



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 _____

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: _____