

Premier Dermatology  
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Premier Dermatology  
Marie Jhin, MD  
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Patient Name: \_\_\_\_\_  
Last First Middle Initial

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_

Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Occupation/Employer: \_\_\_\_\_

Social Security #: \_\_\_\_\_

How did you hear about us/ who referred you? \_\_\_\_\_

**Responsible Party/Insured (if other than Patient)**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Acknowledgement of Receipt of Notice of Privacy Policies  
(Copy available upon request)**

My initials indicate that I have read and understand Dr. Jhin's Notice of Privacy Practices: \_\_\_\_\_  
initials

**Payment Policy**

**Insurance Patients:** Your co-payment and any charges for non-covered, cosmetic services will be collected at the time of your visit. You will be responsible for paying your deductible and any additional coinsurance per your insurance policy. There is a charge for or acne treatment, Thermage, Sculptra and Laser Hair Removal appointments missed or cancelled with less than 24 hours notice.

**Cosmetic Patients:** Payment is required, in full, at the time of service.

Your signature below signifies your understanding and willingness to comply with our policies.

\_\_\_\_\_  
**Patient/Responsible Party Signature**

\_\_\_\_\_  
**Date**