DATE

Advanced Dermatology & Skin Care Centre

A FOREFRONT DERMATOLOGY PRACTICE

CIRCLE ALL THAT APPLY **NEW PATIENT** **ESTABLISHED/RETURNING PATIENT** **REFERRED** **WORK COMP**

PATIENT INFORMATION - Circle Applicable Answers

Patient's FIRST Name, MI:	Patient's LAST Name:
Street Address:	○Home ○Cell ○Work Primary Phone #: ( )
City: State: Zip:	○Home ○Cell ○Work Secondary Phone #: ( )
SS#: Marital Status: M / S / D / W	E-mail:
Date of Birth: Gender: M F	Preferred Pharmacy Advanced Care Pharmacy Other:
Employment Status: Full time Part time Retired Student N/A	Referred by: Physician Web Site Insurance Company Family/Friend/Patient (name)
Occupation:	Does your insurance require referrals? Yes / No
Company or School Name:	Did your physician refer you to us? Yes / No
Circle Race: African-American Asian Caucasian Hispanic Other	Referring Physician Full Name:
Circle Ethnicity: Cuban Not Hispanic or Latino Other:	Primary Care Physician Full Name:
Language: English Spanish Other:	Physically Impaired: No Hearing Vision Other:
Are you currently receiving Hospice/Home Health Care? NO YES ☞	Hospice/Home Health Care Company Name

EMERGENCY CONTACT:

Name (First, Last):	Name (First, Last):
○Home ○Cell ○Work Contact#: Relationship Self Spouse Child Other	○Home ○Cell ○Work Contact #: Relationship Self Spouse Child Other

OTHER THAN PATIENT - PERSON RESPONSIBLE FOR ACCOUNT BALANCES -- COMPLETE REQUIRED INFORMATION INCLUDING MAILING ADDRESS

FIRST Name, MI:	LAST Name:
Street Address:	○Home ○Cell ○Work Primary Phone #: ( )
City: State: Zip:	Date of Birth: Gender: M F

IF OTHER THAN PATIENT - COMPLETE REQUIRED INFORMATION BELOW ONLY IF WE ARE TO FILE YOUR INSURANCE

PRIMARY INS. SUBSCRIBER/CARDHOLDER Circle Relationship to Patient: Self Spouse Child Other

Primary Ins. Name:	Co-pay Amt
Effective Date: Group #:	Policy/ID #:
Subscriber's Name:	Subscriber's DOB: Gender: M F

SECONDARY INSURANCE -- COMPLETE INFORMATION BELOW

SECONDARY INS. SUBSCRIBER/CARDHOLDER Circle Relationship to Patient: Self Spouse Child Other

Secondary Ins. Name:	Co-pay Amt
Effective Date: Group #:	Policy/ID #:
Subscriber's Name:	Subscriber's DOB: Gender: M F

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developed 9/4/2014
Y:REGDOC:2018:2018 REGDOC

Medical History

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Name: _____ Date of Birth: _____

Medications

List all current medications:

_____

_____

Allergies

List all allergies and reactions if known:

_____

_____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

_____

_____

_____

Past Surgical History

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement
- ☐ Kidney: Biopsy, stone removal, Nephrectomy
- ☐ Liver: Hepatectomy, Transplant
- ☐ Live: Shunt
- ☐ Ovaries: Endometriosis

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- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy: Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ NONE
- ☐ Other

_____
_____
_____

SKIN DISEASE HISTORY

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma of Skin
- ☐ NONE
- ☐ Other_____

Do you wear Sunscreen?

○ Yes ○ No

If yes, what SPF? _____

Do you tan in a tanning salon?

○ Yes ○ No

Do you have a family history of Melanoma? ○ Yes ○ No

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Granddaughter
- ☐ Grandson
- ☐ Other_____

SOCIAL HISTORY

Smoking Status (Please choose one):

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smokes

Start smoking: mm/dd/yyyy: _____
Quit Smoking: mm/dd/yyyy: _____
Number of Packs per Day: _____
Total Years Smoking: _____

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Are you pregnant or currently breastfeeding?

☐ YES ☐ NO

Family History: (Please include only first degree relatives)

_____
_____
_____

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Patient Communication & Financial Policies

The Following are internal policies set in place by the administration of Forefront Dermatology, S.C., d/b/a Advanced Dermatology & Skin Care Centre ("Forefront"). Signature is required before services can be provided.

Patient Communications: Confidential messages may be left on your voicemail or answering machine at the preferred number(s) you have provided to Forefront or with a friend or family member who answers the telephone at one of the preferred numbers or at your residence and who can verify your address and date of birth. Such message may include, without limitation, reminders of upcoming scheduled appointments information regarding your pathology or laboratory tests, billing information, or answers to medical questions you may have inquired about to our staff. Forefront may also communicate with you via e-mail, text message, or post card to your home address provided such method complies with applicable HIPAA communication standards. You understand that you are not required to agree to this provision in order to receive treatment.

Research: I authorize Forefront to contact me regarding any research study in which I may be eligible to participate relating to my care.

Insurance Filing: As a courtesy we will bill your insurance company for charges incurred at our clinic. Please remember your health insurance is a contract between you and your insurance company. Our office will make two attempts to settle any outstanding bill with your insurance company. If your insurance deems a service to be not covered by your insurance plan you will be responsible for the balance of this service and you expressly agree to pay for such non-covered services. Claims not paid by your insurance carrier within 90 days will be considered a non-covered service. We will furnish information required by the insurance company to receive payment. Benefits should be paid directly to the Practice from your insurance company, if your insurance company pays copays, coinsurance, or other similar charges. I hereby assign to Forefront all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

Bad Debt & Bankruptcy Account Status: I realize that if my account is in bad debt or bankruptcy status I will be required to pay $150.00 prior to my scheduled appointment. This payment will serve as a down payment toward services to be rendered at the future encounter. If, after the provider has billed for services and/or the insurance has responded, the practice determines that I do not owe the $150.00 for the current encounter (and if I am not currently under bankruptcy or any other insolvency protection from collection on past debt) the practice will review my account to see if I owe a balance on any other recent encounters or if I owe anything to Americollect, the practice's collection agency. If it is determined that I do owe on past balances and am not protected from collection by applicable law, the practice will apply the remaining amount towards such amounts owed. If I owe less than what was overpaid on the account a refund will be returned to me for the appropriate amount. I realize that if my account is sent to collections, Forefront may alternatively elect to dismiss me as a patient from the practice. If I pay off my account with Americollect, my account will be returned to good standing status with the practice and I will not be required to pay $150.00 prior to appointments unless I am placed into collections in the future.

Non-sufficient Funds: A $35.00 charge will be added for any non-sufficient funds notice from the bank. If your account is sent to collections and we have to litigate in court, your visit/s with our office may become a matter of public record.

Medicaid Insurance Coverage *(ALL patients must fill this out)*

At this time I, _____ warrant and represent that I (DO) or (DO NOT) have Medicaid health insurance coverage.
Print Your Name *circle one*

If we find at a later time that you did not provide accurate information above, you will be responsible for the balance of the charges incurred. It is your responsibility to inform our office if you acquire any type of Medicaid coverage at a later time. If you don't provide the updated information to our office you may be responsible for the balance of your bill. Not all locations and providers participate in Medicaid programs. The patient will be responsible for the full amount of services provided when this circumstance is applicable.

Non-Insured Patients: Non-insured patients will be charged a fee prior to seeing a provider on the date of service. These funds will be allocated to the services rendered by the provider for that day however these fees serve only as a down payment and are not considered payment in full. The down payments are as follows:

New patient Office Visit: $178 Established Patient Office Visit: $150 Excision Visit: $800 MOHS Visit: $1,000

Final charges will be determined after the provider sees the patient and a complete assessment is made. The provider may require payment in full for procedural services prior to rendering such a service. Additional fee information is available upon the patient's request. A statement with the balance due for services provided will be mailed to you within a few days. If the balance is paid in full within two weeks from the date of the statement, a 20% discount for cash/check or a 15% discount for credit card will apply. This discount does not apply to *Cosmetic procedures and injectables.* _____ *Initial*

Co-payments, Co-Insurance, Deductible, & Cosmetic Procedures: Payment is due on the date of service prior to seeing the provider. Deductible amounts may be collected prior to the physician completing the service. Payment for a cosmetic procedure is due in full prior to treatment. There are no returns on cosmetic products sold unless such products are defective or, in the opinion of your provider, caused an adverse reaction.

Procedure Pricing

I understand that procedure estimates are only provided in writing. Written estimates must be requested prior to the appointment.

X _____ _____ ____/____/____ until revoked
Signature of Patient or Legal Representative *Relationship to Patient* *Date*

DOB: _____

Advanced Dermatology & Skin Care Centre

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Consent to Clinical Procedures

Patient Name: _____ **Date of Birth:** _____

I hereby consent to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. This may include, but is not limited to laboratory procedures (including diagnostic testing such as lab draws and skin biopsies), medical and surgical treatment or procedure (including wart treatments, surgical removals, or excisions), or other services rendered during my visit with Forefront Dermatology, S.C., d/b/a Advanced Dermatology & Skin Care Centre ("Forefront").

In order to ensure that you understand all aspects of your visit, you are encouraged to ask any questions or clarify any procedures prior to them being performed. Our dermatology providers will answer any questions and discuss any procedures, concerns and goals with you in regard to the following:

- Benefits of the proposed procedure.
- The way the treatment or procedure is to be performed.
- Alternative treatment options.
- Probable consequences of not receiving the treatment.
- The right to withdraw informed consent at any time, in writing.
- Risk and side effects involved with the procedure.
- Potential for additional incurred charges.

Should a biopsy be performed, or any other procedure in which a section of your skin is removed, the specimen will be sent to a pathology lab for an accurate diagnosis, unless otherwise recommended by your clinician. This process will involve any testing necessary including special staining or outside consultations which will incur additional charges. _____ ***(initials)***

I acknowledge that some medical diagnoses (such as warts) will require multiple treatments with one or more methods that may change throughout the course of treatment and each office visit and procedure will be billed accordingly. _____ ***(initials)***

With any procedure, there are risks involved which include, but are not limited to the following:

- Scar – Scarring is possible with any procedure of the skin. We will do everything we can to provide you with the best cosmetic result possible, but the final cosmetic outcome is not guaranteed.
- Infection – The entire procedure will be done in a sterile and/or clean fashion. Still, a small number of people will get a wound infection.
- Bleeding – Some procedure may create some bleeding. Rarely will someone have significant bleeding after they leave such that they would have to come back to have us treat it.
- Nerve damage – This will be thoroughly discussed with you by your physician if it is a potential during your procedure.
- I authorize pictures to be taken before, during and after the procedure. These pictures will become part of your medical record. They may also be sent to your family physician and/or referring physician. They will not be used for any other purpose without a proper consent.

If a complication after the procedure would arise, there may be a charge for the medical management that will be submitted to your insurance company. I recognize that the practice of medicine is not an exact science and acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures.

Since each insurance company has its own policies regarding the coverage of procedures, I also acknowledge that I am responsible for payment in full for the charges incurred for procedures regardless of the coverage provided by my insurance carrier. If I am concerned about the cost associated with treatment, it is my responsibility to request a procedure estimate prior to starting treatment.

_____ ***(initials)***

I have read the consent form in its entirety. I understand the risks associated with procedures that may occur during my visits at Premier Dermatology. I do not impose any limitations on Premier Dermatology and its staff. I understand that I should discuss any questions or concerns with my dermatology provider prior to any procedure and therefore; with my signature, agree to have any necessary procedures performed.

_____ _____

Patient signature / Date Witness signature / Date

The undersigned hereby provides consent as the parent or guardian of the above referenced minor patient.

_____ _____

Parent or Guardian signature/ Date ***Relationship to Patient***

Advanced Dermatology & Skin Care Centre

A FOREFRONT DERMATOLOGY PRACTICE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT

Patient Name (PLEASE PRINT) _____ **Date of Birth** _____

By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" (the "Notice") of Forefront Dermatology, S.C., d/b/a Advanced Dermatology & Skin Care Centre. Our Notice provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice is subject to change. If we change our Notice, you may obtain a copy of the revised Notice by contacting our practice at 855-535-7175.

Please note that Forefront Dermatology may communicate with you in the following ways, unless you instruct us otherwise:

- In Forefront Dermatology's discretion, a confidential message may be left on your voicemail or answering machine at the preferred number(s) indicated below or with a friend or family member who answers the telephone at one of the preferred numbers or at your residence and who can verify your address and date of birth. Such message may include, without limitation, reminders of upcoming scheduled appointments information regarding your pathology or laboratory tests, billing information or answers to medical questions you may have inquired about to our staff.

Preferred Number _____	☐ Mobile (cell) ☐ Work ☐ Home
Preferred Number _____	☐ Mobile (cell) ☐ Work ☐ Home
Preferred Email Address _____	

- Forefront Dermatology may also communicate with you via e-mail, text message, or post card to your home address provided such method complies with applicable HIPAA communication standards.
- **Unless you check below**, you specifically authorize and give your express consent to receive autodialed and/or pre-recorded calls—including, but not limited to, voice and short message service (SMS) text messages and other electronic messages—from or on behalf of Forefront Dermatology and its representatives at the residential or cellular telephone number provided above or an appropriate e-mail address, not only in order to communicate appointment reminders, and notifications regarding the availability of pathology or laboratory results, but also for marketing or advertising messages offering products or services that may be of interest to you. Forefront Dermatology may receive direct or indirect payment for these marketing or advertising messages. You understand that by providing your telephone number and/or e-mail address to Forefront Dermatology, you consent to being contacted using the above-described methods. You understand that you are not required to sign this agreement in order to receive treatment. You further understand that you are not required to give this consent and that your consent is not a condition of purchasing or using any services offered by Forefront Dermatology.

  Marketing Related Opt-Out: *(Check all that apply)* ☐ Do Not Text ☐ Do Not Email

- If you have any questions about our Notice, please contact our compliance department – Phone: 920-663-0505, e-mail: compliance@forefrontderm.com

I acknowledge receipt of the Notice of Forefront Dermatology. I understand and agree to how Forefront Dermatology may communicate with me, as stated above.

X _____ _____

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

Parents may not sign for children over the age of 18.

If signed by someone other than patient, indicate relationship: _____

Print name _____

(Legal representative)

For Office Use Only

Complete this section if this form is not signed and dated by the patient or patient's representative.

Reasons why the acknowledgement was not obtained:

- ☐ Patient refused to sign this Acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices.
- ☐ Other _____

_____ _____

Employee Name Date

Messages/Voice If I am unreachable, Advanced Dermatology physicians or staff ☐ may ☐ may NOT leave messages

PERSONAL RELEASE OF INFORMATION – You consent to verbally releasing authorized contacts of your medical information to Advanced Dermatology employees. You may also elect to RESTRICT OR ALLOW Advanced Dermatology from discussing medical information including but not limited to appointments, treatments, diagnosis, prognosis, medications, with the following people listed. **PLEASE INDICATE BELOW:**

☐ **RESTRICTED – DO NOT RELEASE INFORMATION** ☐ **ALLOW – RELEASE INFORMATION TO PERSON(S) BELOW**

YOU MUST LIST FULL NAMES OF EACH PERSON(S)

PATIENT RESPONSIBILITY – Our physicians participate in many insurance plans and managed health care programs. Our office will submit a claim for services rendered for patients participating in those plans for which our physicians are providers. *Provide our office with accurate and complete insurance information. You are responsible for payment of any resulting denied claims. *Federal (Red Flag Rules) prevent us from filing to insurance without proof of identification. We will mot bill your insurance carrier. *Present photo ID and insurance card(s) to every office visit. We will not bill your insurance carrier without valid photo ID. *Pay all amount(s) due, including but not limited to balances, co-pay, coinsurance and/or deductible prior to each visit. Payment can be made by cash, check or credit card, or a payment plan may be arranged.

REFERRALS/AUTHORIZATIONS – I understand it is my responsibility to request & to notify Advanced Dermatology of any referrals or prior authorizations required by MY insurance company. If I do not have the correct authorization/referral my visit may be rescheduled or I will be responsible for payment for all costs of treatment.

CONSENT TO MEDICAL SERVICES – I authorize Advanced Dermatology to render treatment to me/my dependents for Dermatological care as may be deemed necessary. I understand any procedure including but not limited to laser treatments, cryotherapy, biopsy, chemical peel; may result in discoloration or scarring; the risk is significantly increased with sun exposure 4 weeks prior to treatment. I understand I am to notify & return to clinic if any lesion or rash does not improve and resolve within 2 weeks for further examination/treatment. I understand surgical procedures including repair may be assisted/performed by a surgical RN or CRNP.

DIGITAL PHOTOGRAPHY/VIDEO – I authorize physicians and staff of Advanced Dermatology to take digital photographs that relate to my care. Advanced Dermatology will only disclose information relevant to MY treatment. Advanced Dermatology may use images that do not disclose identity in professional publications, teaching purposes, or textbooks unless stated otherwise. I am aware there is video surveillance at all building sites at Advanced Dermatology.

PERSONAL PROPERTY – I understand & agree to Advanced Dermatology, physicians and staff harmless from any and all liability and relieve Advanced Dermatology, from any and all responsibility for loss or damage of any personal property, valuables, money or any other personal belongings located in or on the premises.

MISSED APPOINTMENTS – Our office requires 24-hour notice for cancellations/appointment/procedure rescheduling. Failure to do so may result in a $30 fee for medical appointments and a $50 fee for cosmetic appointments.

ADVANCED CARE PHARMACY – FINANCIAL DISCLOSURE TO PATIENTS – This notice informs you that Gulf Coast Dermatology & Skin Care Centre DBA Advanced Dermatology & Skin Care Centre has ownership interest in Advanced Care Pharmacy. Physicians who have ownership interest in Advanced Dermatology & Skin Care Centre may indirectly receive compensation for prescriptions you have filled at this entity or other items or products you purchase. You have a choice in pharmacies and are not obligated to use this pharmacy.

PRIVACY POLICY NOTICE – I understand I may request a copy of Advanced Dermatology's Notice of Privacy Policies detailing how my information may be used and disclosed as permitted by federal law.

E-RX – I understand as part of my electronic health record; Advanced Dermatology will transmit my prescriptions electronically as permitted to the pharmacy that I designate as my primary pharmacy provider.

SURESCRIPTS PRESCRIPTION NETWORK DATABASE – I authorize Advanced Dermatology & Skin Care Centre to access my Surescripts Medication history in order to make more informed clinical decisions regarding my healthcare. I understand this information will become part of my electronic health record. Surescripts Policy is available upon request.

STATEMENT TO PERMIT PAYMENT OF BENEFITS TO PROVIDER – I hereby assign and authorize payment of my insurance benefits, including authorized Medicare benefits, sick benefits, injury benefits due because of liability of a third party, or proceeds of all claims resulting from liability of third party, payable by any party, organization directly to Advanced Dermatology & Skin Care Centre to release any medical or other information for the purpose of processing claims to my insurance carriers, including Health Care Financing Administration and future insurance changes. This includes information as defined by and for the purposes outlined in the Privacy Notice. I have read and understand all of the above. I understand that in the event I do not pay for services rendered and amounts become delinquent, I am obligated for all costs including collection, court and attorney fees. ***I permit a copy of this authorization to be used in the place of the original***

Advanced Dermatology aims to provide exemplary patient care during each and every interaction. Your satisfaction is our primary concern. If you have any issues or concerns notify us by email Info@AdvancedDermClinic.com. Thank you for entrusting Advanced Dermatology with all of your skin care needs.

Signature of Patient or Authorized Representative Date

Witness Signature Date

Advanced Dermatology & Skin Care Centre
A FOREFRONT DERMATOLOGY PRACTICE

Minor Patient Consent Form

Patient's name: _____ **Patient's date of birth:** _____/_____/_____

It is always desirable and recommended that a parent or legal guardian attend a minor child's appointment. **If a parent or legal guardian is not present at the time of a minor child's appointment, the child will be evaluated but no treatment will occur unless authorized by a parent or legal guardian by filling out this form.**

1. **Treatment authorization** by parent/legal guardian only: (***Check one box only)***

☐ I will be attending the appointment(s) with my minor child and will be present to give consent if a procedure is recommended.

☐ I will not be attending the appointment(s) with my minor child and understand my child will be evaluated but request no treatment be initiated without first contacting me.

☐ I will not be attending follow up appointment(s) with my minor child and give consent for ongoing care of a previously diagnosed condition.

2. Insurance information:

If you ***are*** attending the appointment with your minor child, please present the insurance card(s) and photo identification to the receptionist.

If you ***are not*** attending the appointment(s) with your minor child, please have your minor child bring the card(s) to the appointment or attach a copy of the card(s) to this form. Also send along any co-payments.

Name of parent/guardian: _____ Parent/Guardian's date of birth: _____/_____/_____

Parent/Guardian's relationship to patient: _____

3. Payment Policy:

The parent or legal guardian who signs this form will be responsible for all co-payments and deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees. We will only respond to a court order that directs Advanced Dermatology & Skin Care Centre to act in a certain way.

Guardian Signature: _____

Today's Date: _____/_____/_____

4. Parent/Guardian Contact information:

Father/Guardian (please print): First name_____ Last name _____

Phone (8 am-5 pm): _____-_____-_____ home / mobile / work (circle one)

Secondary # (8 am-5 pm): _____-_____-_____ home / mobile / work (circle one)

Mother/Guardian (please print): First name_____ Last name _____

Phone (8 am-5 pm): _____-_____-_____ home / mobile / work (circle one)

Secondary # (8 am-5 pm): _____-_____-_____ home / mobile / work (circle one)