2256 Northlake Parkway, Suite 300A Tucker, Georgia 30084
Phone (404) 474-2301 **Fax** (888) 662-1751

Dr. Nikki D. Hill, MD, FAAD

Patient Acknowledgement Receipt of Privacy Notice

I, _____(Patient's name), hereby affirm that I have received a copy of the *Notice of Privacy Practices* from **Skin of Culture and Hair Center**. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my health-care provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the *Notice*, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my health-care provider, whether I sign this Acknowledgement or not.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

Nikki D. Hill MD LLC, Skin of Culture and Hair Center

Legal Assistant of Benefits and Designation of Authorized Representative For The Release of Medical and Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws

Name_____ **DOB**_____ **Date**_____
Insurance name_____ **Policy #**_____ **Group #**_____
Insured Name _____ **Insured DOB**_____
Relationship to insured: Self: _____ Spouse: _____ Parent: _____ Other: _____

I hereby instruct and direct above named insurance company to pay by check made out and mailed to:

Skin of Culture and Hair Center
2256 Northlake Parkway Suite #300A
Tucker, GA 30084

If my current policy prohibits direct payment to the medical practice henceforth represented as Skin of Culture and Hair Center or Nikki D. Hill MD LLC, or any of the provider(s). I hereby also instruct and direct you to make out the check to me and **mail it to the above address** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **This is a direct assignment of my rights and benefits under this policy and designation of authorized representative.**
This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.
A copy of this Assignment shall be considered as effective and valid as the original.

- **I hereby authorize the above medical practice and the associated provider(s) to release all medical information necessary to process my claims under HIPPA** to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims, claim appeals, grievances, and securing payment of benefits. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.
- I authorize the above name provider(s) and medical practice to deposit insurance checks in my name.
- I authorize the above named healthcare provider(s) and medical practice to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- I understand that I am financially responsible for all charges whether or not paid by insurance.
- I understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of my benefits based on billed charges, within ninety (90) days of any and all appeals or request for information.
- I understand that if my account is referred to an attorney or outside agency for collection, I will pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at legal rates.
- I also agree that any fines levied against my insurance company will be paid to **Skin of Culture and Hair Center** for acting as my personal representative.
- In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee healthcare benefits coverage, and hereby assign and convey directly to the above name healthcare provider(s) and Skin of Culture and Hair Center and Nikki D. Hill MD LLC, as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. Unless revoked, this assignment is valid for all administrative and judicial review under PPACA, ERISA, Medicare and applicable federal and state laws.

CHECK BOX: ☐ I have read and fully understand this agreement.

_____ _____ _____
Signature of Policyholder **Printed name of Policyholder** **Date**

Skin of Culture and Hair Center Financial Policy

Please read the following, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We accept most insurance plans. Most of our plans process out of network. Knowing your insurance benefits is your responsibility; however we can assist with any questions. Please contact your insurance company with any questions you may have regarding your coverage. If we are out of network with your plan, we can apply your insurance network co payment toward your out of network deductible or coinsurance. After your claim has been processed you will receive a bill for the balance. **If you receive any notice from the insurance company regarding fees owed, please contact our office.**

2. **Co-payments, deductibles, and Coinsurance.** All co-payments, deductibles, and coinsurance must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payments at each visit. If you are not able to pay what you owe, we can offer you a payment plan. We have payment plans as low as five dollars a month.

3. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license/state issued ID and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

4. **Claim submission.** We will submit your claims and assist you in any way we reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not you insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

5. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. For the most part, we expect all patients to make an effort to pay on their bills. We do offer Affordable care payment plans as low as five dollars per month.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**