Elizabeth A. Liotta, MD, LLC

Clinical and Cosmetic Dermatology

Patient Information Form

Patient's Full Name_____Birthdate_____

Residence Address_____

EMAIL_____Patient's SSN#_____

Cell Phone_____Land Line Phone_____Work Phone_____

Does your cell phone receive text messages? YES_____ NO_____

INITIAL_____: AS PARENT/LEGAL GUARDIAN I ASSUME FINANCIAL RESPONSIBILITY FOR THIS PATIENT

NAMED PARENT/LEGAL GUARDIAN MUST BE THE PERSON SIGNING THIS FORM

Parent/Legal Guardian_____Birthdate_____

Parent/Guardian's Address_____

Parent/Guardian SSN#_____Relationship to Patient_____Phone_____

Emergency Contact Name_____Phone_____

Emergency Contact Relationship_____

INITIAL_____: YOU MUST BRING YOUR INSURANCE CARD TO EVERY APPOINTMENT TO BE SEEN

INITIAL_____: IF A REFERRAL IS REQUIRED, WE MUST HAVE IT ON FILE FOR YOU TO BE SEEN

Primary Insurance Company_____

Policy Holder_____Birthdate_____Relationship_____

I hereby authorize Elizabeth A Liotta, MD to verbally disclose my health information, and discuss my medical care, treatment, laboratory results and billing account with the following person(s):

Name_____Relationship_____Phone_____

Name_____Relationship_____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)_____ _____

Print Name of Patient or Parent/Legal Guardian — Relationship

(SEAL)_____ _____

Signature (Type Name here if completing form online) — DATE