PATIENT INFORMATION

First Name	M.I.	Last Name	
Street Address		City	State
Zip Code	Home Phone #	Work Phone #	Cell Phone #

Birth Date	Age	Sex (circle one) F M	Race	Marital Status	Spouse's Name

E-mail Address	Preferred Phone Number:

RESPONSIBLE PARTY OR INSURANCE POLICY HOLDER (IF OTHER THAN PATIENT)

First Name	M.I.	Last Name	
Street Address		City	State

Zip Code	Home Phone #	Work Phone #	Cell Phone #	Birth Date

Who may we thank for referring you to our office?	Please tell us the name of your primary/referring physician:

Please read and check the boxes below:

☐ I understand this office ONLY participates with Medicare Part B insurance and I will be responsible for today's services if I do not have Medicare Part B as my **primary** insurance.

☐ I understand that if payment is required, it is due at the time of service and this office ONLY accepts Visa, AMEX, Master Card, Discover, and EXACT cash.

PLEASE NOTE: FOR ALL SCHEDULED APPOINTMENTS IN WHICH NOTIFICATION OF CANCELLATION IS NOT MADE AT LEAST 24 HOURS PRIOR TO APPOINTMENT TIME; YOU WILL BE CHARGED A FEE OF $50.00. FOR SURGICAL AND COSMETIC APPOINTMENTS, THIS FEE INCREASES TO $100.00 DUE TO THE LENGTH OF TIME SET ASIDE FOR THESE APPOINTMENTS. EXCEPTIONS WILL BE MADE ONLY IN THE CASE OF AN EMERGENCY, AND AT THE DISCRETION OF THE OFFICE MANAGER. PLEASE SIGN BELOW AS ACKNOWLEDGEMENT OF THIS POLICY.

Signature: ______________________________ Date: ____________________

PAYMENT IS DUE AT TIME OF SERVICE!
WE ACCEPT: VISA, MASTERCARD, DISCOVER, AMEX, or EXACT CASH!