Account Number: _____ (Employee use only)

Patient Information:

Patient Last Name: _____ First: _____ MI: _____

SS#_____/_____/_____ DOB: _____ Marital Status: Single Married Other Sex: M / F

Home Address: _____ City: _____

State _____ Zip Code: _____ E-Mail Address: _____

Home Phone: (_____) _____ Cellular Phone: (_____) _____

Employer: _____ Occupation: _____

Primary Care Physician: _____ PCP Phone Number: (_____) _____

PCP Address:_____

Race: Asian Asian-Pacific Black Caucasian Hispanic Native American Other: _____

Preferred Language: _____ **Ethnic Group:** _____

How did you learn of our office? ☐ Insurance Directory ☐ Yellow Pages ☐ Family member

☐ Friend ☐ Co-worker ☐ Physician Referral: _____

Primary Insurance Information:

Insured Person's Name: _____Birth Date: ___/____/____

ID# _____ Group #_____

SS#_____/____/_____Employer _____ Work Phone: (_____) _____

Work Address: _____ Occupation: _____

Secondary Insurance Information:

Insured Person's Name: _____ Birth Date: ___/____/____

ID# _____ Group # _____

SS#_____/____/_____ Employer _____Work Phone: (____) _____

Work Address: _____ Occupation: _____

Preferred Pharmacy Name: _____ **Phone#:** (_____) _____

Preferred Pharmacy Address:_____

Authorization For Disclosure Of Medical Information:

By signing below, I authorize Bakal Dermatology Associates, S.C., its medical staff members, employees, agents and representatives (together, "you") to release clinical and other information, including medical records related to my diagnosis and treatment and that of my dependents listed below to third parties and their respective medical staff members, employees, agents and representatives, including, without limitation, hospitals, medical providers and insurance companies and, for Medicare beneficiaries, the Social Security Administration.

In conjunction with these privacy practices you will need to provide us with the following information:

- Do we have your permission to leave a message with laboratory results on an answering machine, voicemail or with a family member? Yes No (Circle one)
- Do we have your permission to leave a detailed message? Yes No (Circle one)
- The preferred phone number(s) we may use to contact you _____
- The Name(s) and relationship of the person(s) we may speak to regarding your health.

_____

- Emergency Contact: _____ Phone Number: (_____) _____

The Private Policy Notices of Bakal Dermatology Associates, S.C. are posted in the waiting room for your convenience.

Agreement to Pay For Medical Services:

I agree to pay you for the medical and surgical services, diagnostic procedures, medications and related services (together, "your medical services") that you deem necessary or advisable and provide to me and my dependents. I agree to pay the amount owed to you for your medical services upon receipt of written notice from you, including any amounts unpaid by my insurance provider after a final determination of benefits. I understand that co-payments are due at the time of service. Our office policy is to charge $40 for all appointments not kept or cancelled with less than 24 hours' notice.

Where my insurance policy covers your medical services, I authorize my insurance provider to pay you directly for medical services. If my insurance policy requires pre-authorization or a referral from another medical professional before you perform surgical services, diagnostic or other procedures, I understand that my insurance policy may not pay for your medical services unless insurance policy requirements are met. Your health benefits have not been verified. We participate in several managed care plans; however it is your responsibility to confirm directly with your insurance that we are a contracted provider.

I have read your policy with respect to alternative payment plans and I understand that extended payment terms require your express written consent. If I do not pay an amount that I owe for your medical services within thirty (30) days of the date of written notice and you have not provided your express written consent to extended payment terms and you retain a collection agency or attorney to collect the outstanding amount, I agree to pay you for collection costs, including, but not limited to, collection fees not to exceed 40% of the outstanding amount, court costs and attorneys' fees, in addition to the outstanding amount payable for your medical services.

Acknowledgement of Patient or Representative:

I have read this Agreement and Authorization form. I understand the terms and have had an opportunity to discuss any concerns with you. My signature indicates that I agree with the form and I understand that any written statements marked on the document may not change the terms indicated above.

Print Name of Patient: _____

Patient/Authorized Representative's Signature: _____

Date: _____