ADVANCED DERMATOLOGY & SKIN CANCER CENTER
PATIENT INFORMATION SHEET

PLEASE PRINT

Last Name: _____ **Home Phone:** _____
First Name: _____ Middle Initial___ **Work Phone:** _____
Address: _____ **Cell Phone:** _____
City: _____
Zip Code: _____ **Referring Dr:** _____
Sex: □ Male □ Female **Family Dr.** _____
Marital Status: _____ **SS#:** _____
Date of Birth _____ **Age:** _____
Occupation: _____
Employer: _____
Emergency Contact: _____
Emergency Number: _____
How did you hear about our practice: _____

INSURANCE INFORMATION

Primary Insurance: _____
Policy Holder's Name: _____
Date of Birth: _____
Policy Holder's SS# _____
Relationship to Policy Holder: _____

Secondary Insurance: _____
Policy Holder's Name: _____
Date of Birth: _____
Policy Holder's SS# _____
Relationship to Policy Holder: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Advanced Dermatology & Skin Cancer Center for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance or that my insurance company deems not reasonable and necessary. Advanced Dermatology and Skin Cancer Center and its providers are not participating providers for any Medicaid programs. Therefore you are responsible for services rendered at the time of the service.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Advanced Dermatology & Skin Cancer Center to release any medical or incidental information that may be necessary for either medical care or processing insurance claims. I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

AUTHORIZATION FOR TREATMENT

I authorize Advanced Dermatology & Skin Cancer Center staff and/or whomever they may delegate to provide medical, nursing, emergency care or such treatment as necessary.

FINANCIAL POLICY

Co-payments are required at the time of service; failure to pay on service date will result in an additional **$10.00 fee.** Co-insurance and deductibles are to be paid in full at the receipt of your first statement unless prior arrangements have been made.
APPOINTMENT CANCELLATION: A 24hr notice is required for office visit and surgery cancellations. Failure to do so will result in a **$50.00 NO SHOW/LATE CANCELLATION** fee for the office visit and **$100.00 NO SHOW/LATE CANCELLATION** fee for surgeries.
RETURN CHECKS: All NSF checks will be subjected to a NSF fee of **$20.00.**
Overdue accounts subject to monthly interest rate of 3% per year.

Patient name (please print) _____ Date _____
Parent/Guardian (please print) _____ Date _____
Patient Signature _____
(Signature of parent/guardian if patient is a minor)

A photocopy of these assignments shall be valid as the original.