Abington Dermatology

Release of Information:

I _____, give permission to the staff of Abington Dermatology Associates to leave a message:

_____ on my home answering machine _____ on my cell phone

_____ with the following person(s) Name: _____

Relationship: _____ Phone # _____

Patient/Representative Signature: _____ Date: _____

Receipt of HIPPA Policy:

I, _____, acknowledge that I have received The Notice of Privacy Policy for Abington Dermatology Associates (available at the receptionist's desk).

Cancellation Policy:

We request 24 hours notice for all canceled appointments. We reserve the right to charge a $40.00 missed appointment fee if you cancel within 24 hours or fail to show for your scheduled appointment time. Thank you for your consideration in this matter.

Patient/Representative Signature: _____ Date: _____

500 Old York Road
Suite 201
Jenkintown, PA 19046
(215) 517-1212 · f: (215) 517-1229

www.abderma.com

1190 Old York Road
Suite 200
Warminster, PA 18974
(215) 420-1340 · f: (215) 420-1363