P.C. Regulations pertaining to Medicare or Medicaid Assignment of Benefits apply.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

As required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I have received or had opportunity to review a copy of the Notice of Privacy Practices of West Georgia Dermatology, P.C. on the date indicated below. I understand that if any changes are made to this notice of Privacy Practices, a revised copy of the notice will be posted in the offices of West Georgia Dermatology. I also understand that if I wish to receive additional copies of this notice in the future, or if I have any questions with regards to this Notice of Privacy Practices, I may contact:

Chief Privacy Officer

West Georgia Dermatology, P.C.

1605 Whitesville Street • LaGrange, 706-882-5119

www.drbarth.com • 800-388-8829

Fax 706-882-0270

Signature of Patient or Personal Representative	Printed name of Patient or Representative	Date