Patient Information

Address:
City, State, Zip: NY 10965
Date of Birth:
Gender:
Social Security:
Marital Status:
Home Phone:
Cell Phone **Cell provider:**
Email Address:
Occupation:
Referring Doctor (if any):
Insurance holder (if not self): **Name:**
Address:
City, State, Zip:
Date of Birth:

The following information is optional, but we are required to ask for it by the Department of Health and Human Services:

Race: NotSet
Ethnicity:
Language: English (United States) 1033

On which phone number can we leave a confidential message if we can not reach you? Home phone ☐ Cell phone ☐ None ☐

Contact person we can discuss your confidential health information with:

Name, relationship, phone number(s):

Statement of Accuracy of Information: I have reviewed the above information sheet and corrected/updated it as necessary. I affirm that all the information is up to date and accurate.
Initials: _____

Assumption of Financial Responsibility: I acknowledge and agree that I will be financially responsible and liable for payment for services provided for me (or the minor/dependent under my care) by The Skin Center Dermatology Group. If I have health insurance and my insurance company - for whatever reason - refuses to pay for these services, I agree to assume financial liability and I agree to pay for all services rendered to me (or the minor/dependent under my care). I also agree to pay any and all insurance co-pays, deductibles and out-of-pocket charges. I understand that payment of co-pays is required at the time of the visit and billing fees and late payment charges may be assessed if I do not return payment promptly.
Initials: _____

No Guarantees: I acknowledge and agree that any statements made by the physicians, employees or representatives of The Skin Center Dermatology Group or any written, verbal, electronically delivered or other information or communications received from or on behalf of The Skin Center Dermatolgy Group shall not be constured as presenting any guarantees, promises or warranties regarding outcomes or otherwise.
Initials: _____

Miscellaneous: I received a copy of the Privacy Notice of The Skin Center Dermatology Group. I was advised regarding the 24 hours cancellation notice and no-show policy. I received information about non-covered, cosmetic or not medically necessary procedures and treatments.
An internet Patient Portal will be created for me - if I supply the necessary information - where I will be able to access information about my care.
Initials: _____

Signature of patient or parent/legal guardian: X_____ Date:_____