Advanced Dermatology & Skin Care Center
Patient Information Sheet

Name: _____ Date: _____

Street Address: _____ City / State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Home Phone: _____ Mobile Phone: _____ Text Reminders? ☐

Email Address: _____ Social Security #_____

Primary Care Doc:_____ Referring Doc:_____

Preferred Language: _____ Race: _____ Ethnic Group:_____

Emergency Contact: _____ Emergency Contact Phone: _____

Preferred Pharmacy Name / City or Zip Code: _____ / _____

Occupation and Workplace: _____ How did you hear about us? _____

Insurance Information

Primary Insurance

Insurance Provider: _____

Policy Holder's Name: _____

Date of Birth: _____

Policy Holder's SS#: _____

Relationship to Policy Holder: _____

Secondary Insurance

Insurance Provider: _____

Policy Holder's Name: _____

Date of Birth: _____

Policy Holder's SS#: _____

Relationship to Policy Holder: _____

Terms of Agreement

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

J 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.**

I give permission to be photographed by Dr. Bernat/Dr. Shannon and/or their associates during my visit as an aid in my course of treatment.

PATIENT NAME (please print): _____ **DATE**: _____

PARENT / GUARDIAN NAME (please print): _____ **DATE**: _____

PATIENT SIGNATURE: _____
(signature of parent / guardian if patient is a minor)