

Payment policy:

Please remember you are responsible for co-payments, annual deductibles, co-insurances or any other charges that are not covered by your insurance company.

Emergency Contact Information:

In case of emergency, whom should we notify? _____

Relationship to patient _____ Phone () _____

Do you give our office permission to discuss medical information with your family members?

Yes No If yes, please list their names and numbers below.

1. Name: _____ Relationship _____ Phone () _____

2. Name: _____ Relationship _____ Phone () _____

3. Name: _____ Relationship _____ Phone () _____

Patient/Responsible party signature _____ **Date** _____

Receipt of Notice of Privacy Practices

I have received a copy of Jacksonville Dermatology Associates, PL's Notice of Privacy Practices.

Signature of Patient

Date