



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.

If unable to reach me at my number: (Home)-\_\_\_\_\_ (Cell)-\_\_\_\_\_

- checkbox You may leave a detailed message OR
checkbox You may only leave a message asking me to return your call

I understand and agree I may also receive detailed messages on the phone numbers I've reviewed upon checking in for my office visit.

This information may also be released to one or more of the following:

- checkbox Spouse/Partner Name: \_\_\_\_\_ Number: \_\_\_\_\_
checkbox Parent(s) Name(s): \_\_\_\_\_ Number: \_\_\_\_\_
checkbox Children Name(s): \_\_\_\_\_ Number: \_\_\_\_\_
checkbox Other Name: \_\_\_\_\_ Number: \_\_\_\_\_
checkbox NO ONE OTHER THAN MYSELF

I understand I will receive automatic reminders including: E-Mail and Text messages.

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.

By signing below, I authorize Advanced Dermatology Care to disclose my protected health information including; diagnosis, examination rendered to me, and appointment information to above listed person(s).

Patient/Guardian Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Printed name of signer if not the patient: \_\_\_\_\_