ADVANCED DERMATOLOGY LASER & COSMETIC SURGERY
1220 Avenue P Brooklyn, NY 11229
718-375-7546 (Tel) 718-376-6475 (Fax)

PATIENT OFFICE VISIT AGREEMENT

I hereby attest that the information given to the Front Desk is **complete** and **curren**t.

Any Bills resulting from inappropriate information including but not limited to inaccurate insurance card, inactive insurance card, and other insurance cards available not handed, or missing referral are my responsibility.

Any bills resulting from **Incomplete**, **inaccurate**, or **missing information** will be my responsibility and will be paid by me in full.

Any bills resulting from outstanding balance of **Insurance Deductible** will be my responsibility and have to be paid in full before I can see the Doctor.

_____	Apr 10, 2014
Patient's Signature	Date
_____	Apr 10, 2014
Patient's Name (print)	Date
_____	Apr 10, 2014
Signature of Patient's Representative/ Relationship	Date

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