Ablon
Skin Institute
For Dermatology,
Laser Rejuvenation & Research

Patient Registration

D.O.B:_____ Social Security#_____ Date:_____

Name:_____ Gender: M F Marital Status: S M W D SEP

Last , First Middle

Address:_____ City, State, Zip:_____

Home Phone #:_____ Work Phone #_____

Cell Phone #_____ Fax#:_____

Email Address:_____ Occupation/Employer: _____

Spouses Name: _____ D.O.B: _____

Emergency Contact: (Other than spouse) _____ Phone #_____

Referred by: _____

Preferred method of contact (please circle one): Cell Phone, Home Phone, Email or Text

PAYMENT REQUIRED AT TIME OF SERVICE

Insurance Company:		Policy #:	
Name of Insured:			

Assignment of Insurance Benefits
I hereby authorize direct payment of surgical/medical benefits directly to Dr. Glynis Ablon for services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance. I understand that I am responsible, prior to treatment, for inquiring with my insurance company as to the benefits of my policy for services to be provided by Dr. Ablon.

Dr. Glynis Ablon is not contracted with any insurance plans. For all patients, payment will be required in full at time of service. You will be given a superbill to submit to your insurance carrier for reimbursement. Cosmetic treatment is not covered by insurance plans and must be paid for at the time of service. **Dr. Ablon is not a MediCare provider. Supplemental insurance <u>will not</u> cover any costs because we are not MediCare providers.**

Authorization to Release Information
I hereby authorize Dr. Glynis Ablon to release my medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand that my medication renewal is subject to periodic review of my health status to assess indications, side effects and to monitor therapy.

Cancellation Policy
Regular Medical office visits must be cancelled 24 business hours in advance of appointment. **Any no-shows or late cancellations will incur a $50 fee. Cosmetic treatments require additional advance cancellation notice.**

Patient Signature_____ **Date**_____

REV 06.16

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