WELCOME TO AFFILIATED DERMATOLOGISTS OF VIRGINIA

Date:_____ Referred by:_____ Chart #_____
(_)Dr. (_)Friend (_) Family

Patient's Name_____ Primary Dr._____
(Last) (First) (Middle)

Date of Birth_____ SSN_____ Marital Status: M D S W

Responsible Party: (_) same as above or_____ Relationship_____

Address_____
(Street) (City) (State) (Zip)

Mailing Address (if different)_____ Email Address_____

Primary Phone (____)_____Alternate Phone(____)_____
(_)home (_)cell (_)home (_)cell (_)work

Employer_____ Occupation_____

Medical Emergency Contact_____ Telephone_____

INSURANCE INFORMATION

PRIMARY	**SECONDARY**
COMPANY NAME_____	COMPANY NAME_____
POLICYHOLDER_____	POLICYHOLDER_____
POLICYHOLDER'S DATE OF BIRTH_____	POLICYHOLDER'S DATE OF BIRTH_____
POLICYHOLDER'S SSN_____	POLICYHOLDER'S SSN_____
RELATIONSHIP TO PATIENT_____	RELATIONSHIP TO PATIENT_____
ID #_____	ID #_____
GROUP #_____	GROUP #_____

I understand that my insurance policy is a contract between myself and the insurance company and Affiliated Dermatologists of VA (ADOV) is not a party to that contract. I am ultimately responsible for unpaid balances and non-covered services. I am responsible for informing the office of all changes to my information and insurance PRIOR to my appointments. Insurance must be in force and verifiable at time of treatment. If my insurance company requires a referral, it is my responsibility to obtain one PRIOR to my appointment. If I do not have insurance or a referral, I agree to pay in full at the time of the appointment. I hereby assign all insurance benefits for services rendered, otherwise payable to me, directly to ADOV from Medicare or my private insurance. I authorize ADOV to release medical information to my insurance company, its agents or any third party for use in determining my benefits. If my account enters a delinquent status, I agree to pay all costs of collections including attorney fees and court fees. If my account enters court collection status, I understand that I am no longer a patient of record. I understand that the fee for a returned check is $35. AS A COURTESY ONLY, we will attempt to confirm your appointment prior to the date. ADOV cannot guarantee a reminder call. I understand that ADOV charges a minimum fee of $50 for appointments missed or cancelled without 24 hours notice. I agree to pay such fee. * *ADOV will maintain patient records for a minimum of six years following the last visit, barring any exceptions where we may be required to keep them longer.*

By signing below I indicate my understanding and agreement with the policies listed above and authorize Affiliated Dermatologists of Virginia to render treatment to the patient named.

_____ _____
Signature of Patient or Responsible Party Date