

**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 () _____

Relationship to patient: _____

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): (____) _____

Name: _____ Relationship: _____

Phone # (day): (____) _____ Phone # (evening): (____) _____

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.

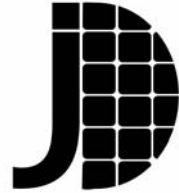
Patient or Responsible Party Signature _____ Date ____/____/____

PAYMENT POLICY: No show fee: You will be responsible for paying a \$25 no show fee for an appointment missed or not cancelled 24 hours in advance. For a surgical appointment, the no show fee is \$75.

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 at the time of service.

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 50% 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 ____/____/____



JACKSONVILLE
DERMATOLOGY
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