*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!

DOCS
DERMATOLOGISTS OF CENTRAL STATES

# CONSENT FOR TREATMENT

**(Complete Every Three Years)**

## CONSENT FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

For the purpose of this consent, Dermatologists of Central States ("DOCS") includes all facilities providing healthcare services, physicians, other healthcare providers and staff of all subsidiaries and affiliates thereof.

**Consent for Treatment**

I consent to the provision of medical treatment which may include, but is not limited to, routine examination, diagnosis/diagnostic tests and general treatment to be performed by DOCS. I acknowledge that no guarantees or assurances have been provided to me as to the outcome of any examination or treatment. I understand that if further medical procedure(s) or surgery is required, I may need to sign specialized consents.

**Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Care Operations**

I authorize DOCS to use and disclose my protected health information in order to carry out treatment, payment or healthcare operations. I acknowledge that I have been presented with the Notice of Privacy Practices which provides a more complete description of how my protected heath information may be used or disclosed. I understand that I have the right to review the Notice prior to signing this consent. I understand that DOCS reserve the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the office. An electronic version of our Notice of Privacy Practices may be found by visiting our website.

**Financial Agreement**

I authorize DOCS to bill my insurance carrier and that any payment of insurance benefits be made directly to DOCS. I acknowledge that I am responsible for all charges for services provided, including any amount not paid by my healthcare plan(s). This also applies if I am covered by Medicare, a health maintenance organization (HMO) or any other payer. I understand that it is my responsibility to verify with my insurance company if the provider is "in-network" to receive full insurance benefits. I certify that the information I provided related to my insurance coverage or other payment source(s) is correct.

I understand that self-pay accounts, co-payments, co-insurance, deductibles and non-covered services are required to be collected at the time of service.

I understand that services which are normally covered may be denied in a situation because of certain conditions (for example: non-allowable diagnosis) and I will be responsible for these balances.

I understand that cosmetic procedures are not covered/paid by healthcare plan(s) and I acknowledge that I am responsible for any balance due for such services.

I understand that an outside laboratory is used for pathology services. Billing for pathology services is separate and I am responsible for any balances related to pathology services.

I understand that DOCS may contact me by telephone (including mobile phone), and its affiliates and agents may use a pre-recorded/artificial voice messages and/or an automated telephone dialing system, or by text message or email for any communication related to my account(s).

I understand that DOCS may store my credit card on file for ease of future payments (DOCS's team members do not have access to credit card information – only last for digits). If you want to opt out, please let the front desk team know when checking in.

This is a legal document. By signing, you agree that you understand and accept the terms on this form. You have the right to revoke the authorizations on this form at any time by notifying DOCS in writing, except to the extent that DOCS has already acted in reliance upon them. These authorizations will remain valid until I revoke them in writing.

**Signature of Patient (or Authorized Representative)** **Date**

**Printed Name of Patient (or Authorized Representative)**

**If Authorized Representative, please explain authority to act on behalf of the Patient**