

PATIENT INFORMATION

Personal

Please Print Clearly

Date _____

Last Name _____ First Name _____ M.I. _____

Address _____ City _____ State _____ Zip code _____

Billing Address _____ City _____ LA _____ Zip code _____

E-mail _____ Cell Phone _____ Phone _____

Social Sec# _____ Date of Birth _____ Female _____ Male _____

Patient's marital status: Please Circle M S D W Other Student status: Full _____ Part _____

Person responsible for visit: _____ Relationship to patient: _____

Insurance Information - Please present insurance card to receptionist.

Insured's name _____ Employer _____

Date of birth _____ Social Sec# _____ Relationship to patient _____

I chose BALDONE REINA DERMATOLOGY based on which type of referral: Please check one

- Physician's Family Friend Company Yellow Pages Newsletter Newspaper Ad
 Newspaper Article Hospital or Club Speech Brochure Practice Website Internet

Whom may we thank for referring you? _____

Person to contact in an emergency _____ Relationship _____

Phone _____ Alternate Phone _____

1. I acknowledge full financial responsibility for services rendered and understand that payment of charges incurred is due at the time of service.
2. I authorize and request that insurance payments be made directly to Baldone Reina Dermatology, APMC should we elect to bill my insurance company and accept such payments.
3. I authorize Dr. Rhonda R. Baldone or Dr. Rachel Reina to evaluate and treat my medical condition.
4. I authorize the release of my Personal Health Information to the referring physician, to my insurance company, to laboratories, if applicable, for the purpose of treatment, payment, clinical management and administrative duties.
5. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and consent to insurance authorization and pre-certification for treatment.
6. I understand that it is my responsibility to notify this office of any changes in the above information.
7. I understand there will be a \$15.00 service charge on any returned check.
8. I have been given the opportunity to review and/or receive a copy of this office's Notice of Privacy Practices.

Signed: _____ Date: _____