PLEASE PRINT & FILL IN ALL BLANKS DATE: _______________

PATIENT NAME ____

DATE OF BIRTH ___________ AGE ____ M F SS# ________________

PATIENT HOME ADDRESS ______________________________________

CITY, STATE, ZIP ____

CELL PHONE ________________________ SECOND PHONE______________________

MAY WE CONFIRM APPOINTMENTS BY TEXT? Circle **YES** or **NO**

INSURED POLICYHOLDER NAME _________________________

POLICYHOLDER'S DATE OF BIRTH ________________

E-MAIL ADDRESS ____

PATIENT OCCUPATION ___________________________

PATIENT EMPLOYER NAME _______________________________

PARENT (IF MINOR) OR SPOUSE ________________________________

EMPLOYER NAME _________________________WK PHONE __________________________

PERSON RESPONSIBLE FOR COPAYS AND DEDUCTIBLE ______________________________

HOW REFERRED ____

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I authorize Jennifer Caudill MD, FAAD to bill my insurance company for covered services provided. I also authorize payment directly to the physician for services rendered, and understand that it is my responsibility to make sure the bill is paid in a reasonable time. I also understand that it is my responsibility to be aware of my insurance benefits. If, for any reason, any portion of my bill is not paid by my insurance, I further agree TO PAY ANY OUTSTANDING AMOUNTS NOT COVERED BY MY INSURANCE PROMPTLY. In the event of non-payment, I will bear the cost of collection proceedings should this be required. I understand that it is my responsibility to obtain referrals if required by my insurance plan. Additionally, I authorize the release of medical information necessary to process any claims in compliance with the HIPAA Privacy Policy Act of 1996. A photocopy of this authorization shall be considered as effective and valid as the original.

SIGNED: ____ DATE: _______________

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