Account #____________(Employee use only)

Patient Information

Personal Information:

Patient Last Name: ______________________________ First: _____________________ MI: ______

DOB: _______________ Birth Sex: M / F Gender Identity:________________________

Marital Status: Single / Married / Other

Home Address ____ City: __________________

State ______ Zip Code: _____________ E-Mail Address: __________________________________

Home Phone: (___) _________________________ Cellular Phone: (___) _____________________

Employer: ___________________________________ Occupation: __________________________

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 Care Physician: ______________________________ PCP Phone#:___________________

PCP Address: ____

Preferred Pharmacy Name: ______________________________ Phone#: ____________________

Preferred Pharmacy Address: ____

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: _______________________

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 please provide us with the following information:

- The preferred phone number(s) we may use to contact you. ___________________________
- Do we have your permission to leave a detailed message in regards to your healthcare or laboratory results? Yes No (Circle one)
- Do we have your permission to speak to a family member in regards to your healthcare or laboratory results? Yes No (Circle one)
- The Name(s) and relationship of the person(s) we may speak to regarding your health.

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- Emergency Contact: ___________________________ Phone Number: ( ) ________________

The entire Private Policy Notices of Bakal Dermatology Associates, S.C. is posted in the waiting room for your convenience. ***A written copy of The Private Policy Notices of Bakal Dermatology Associates, S.C is available through our front desk staff and is posted on our website at www.bakalderm.com.***

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: _________________