PLEASE PRINT VERY CLEARLY

Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information**

Name (Last, First, Middle) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date \_\_\_\_\_\_\_\_\_ Sex \_\_\_\_\_

Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_ Zip \_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status (Circle one):** Single Married Divorced Widowed Separated

**Occupation**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Industry:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race (Circle one):** Caucasian Hispanic Non Hispanic African American Asian Other Rather Not Specify

**Ethnicity (Circle one):** Hispanic Non Hispanic Other **Language (Circle one):** English Spanish Other

Referring Physician (Last, First, Middle) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance**

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please enter the policy holder’s information below. If you are the policy holder yourself, check this box  and skip to the next section.***

Policyholder’s Name (Last, First, Middle) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you require an insurance referral? Yes [ ] No [ ]

**Secondary Insurance**

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please enter the policy holder’s information below. If you are the policy holder yourself, check this box  and skip to the next section.***

Policyholder’s Name (Last, First, Middle) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assignment Release**

**I hereby authorize payment directly to Center for Dermatology & Skin Surgery, PLLC of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me or for my dependents. I authorize the doctors and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above.**

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the patient is a minor (under 18 yrs. of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information**

Reason for today’s visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who referred you to our practice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name & Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Questionnaire**

1. Are you currently under medical treatment? **Yes** **No**

If yes, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever had any serious illnesses or operations? **Yes** **No**

If yes, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you taking any medications? **Yes** **No**

If yes, please list, or provide us with a copy of your list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you smoke? **Yes** **No** 5. Do you drink alcohol? **Yes** **No**
2. Do you use cocaine or other drugs? **Yes** **No**
3. Have you ever had any allergic reactions to the following:?

Local Anesthetics (ex. Novacaine) **Yes** **No**

Penicillin or other Antibiotics **Yes** **No**

Sulfa Drugs **Yes** **No**

Barbiturates (sleeping pills) **Yes** **No**

Other Sedatives **Yes** **No**

Iodine **Yes** **No**

Aspirin **Yes** **No**

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Women only: Do you have regular periods?

Are you using birth control pills / patch / injection?

Are you pregnant now?

Have you ever been pregnant?

Number of pregnancies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Personal history of skin cancer? **Yes** **No** Comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Family history of skin cancer? **Yes** **No** Comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please indicate which of the following conditions/illnesses you have or have not had:**

Anemia (low blood count) **Yes** **No** Herpes **Yes** **No**  Skin Rash **Yes** **No**

Anorexia (no appetite) **Yes** **No** HIV / AIDS **Yes** **No** Stroke **Yes** **No**

Arthritis **Yes** **No** Jaundice **Yes** **No** Thyroid Problems **Yes** **No**

Asthma **Yes** **No** Kidney Disease **Yes** **No**  Tonsillitis **Yes** **No**

Back Problems **Yes** **No** Latex Sensitivity **Yes** **No**  Tuberculosis **Yes** **No**

Bleeding Tendency **Yes** **No** Liver Disease **Yes** **No**  Ulcer **Yes** **No**

Blood Disease **Yes** **No** Low Blood Pressure **Yes** **No**  Venereal Disease **Yes** **No**

Cancer **Yes** **No** Measles **Yes** **No** Any other condition? **Yes** **No**

Drug Dependency **Yes** **No** Migraines **Yes** **No** Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chemotherapy **Yes** **No** Headaches **Yes** **No**

Chicken Pox **Yes** **No** Mitral Valve Prolapse **Yes** **No** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chronic Fatigue Syndrome **Yes** **No** Mumps **Yes** **No**

Circulatory Problems **Yes** **No** Multiple Sclerosis **Yes** **No**

Congenital Heart Lesions **Yes** **No** Pacemaker **Yes** **No**

Cough – Persistent or bloody **Yes** **No** Pneumonia **Yes** **No**

Diabetes **Yes** **No** Polio **Yes** **No**

Emphysema **Yes** **No** Prostate Problem **Yes** **No**

Epilepsy **Yes** **No** Psychiatric Care **Yes** **No**

Glaucoma **Yes** **No** Respiratory Disease **Yes** **No**

Heart Murmur **Yes** **No** Rheumatic Fever **Yes** **No**

Heart Disease **Yes** **No** Scarlet Fever **Yes** **No**

Hepatitis Type \_\_\_\_\_\_\_\_\_ **Yes** **No** Shortness of Breath **Yes** **No**

Hernia **Yes** **No** Sinus Trouble **Yes** **No**

**BILLING AND COLLECTION POLICIES**

Our goal is to provide you with high-quality and efficient care. There are many details involved in the process of payment for the services that you receive. In order for this process to flow smoothly, it is essential that you understand what information we must share with each other and with health insurance companies, and what both of our responsibilities are.

Upon scheduling and registration, we require you to provide your medical insurance card (if you have coverage), photo identification, your address, date of birth, and phone number. If you receive health benefits through a spouse, partner, or parent, we require you to provide that person’s address, date of birth, and phone number as well. Our billing process works better if you provide social security numbers as well.

Health Insurance Cards: Upon scheduling each appointment, our team will ask to verify your insurance information, and will ask to see your insurance card upon check-in at each appointment. Please bring your card to every appointment and notify the office at your first appointment after if of any changes. Intentionally failing to notify us of changes to your insurance coverage may constitute fraud, and we may be obliged to report such behavior to the authorities. We will not engage in any fraudulent practices under any circumstances.

Keeping Appointments: Should you not arrive for a scheduled appointment, unless that appointment has been cancelled at least 24 hrs. in advance, you may be charged $50 for each no-show occurrence. Should this occur more than twice within a 12-month period, you may be dismissed from the practice or required to put down a deposit to hold the appointment. By signing below, you accept this policy.

Late Policy: Each appointment has a 15-minute late policy. If a patient arrives to their scheduled appointment 15 minutes past the scheduled time, without giving the office any notice, the office may reschedule your appointment to another date and time. By signing below, you accept this policy.

Health Insurance Plans: It is your responsibility to understand the provisions of your health insurance plan and coverage. As helpful as we pride ourselves on being, our team cannot be expected to know the details of your particular plan, as we see hundreds of different plans each week. We recommend contacting your carrier prior to receiving services in order to verify your coverage levels and responsibilities.

Authorizations: You are responsible to obtain all necessary referrals, pre-certifications or other required documentation prior to your appointment. If our office team determines that your plan requires an authorization, and you do not provide such a referral, authorization, or certificate, you may be required to sign a waiver in order to receive services. This waiver includes a credit card authorization and permits us to charge you for the services rendered at that visit should your health insurance carrier deny payment due to lack of authorization. Additionally, even should our team fail to request such a waiver, you will nonetheless be responsible for all charges that are not paid by your insurance carrier due to lack of authorization. Should our team determine that your plan requires a referral, you do not have one, and you reschedule instead of signing a waiver, you may be charged $30 for a no-referral cancellation. By signing below, you accept this policy.

Copayments: It is our responsibility, as detailed by the terms of our contracts with health insurance companies, to collect any copayment amounts at the time of your appointment. It is your responsibility, as detailed by the terms of your health insurance coverage, to pay any copayment amounts at the time of your appointment. Please have your payment ready upon check-in. Please be aware that, should you not pay your copayment at the time of service, and should our team need to invoice you for that payment, you will be responsible to pay an invoice fee in the amount of $10 for each instance we send you an invoice for an unpaid copayment, including multiple invoice instances for the same occurrence. By signing below, you accept this policy.

Previous balances and/or deductibles: By signing below, you accept this policy. It is our responsibility, as detailed by the terms of our contracts with health insurance companies we participate with, to bill you for any portion of your treatment that your health insurance carrier assigns to your responsibility. It is your responsibility, as detailed by the terms of your health insurance coverage, to pay any such portion. If you do not remit any full payment on any such bills within a reasonable period and with reasonable notice, your account may be sent to collections. In that event, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs and expenses, including reasonable attorneys’ fees, which we incur in such collection efforts. You may be dismissed as a patient by our practice for failure to meet your financial obligations. By signing below, you accept this policy.

Health insurance non-payment: Services that have not been paid by your health insurance carrier within 60 days of claim submission will become your responsibility to pay in full. Should your health insurance carrier later pay us for those services you paid for, you will be reimbursed within 30 days. By signing below, you accept this policy.

Self-pay patients: If you do not have health insurance, or are receiving a known non-covered service, it is our policy that you must pay for your service before leaving the office. Uninsured patients who would like to discuss discounted rates must do so in advance, before receiving services. We are required to comply with our managed care contracts and federal regulations, but we do have policies in place to assist uninsured patients which allow us to comply with those rules and still assist such patients. By signing below, you accept this policy.

Cosmetic services: Some cosmetic services require a deposit upon scheduling, which may be taken over the telephone and charged to a credit and are not refundable. Should your credit card subsequently be declined or charged back, you will still be responsible for the deposit amounts. By signing below, you accept this policy.

I have read, fully understand, accept and agree to comply with all the above policies. I consent to the assignment of authorized health insurance benefits by my health insurer to Center for Dermatology & Skin Surgery LLC for any services furnished to me or my dependents.

Patient Name (Please print clearly) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the patient is a minor (under 18 yrs. of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Privacy Practices Acknowledgement and Consent Form**

I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it. I understand that it can be found on your website, [www.centerfordermatologynj.com](http://www.centerfordermatologynj.com).

I agree that telephone messages regarding my appointments, prescription renewals, lab results, and all other Protected Health Information (“PHI”), may be left for me on voicemail systems and answering machines at the following telephone numbers, in addition to any other numbers provided to you by me:

Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home / Office / Cell / Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home / Office / Cell / Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home / Office / Cell / Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[If we need to contact you with lab results, please place a check mark next to the preferred contact number, if any.]

\_\_\_\_\_ I agree that my PHI may be shared with my spouse.

\_\_\_\_\_ I agree that my PHI may be shared with my other medical providers.

\_\_\_\_\_ I agree that my PHI may be shared with the following people.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I can change any of the foregoing agreements, at any time, by giving written notice to Center for Dermatology & Skin Surgery LLC, to the attention of the HIPAA Compliance Officer.

I agree that Center for Dermatology & Skin Surgery LLC may contact me at any email addresses provided to you by me regarding both PHI and non-PHI.

*\*as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time (“HIPAA”)*

I waive my rights to any photographs and videos taken before, during, and after procedures for the purposes of my medical record. I also understand these photographs or videos may be published in a variety of sources and in the event, that they are published, I will not be identified by name. I expect no compensation for these photographs or videos and waive all rights to any claims for payment or royalties. I also release Center for Dermatology & Skin Surgery LLC from any liability in connection with the use of such photographs and videos.

Patient Name (Please print clearly) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the patient is a minor (under 18 yrs. of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPOINTMENT CANCELLATION AGREEMENT**

Your appointment time is reserved for you. If you miss or cancel an appointment ***without 24 hour notice*** it is our policy to charge you a fee of $50.00 (exceptions are true medical emergencies and weather related problems; state of emergencies ONLY). Payment will be expected before you can be seen for your next scheduled appointment. **Please understand that insurance companies do not pay for missed appointments.**

My signature represents my understanding of the Center for Dermatology & Skin Surgery LLC cancellation policy.

­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Signature Date

**LATE POLICY**

Your appointment time is reserved for you. If you arrive to your scheduled appointment 15 minutes past the scheduled time, without giving the office notice, your appointment may be rescheduled to the next available appointment which may be at a different time and date.

My signature represents my understanding of the Center for Dermatology & Skin Surgery LLC cancellation policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Signature Date

­­­­­­ **Assumption of the Risk and Waiver of Liability Relating to COVID-19**

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

Center for Dermatology & Skin Surgery has put in place protective measures to reduce the spread of COVID-19; however, the office cannot guarantee that you or your child(ren) will not become infected with COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 while attending Center for Dermatology & Skin Surgery and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at Center for Dermatology & Skin Surgery may result from the actions, omissions, or negligence of myself and others, including, but not limited to, Center for Dermatology & Skin Surgery employees, volunteers, and pharmaceutical representatives.

I voluntarily agree to assume all the foregoing risks and accept sole responsibility for any injury to myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I may experience or incur in connection with my attendance at the Center for Dermatology & Skin Surgery or (“Claims”). On my behalf, I hereby release, covenant not to sue, discharge, and hold harmless the Center for Dermatology & Skin Surgery, its employees, volunteers, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs, or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of Center for Dermatology & Skin Surgery, its employees, volunteers, and representatives, whether a COVID-19 infection occurs before, during, or after attending Center for Dermatology & Skin Surgery.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Print Name Sign Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Parent of Guardian Print Name Parent or Guardian Signature Date