FOR OFFICE USE
Acct#_____
UPDATE_____
UPDATE_____
UPDATE_____

TODAY'S DATE _____

PATIENT INFORMATION

PLEASE PRINT

Patient Name | Date of Birth | Age | M/F

Address | Social Security #

City | State | Zip

Home Phone | Work Phone | Cell Phone

E-mail

Employer | Occupation

Financial Responsible Party | Social Security #

Relationship to Patient | Date of Birth

Address | City | State | Zip

Home Phone | Work Phone | Cell Phone

Employer | Employer Phone

INSURANCE INFORMATION

Primary Insurance Company

Insured Name | Relationship to Patient

Employer | Date of Birth | Social Security #

Secondary Insurance Company

Insured Name | Relationship to Patient

Employer | Date of Birth | Social Security #

IF YOU DO NOT HAVE INSURANCE COVERAGE, FULL PAYMENT IS EXPECTED AT THE TIME OF YOUR VISIT. IF WE ARE BILLING YOUR INSURANCE COMPANY, A COPY OF YOUR INSURANCE CARD(S) WILL BE PHOTOCOPIED AT EACH VISIT. IF YOU DO NOT HAVE YOUR CURRENT INSURANCE CARD(S), FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE. PLEASE SIGN THE AUTHORIZATIONS ON THE BACK OF THIS FORM STATING YOU UNDERSTAND THIS POLICY.

IF I CANNOT BE REACHED AT THE PHONE NUMBERS LISTED ABOVE, I AUTHORIZE BILL H. HALMI MD AND ASSOCIATES TO CONTACT THOSE LISTED BELOW: Please initial _____

Name | **Relationship** | **Phone Number**

Name | **Relationship** | **Phone Number**

Name | **Relationship** | **Phone Number**

Primary Care Physician

Referring Physician

SIGNATURE AUTHORIZATION FOR PAYMENT

I request that payment of authorized Medicare and or any other insurance benefits be made directly to Bill H. Halmi, MD PC and Associates for services furnished to me. I authorize any holder of medical information about me needed to determine these benefits or the benefits payable for related services, be released to Bill H. Halmi, MD PC and Associates and their agents. I am aware that cosmetic procedures will not be billed to my insurance company and that I am responsible for payment at the time of service. I understand that if my financial account needs collection, all collection fees will be *added* to the original balance. I understand if I do not cancel my appointment 24 hours prior to the appointment time, or as indicated on a signed cancellation agreement, I will be charged a cancellation fee.

SIGNATURE OF PATIENT/RESP. PARTY_____ **DATE**_____

_____ _____

PRINT NAME OR NAME OF RESPONSIBLE PARTY RELATIONSHIP

RECORDS RELEASE AUTHORIZATION

I hereby authorize and request Bill H. Halmi, MD PC and Associates to release the complete medical records in their possession concerning my illness and or treatment to my primary care physician, referring physician or my insurance company.

SIGNATURE OF PATIENT/RESP. PARTY_____ **DATE**_____

WAIVER OF REFERRAL (HMO POLICIES ONLY)

I understand that I am responsible for obtaining referrals from my primary care physician for each and every visit with our office. I understand that IF I do not have my referral for my visit, or I wish to waive the use of my referral under my HMO program, I am responsible for my balance at the time of service.

SIGNATURE OF PATIENT/RESP. PARTY_____ **DATE**_____

RELEASE OF MEDICAL INFORMATION TO OTHERS

____**I DO** ___**I DO NOT** authorize Bill H. Halmi, MD PC and Associates or their agents to discuss my financial and medical condition and/or results of laboratory or pathology testing with those **listed below** (this includes general information about my account, including upcoming appointments):

_____

_____

SIGNATURE OF PATIENT/RESP. PARTY_____ **DATE**_____

THANK YOU FOR CHOOSING ARIZONA ADVANCED DERMATOLOGY!