



**REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND  
SIGNATURE ON FILE**

Patient Name: \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Other family members that are patients \_\_\_\_\_

Referred by: \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone (    ) \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

In case of emergency, who should be notified? \_\_\_\_\_ Phone (    ) \_\_\_\_\_

**Do you give our office permission to discuss your medical information with family members?**

YES  NO If yes, please provide their names and phone numbers below.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone # (day): (    ) \_\_\_\_\_ Phone # (evening): (    ) \_\_\_\_\_

**May we leave personal medical information on your answering machine at home?**

YES  NO

**May we e-mail personal medical information to you?**

YES  NO E-mail address: \_\_\_\_\_

**RECEIPT OF NOTICE OF PRIVACY PRACTICES:**

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**PAYMENT POLICY:**

**HMO, PPO or other managed care patients:** You will be responsible for paying your annual deductible, copayment and charges for any non-covered, cosmetic services.

**Commercial Patients:** Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 35% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient or Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_