Patient Name: _____ **Patient Date Of Birth:** _____

Patient Privacy is important to Advanced Dermatology Care. Therefore, we ask that you carefully review the following information, and indicate your preferences for the communication of your protected health information.

By signing below, I authorize Advanced Dermatology Care (ADC) to disclose my protected health information including; diagnosis, examination rendered to me, and appointment information. This information may be released to one or more of the following:

- ☐ Spouse/Partner Name: _____
- ☐ Parent(s) Name(s): _____
- ☐ Children Name(s): _____
- ☐ Other Name: _____
- ☐ NO ONE OTHER THAN MYSELF

Messages:

If unable to reach me:

- ☐ You may leave a detailed message at the following phone number:_____
- ☐ You may leave a message, asking me to return your call at the following number:_____

I understand **I will** receive automatic reminders including: E-Mail and Text messages.
Please check below if you would like to **Opt Out** from receiving these message:

- ☐ Text
- ☐ E-Mail

The information I have provided is true to the best of my knowledge. I understand that I am financially responsible for any balance; co-pays, cosmetic service and private/out-of-network insurance are collected at the time of visit. I understand that cosmetic service payments are due upon check-in, unless otherwise notified. I authorize my insurance benefits to be paid directly to ADC. If your balance is not paid within 60 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 may be required to pay a $50.00 reservation deposit to secure my next appointment, which will be used towards my co-pay or any outstanding balance. I have been given the opportunity to review and read the "Notice of Privacy Practices" available at the office or at www.ADCderm.com. Authorization is void one year from date of signature.

Patient/Guardian Signature: _____Today's Date: _____

Printed name of signer if <u>not</u> the patient: _____