Aesthetic Dermatology & Cosmetic Surgery, Medical Associates , Inc. Jeffrey H. Binstock, M.D. & Associates www.BeautyBeforeAge.com

	PA	TIENT INFORM	MATION			
Today's Date:	D	Date of Birth:	Age:			
Patient: Last Name Social Security#:			F Marital St	atus: S	Middle Name M D W	
Address: Stree	t Apt #	City		State		Zip
Home Phone: You may communicate with				_Email:		
Primary Doctor:Address:			Phone:			
		-	Phone:Phone:			
I found you: ☐ Google I was recommended to the I give permission to leave	doctor by:					
	INSU	JRANCE INFOR	RMATION			
Primary Insurance:	ID	ID#:		Group#:		
Subscriber's Name:		DOB:		_Relationsh	ip:	
Subscriber's Address:				Subscriber's Social Security#:		
Employer Name/Address:_						
Secondary Insurance:		ID#:		(Group#:	
Subscriber's Name:		DO!		:Relationship:		
FamilyPhysician:	N.				DI.	
Referred by MD:	Name	Addres			Phone	

I hereby authorize ADCSMA, Inc. to release to my insurance carrier any medical information necessary for the completion of my medical claim. I understand that this may include copies of my medical records or lab results.

GUARANTEE TO PAY

I authorize payment of my medical benefits for treatment and/or surgery directly to ADCSMA, Inc. I understand that any outstanding balance not covered or paid by my insurance, in addition to all consultation fees, will be my responsibility to pay. If my account is turned over to an attorney or collections agent to obtain payment, then I shall be responsible for the attorney's fee, court costs, and any other costs incurred by the collection agency.

I understand that any cosmetic procedure is payable on the day of service. I realize there is a fee for a consultation. A copy ofmy signature shall have the same force and effect as the original. I confirm the above information is accurate. ADCSMA, Inc. does not honor ADVANCE DIRECTIVES.

I understand that UCSF DERMATOPATHOLOGY WILL BILL ME DIRECTLY for diagnostic and consultative services rendered on any biopsy specimen or slide sent to them on my behalf.

I agree to pay a service charge of \$24.00 per hour, and .25 per page plus postage for Photocopying of my Medical Records or completing my insurance inquiry/ disability forms, and to pay before the service is rendered.

I accept absolute responsibility for knowing whether or not ADCSMA is a member provider of my insurance's physician panel, and agree to pay for all services rendered if they are not. I understand that ADCSMA belongs to a limited number of HMOs, and it is my sole responsibility to obtain prior authorization for my consultation and treatment.