Dr. Angela Kyei, MD
Melissa Telenko, NP

Cosmopolitan Dermatology
MEDICAL | SURGICAL | COSMETIC

Dr. Oscar Saffold, MD
Liz Davis-Walker, NP

**Today's Date:** _____

(Please Print)
**Name: Mr./Mrs./Miss/Ms.**_____

**Marital Status:** Single/Married/Divorced/Separated/Widowed

**Street**

**Address:**_____

**City:**_____ **State:**_____ **Zip Code:** _____

**Home Phone:(  )**_____**Cell: (  )**_____

**Social Security #**_____-____-_____ **Birth Date:**____/____/_____**Male: ___Female: ___**

**Email:**_____

**Referring Physician:** _____ **Primary Care Physician:**_____

**Primary Insurance:**_____**ID#**_____**Group#**_____

**Secondary Insurance:**_____**ID#**_____**Group#**_____

**(PLEASE PROVIDED A COPY OF YOUR INSURANCE CARD TO THE RECEPTIONIST)**

**How did you hear about us?**

Family/Friend: _____Patient: _____Insurance:_____Location:_____

Online/Radio Ad:_____Search Engine: _____ Website:_____Yellow Pages:____

**Emergency Contact Name:**_____**Relationship:**_____

Home Phone:(  )_____ Cell: (  )_____

The above information is true to the best of my knowledge, I authorize my insurance benefits be paid directly to the physician, I understand that I am financially responsible for any balance, I also authorize Cosmopolitan Dermatology, Inc. Or Insurance company to release any information required to process my claims.

**Patient /Parent or Guardian Signature:**

X _____ Date:_____

# Please Read and Sign Back

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# PATIENT FINANCIAL LIABILITY FORM

**INSURANCE**

Patients are responsible for providing accurate and timely insurance information to our office. Patients will be held financially liable for services rendered if the correct insurance information is not provided within the required filing period for their insurance. Verification of benefits or prior authorization is not a guarantee that an insurance carrier will pay a claim. The insurance carrier makes final determination upon receiving the claim, based upon the plan's level of coverage and associated policies. Denied claims become the responsibility of the patient. Patients are fully responsible for obtaining any necessary referral from another physician before the appointment time. Insurance claims denied due to lack of referral will become the patient's responsibility.

Co-payments are due and payable at the time of service. If we are unsure of copay liability, we will bill the insurance first then the patient will be billed for any applicable co-payments. Patient agrees to pay all deductibles, coinsurance and services deemed "patient responsibility" as identified by the insurance carrier. Payment in full is due upon receipt of statement.

Cosmopolitan Dermatology, Inc. accepts Visa, Mastercard, Discover, American Express, checks, or cash. Checks returned for non-payment will be subject to additional fees. Unpaid patient balances may be placed with an outside collection agency if payment is not made within 120 days. This may adversely affect your credit. Non-emergent medical services may be denied until delinquent balances are paid.

**COSMETIC SERVICES**

All cosmetic services are payable in full at the time of service. A 50% deposit is required at the time of scheduling appointment.

**NO-SHOW APPOINTMENTS**

If you are unable to keep your appointment, please notify our office no less than 24 hours before your appointment. Messages are acceptable and can be left at all times during evening and weekends. Cosmopolitan Dermatology may assess a $35.00 fee for an appointment that is missed without adequate notice.

I have read the above information and agree to the terms contained therein:

_____

Patient's PRINTED Name

_____

Parent/Guardian PRINTED Name (If patient is a minor)

_____ _____

Patient or Parent/Guardian Signature Date

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Today's Date: _____

Patient Name: _____ D.O.B: _____

Pharmacy Name: _____

Pharmacy Location: _____

Pharmacy Phone Number: _____

**Medications**: (Please list all Prescription and OTC Medications)

_____

_____

_____

_____

_____

**Allergies:**

_____

_____

_____