2 Executive Park Drive, 2nd Floor Albany, NY 12203 518.482.8631 | albanyderm.com

INSURANCE INFORMATION

Date: ______________________

Patient Name: First ____________________________ Last ____________________________ DOB: ___/______/____

Please provide your insurance card to receptionist at the time of check in.

Primary Insurance: ____

ID #: _________________________ Policy #: _________________________ Group #: __________________________

Referral Required: Yes or No Copayment: _____________________________________

Name of Insured Party: ____ DOB: ___/______/____

Address of Insured: (If different from patient) ____

Secondary Insurance: ____

ID #: _________________________ Policy #: _________________________ Group #: __________________________

Referral Required: Yes or No Copayment: _____________________________________

Name of Insured Party: ____ DOB: ___/______/____

Address of Insured: (If different from patient) ____

Tertiary Insurance: ____

ID #: _________________________ Policy #: _________________________ Group #: __________________________

Referral Required: Yes or No Copayment: _____________________________________

Name of Insured Party: ____ DOB: ___/______/____

Address of Insured: (If different from patient) ____

I understand that office visit charges are payable on the day service is rendered. I authorize Albany Dermatology to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand if I do not call to cancel my medical appointment, I will be charged a **$25 No Show Fee.** I understand if I do not call to cancel my cosmetic/esthetic appointment, I will be charged a **$65 No Show Fee.** I understand that my contract is between Albany Dermatology and myself.

Signature: ____ Date: ___/______/___