COSMETIC DERMATOLOGY CENTER, PLC, NICOLE HAYRE, MD (703) 827-8600

Patient Information as of __/__/__ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes E-mail _____

Contact Restrictions: _____

Age _____ Birthdate __/__/__ Gender ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

How did you hear about Dr Hayre?: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

Emergency Contact
(Not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip

Please be advised that most of the procedures performed by Dr Hayre are not covered by insurance plans as they are considered to be cosmetic. Therefore, Dr. Hayre does not participate with insurance plans. She will, upon request, provide a billing statement which you may submit to your insurance company. Your insurance company will then issue a check directly to you for the amount covered by them. Please remember that your insurance company may require a referal for your office visit, which you must obtain from your primary physician.

Payment for all visits and services are due in full on the day they are rendered. We accept Visa, Mastercard, and American Express. Personal checks are not accepted. If for whatever reason payment is: delayed; rejected; not received or is cancelled for any reason, Client understands and expressly agrees that he/she is personally liable for the outstanding payment to include additional costs associated with attorney's fees or collection agency fees required to ensure payment by the Client. Further, Client understands and expressly waives any and all privacy concerns associated with the Health Insurance Portability and Accountability Act (HIPAA) and any other relevant state law as it pertains to the release of confidential information required for the purposes of obtaining payment for services rendered. It is understood that the release of personal information will be limited to only that which is required for the purposes of collecting payment.

If you must cancel an appointment, we appreciate at least 24 hours notice. There is no charge for advanced cancellation of an appointment. There is a $25 fee for a 'no-show' for a standard appointment, and a $50 fee for a 'no-show' for a procedure appointment.

I have read the above, and agree to the terms set forth therein.

Signature of Patient/Legal Guardian _____ **Date** _____

Name of Patient / Guardian (Printed) _____

Relationship to Patient _____