Elizabeth A. Liotta, MD, LLC

Clinical and Cosmetic Dermatology

Patient Information Form

Patient's Full Name ____ Home Phone __________________

Patient's Birthdate _______________________ SSN#______________________ Work Phone __________________

Cell Phone _________________________ Does your cell phone receive text messages? _____Yes _____No

Residence Address ______________________________________ City _______________ ST ____ Zip _________

EMAIL ADDRESS____

Parent or Guardian's name (if patient is a minor) ___________________________ Guardian's SSN#_________________

Parent or Guardian's Address (if other than patient)____

Spouse's Name __________________________ Birthdate ____________ Social Security Number _________________

Spouse's Phone Numbers (Home)__________________ (*Cell) ____________________ (Work) _______________

Spouse's Address (if other than patient)____

Other Emergency Contact: Name_____________________________________ Phone ______________________

Do you have insurance? ________ If not, how do you intend to pay? _____ Cash _____ Check _____ Credit Card

Primary Insurance Company______________________________ Insured Name______________________________

Employer___________________________ Policy Number ___________________ Group Number _______________

Secondary Insurance Company____________________________ Insured Name______________________________

Employer ___________________________ Policy Number __________________ Group Number _______________

Family Physician's Name/Address ____ Phone _________________

Name of Person financially responsible for this account ____

Address of Personal financially responsible for this account ____

____

Relationship to Patient ____ Phone __________________________

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize Elizabeth A. Liotta, MD to treat me, and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and all members of my family promptly upon presentment thereof. I hereby authorize the release of any pertinent information to my insurance company. I acknowledge that payments will not be delayed or withheld because of any insurance coverage or because of the pendency of claims thereon. I acknowledge that all proceeds of insurance are assigned to this office where applicable and that this office assumes no responsibility for the collection of any proceeds of insurance.

I hereby authorize Elizabeth A. Liotta, MD to release any pertinent information to my insurance company and any other doctors involved in my case. If my account becomes assigned to a collection agency, I agree to pay all collection agency fees, court costs, and attorney fees. I understand that all accounts with a balance over 30 days will be assessed a 1.5 percent late charge per month on the unpaid monthly balance.

(SEAL)____ ______________________

Signature of Patient and/or Guardian DATE