*Advanced Dermatology & Cosmetic Surgery Center*

Here to see: ( ) **Dr. Monique S. Cohn** or ( ) **Stacey Kimber, PA-C**

Patient Name: _____ Patient Birth Date _____/_____/_____

Parent or Guardian Name
(If patient is under 18) _____ Patient Address _____

Parent or Guardian Phone _____ City _____ State _____ Zip _____

Occupation _____ Person to call in case of an emergency
(or if we cannot reach you)

Employed at _____ Name _____ Phone _____

Age _____ Height _____ Weight _____ Patient Marital Status
( ) Single ( ) Married ( ) Divorced ( ) Widowed

Sex ( ) Male ( ) Female or identify as _____ Patient Race (because skin conditions vary by race)
( )White ( )Black ( )Mid East ( )Hispanic ( )Asian

**Mobile/Cell Phone** _____ **How were you referred to our practice?**

( ) Home or ( ) Work Phone _____ ( ) Family Doctor ( ) Other Dr. _____

**Email address**_____ ( ) Web Search ( ) Our Web site

( ) Sign on Street ( ) Friend _____

Patient Social Security # _____/_____/_____ ( ) Yellow Pages ( ) Other Advertising

**Primary Insurance** _____ **Secondary Insurance** _____

Cardholder _____ Cardholder _____

Cardholder Date of Birth _____ Cardholder Date of Birth _____

Patient Relationship _____ Co-Pay $_____ Patient Relationship _____ Co-Pay $_____

**Family Doctor** _____ *Do you want Patient statements to go to a different address than the Patient's address above? If Yes, please inform our staff and write that address and the person responsible on the back of this page.*

Address _____

_____ Phone_____

**Please read these five statements and sign below:**

1) I agree that insurance copayments, deductibles and any balances due on our accounts with Advanced Dermatology, Inc. (ADI) are to be paid with credit/debit card, cash or check prior to my visits. (And, I will pay a $25 fee for any returned check)

2) I hereby request that ADI bill services on my behalf to third party payers (i.e. insurance company) and I authorize direct payment to ADI for services received that are billed to third party payers.

3) If my medical insurance company cancels or determines benefits are not payable, I agree to be financially responsible to ADI for any and all charges to my account. If my insurance company requires a referral to see a specialist, and I am or my dependent is seen at ADI without a required and authorized referral from your primary care physician, or if my referral has expired, I accept full financial responsibility for any and all charges associated with that visit.

4) In compliance with the Federal HIPPA Privacy Rules, the Medical Privacy Notice of Advanced Dermatology, Inc. provides information about how ADI may use and disclose confidential medical information about me and/or my dependents. I have been offered ADI's Notice of Privacy Practices. I have read it carefully and I agree to these practices. The terms of this notice may change from time to time. If it does change, I may obtain a revised copy during my next visit. I will document any request for confidential communications in writing to ADI's Privacy officer. ADI will accommodate all reasonable requests.

5) The course of treatments provided by ADI may possibly involve ADI sending biopsies or specimens for pathology evaluation and other laboratory testing to companies outside of ADI. ADI has no financial interests in these entities and they will bill me or my insurance for their services.

By my signature on this form, I certify that I have read, understand and agree to all five statements here and that all the information provided on this form is true and correct.

**I agree** _____**signature** **Today's date:** _____/_____/_____

Thank you for your trust and confidence in our medical services and for your very kind referrals!