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DERMATOLOGY – DERMATOPATHOLOGY – DERMATOLOGICAL SURGERY – COSMETIC AND LASER SURGERY
MOHS MICROGRAPHIC SURGERY – SPECIALIZING IN ACNE TREATMENT

PLEASE PRINT

Patient's Name _____ Age _____ Birthdate _____
(LAST) (FIRST)

Home Address _____ Cell Phone _____

(CITY) Zip Code _____ Phone _____

Occupation _____ Soc. Sec. No. _____

Employed by _____ Business Phone _____

Employer's Address _____

Name of Responsible Party for Minor _____

Relationship _____

Address _____ Phone _____

City _____ Zip Code _____

Name of Spouse (husband/ wife) _____ Age _____ Birthdate _____

Spouse Employed by _____

Employer's Address _____

Occupation _____ Bus. Phone _____ Soc. Sec. No. _____

Referred by: _____

Name and Address of Closest Relative (other than husband/ wife) (in case of emergency)

Name _____ Relationship _____

Address _____ City _____ Zip Code _____ Phone _____

MEDICARE NUMBER _____

Date/initials for verification of patient information

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STATEMENT OF OFFICE POLICY REGARDING FEES AND INSURANCE

It is customary to pay for services when rendered unless arrangements are made in advance. Charges incurred for medical treatment including laboratory tests and pathology fees are payable to Dr. Ulmer.

As the responsible party, I assume full liability for medical bills in this office and further understand that payment of said bills will not be contingent upon any insurance coverage I have. Dr. Ulmer, Dr. Lee and Dr. Gabriel are considered out of network providers for all insurance plans. Ulmer Dermatology will provide you with an itemized claim form that you may submit to your insurance company for reimbursement dependent upon your specific plan. Account balances that become 90 days past due will incur a monthly 1.5% finance charge until paid in full. All returned checks will be subject to a \$25.00 fee per occurrence. **Cancellations made with less than 24 hours notice will be subject to a \$50-\$150 cancellation fee.**

Please feel free to discuss fees with Dr. Ulmer, Dr. Lee or Dr. Gabriel prior to any treatment or service.

I have read, understand, and agree to the above policy regarding fees, insurance and cancellations.

Date _____ Signature _____

Relationship to Patient _____ Print Name _____

