Kerry Shafran, MD, FAAD | Lindsay Jayson, PA-C | Ashley Noone, PA-C | Erin Dice, PA-C | Nikki Leahy, PA-C | Mari Klos, CMA, LE

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:____

Where did you hear about Riva?

___ Friend ___ Newspaper Ad ___ Billboard ___ Facebook ___ Charlotte Today ___ Website

___ Magazine ___ Email Campaign ___ Event ___ Radio ___ Reviews ___ Other: _________

___ Medical Referral - Doctor's Name:____

****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:____