



Patient Information

Patient Last Name: _____ First: _____ MI: _____
Home Address _____ City: _____
State _____ Zip Code: _____ E-Mail Address: _____
Home Phone: () _____ Cellular Phone: () _____
SS# ____/____/____ DOB: _____ Marital Status: Single Married Other Sex: M / F
Employer: _____ Occupation: _____
Primary Care Physician: _____ Address & phone #: _____
Emergency Contact : _____ Phone Number: () _____
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: _____

Please list all medications you are currently taking including oral contraceptives and vitamins:

Please list all medication allergies along with the specific reaction they caused:

Do you have any of the following medical conditions: Check all that apply:

- diabetes tuberculosis hypertension peptic ulcer disease heart disease asthma/hayfever
- liver disease or hepatitis kidney disease HIV+ thyroid disease hives/eczema anemia
- arthritis cancer – type _____ Do you have any other medical conditions we should know about? _____

Do you have a family history of: skin cancer melanoma asthma eczema hayfever

We are board-certified experts in the treatment of skin, hair and nails.

We also offer many cosmetic services to rejuvenate the skin and improve your overall appearance.

Some of the services we offer include mole removals, laser surgery, Botox therapy, deep wrinkle fillers, leg vein treatments, microdermabrasion, in addition to general medical and surgical skin care. Please let us know if you are interested in any of the following services:

- I would like a full skin examination to check for any abnormal moles or growths. (The nurses will ask you to change into a gown once in the examination room)
- I would be interested in skin care products that will protect my skin from sun damage and reduce the signs of current damage.
- I am interested in the long term removal of unwanted hair.
- I am interested in removal of liver spots or enlarged blood vessels on my face.
- I would like to learn more about treating leg veins.
- I have "crow's feet" around my eyes or deep lines on my forehead and/or cheeks that I would like to treat.

FINANCIAL POLICY



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:

- If a procedure that will yield laboratory results is performed, please initial here if we have your permission to leave those results on an answering machine or with a family member. _____
- The name of person(s) we may speak to regarding your health (i.e., spouse, child, etc. including phone number)

The entire Private Policy Notices of Bakal Dermatology Associates, S.C. is posted in the waiting room for your perusal.

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: _____