**Patient Intake Form**

First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_\_\_\_\_\_ Last Name:

Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt/Unit #:

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:

Email Address:

SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:

Cell Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone #:

Gender: Male / Female (circle one) Marital Status:

Employment Status: (circle one) Full-Time Part-Time Student

Employer/School:

Emergency Contact (Name and #):

Primary Care Physician:

Referring Physician:

**\*\*Primary Insurance Information\*\***

Insurance Name:

Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Holder:

Policy Holder DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder SSN:

Insurance Holder Address:

**\*\*Secondary Insurance Information\*\***

Insurance Name:

Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Holder:

Policy Holder DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder SSN:

**\*\*Payment Policy\***

Payment in full is expected at the time of service. This includes any deductibles and/or co-pays applicable to your policy. If you are covered by one of our contracted insurance companies, we will file the claim for you. Please see The Office Manager before your visit I special payment arrangements are necessary.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any services rendered. I have read all the information on these registration forms and certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the information above.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Parent/Guardian(If under 18): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

I hereby authorize Riva Aesthetic Dermatology, PLLC to furnish information to insurance carriers concerning my diagnosis and treatments and I request payment of medical insurance benefits to either myself or the party who accepts assignment. I understand that this authorization will remain in effect for as long as my dependent or I remain a patient.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

**Scheduled Appointments**

We understand that delays can happen, however we do not wish to inconvenience our other patients when trying to accommodate late arrivals. **If a patient arrives more than 15 minutes past their scheduled time, they may be asked to reschedule the appointment.**

**Cancellation/ No Show Policy for Doctor Appointments**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from being seen. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule when you would like to be seen. **If your appointment is not cancelled at least 24 hours in advance you will be charged a thirty five dollar ($35) fee: this will not be covered by your insurance company.**

**Cancellation/ No Show Policy for Procedures**

If it becomes necessary to reschedule your procedure, please call our office as soon as possible so that the space may be used by another patient. If you fail to cancel your appointment at least 24 hours in advance, there will be a $50 fee for a 30 minutes or shorter procedures, and a $100 fee for longer procedures. Thank you for calling in advance.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Parent/Guardian(If under 18): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: