Piedmont Dermatology Center, PC

Welcome To Our Practice!

PATIENT INFORMATION:

Today's Date:_____Birthdate:_____

Last Name:_____First Name:_____Initial:_____

Mailing Address:_____City_____State_____Zip_____

Home phone:_____Cell phone:_____

E-Mail address:_____

Gender: Male Female **Circle:** Minor Single Married Divorced Widowed Separated

Employer:_____Business telephone:_____

Business address:_____Occupation:_____

Who should we thank for referring you?_____

Emergency contact:_____Telephone:_____

Notice of Information Practices:

I have read the Notice of Information Practices for Piedmont Dermatology Center **:_____(initial)**

Assignment and Release:

I authorize payment directly to Piedmont Dermatology Center for 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 on my behalf or my dependents._____ **(initial)**

There will be a $25 charge for all returned checks._____ **(initial)**

I authorize Piedmont Dermatology Center to release any information required to secure payment of services. I agree to be contacted at any telephone number associated with my account including wireless telephone numbers, which could result in charges to me. We may also contact you by sending text messages or e-mails. Methods of contact may include using pre-recorder/artificial voice message and or use of an automatic dialing device. If my account is sent to a collection agency, a collection fee of 30% will be added to the principal balance of my account.

I have read this disclosure and agree that the creditor may contact me/us as described above.

Signature of responsible party_____**Date**_____