Name: _____ Date of Birth: _____

Did your health care provider **specifically** send you to Advanced Dermatology Care (ADC) for treatment today? Y____ N _____

**If yes,** please fill out the information below.

Name of Primary Physician/Physician Asst: _____

Name of Primary Clinic: _____

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By signing below, I authorize Advanced Dermatology Care (ADC) to disclose information including the diagnosis, examination rendering to me, and appointment information. This information may be released to:

- Spouse/Partner _____
- Children _____
- Other _____
- **NO ONE OTHER THAN MYSELF**

**Leaving Messages:**

If unable to reach me:

- You may leave a detailed message
- Leave a message asking me to return your call

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The information I have provided is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to ADC. I understand that I am financially responsible for any balance. Co-Pays, cosmetic service and private insurance are collected at the time of visit. If your balance is not paid be 30 days, a finance charge of 1.5% per month will be applied. I also authorize ADC to release any information required to process my claims. In the instance of a No Show Appointment, I will pay a $50.00 holding fee to secure my next appointment spot which will be used towards my co-pay or any outstanding balance. I have been given the opportunity of reviewing and reading the "Notice of Privacy Practices" available at the office or at www.ADCderm.com.

Patient's / Guardian Signature _____ Date: _____