Strother
DERMATOLOGY

# Patient Agreement

**Notice of Privacy Practices**

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

**Authorization of Release of Information**

You are hereby authorized to speak with the following individuals regarding my care at Strother Dermatology:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Leave blank if you do not authorize anyone to speak about your care.

**No Show and Late Cancellation Policy**

We want to thank you for trusting our practice with your medical or cosmetic care. We value all of our patients, under stand their time is valuable and strive to provide the best dermatologic care to everyone. If you cannot make it to your medical appointment we require 2 business days advance notice, otherwise a late cancellation charge of $50 will be incurred on your account. For elective procedures (such as laser hair removal, Thermage, CoolScultpting, etc), failure to provide adequate notice of cancellation will result in you being charged a fee equivalent of the procedure scheduled. Patients arriving more than 10 minutes late to their appointment may be rescheduled to another day.

I agree to policies outlined above and agree to comply with them.

_____ _____

Patient (or guardian if a minor) Date



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