

I. PAUL RAPPAPORT, M.D.
AESTHETIC LASER & SKIN CARE CENTER
Dermatology and Dermatologic Surgery
414 Maple Avenue, Suite 300
Saratoga Springs, NY 12866
Telephone: (518) 587-9243

PATIENT INFORMATION

Today's Date _____

Last Name: _____ First Name _____ Middle _____

Mailing Address _____

City: _____ State: _____ Zip Code _____

Date of Birth _____ Home Phone: _____ Work Phone _____ Cell Phone _____

Email Address: _____ Sex: Male _____ Female _____ Marital Status _____

REFERRAL INFORMATION: (Please check the appropriate box below to help us determine how you were referred to our office)

Physician Friend Relatives One of our patients Yellow Pages Insurance

Primary or Referring Physician: _____

Person to contact in case of emergency: _____ Phone: _____

Other Family Members under Dr. Rappaport's Care: _____

To better serve our patients, we will automatically fax all prescriptions to the pharmacy for you:

Pharmacy: _____ Phone: _____ Fax _____

Pharmacy Location _____

RESPONSIBLE PARTY(If different from patient)

Last Name: _____ First Name _____ Middle _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work phone: _____ Cell Phone: _____

Date of Birth: _____

INSURANCE COVERAGE-(Please present insurance card(s) to receptionist.

Primary Card HolderName: _____ Relationship to patient _____ DOB: _____

AUTHORIZATION AND FINANCIAL POLICY

I, the undersigned certify that I (or my dependent) assign directly to Dr. I. Paul Rappaport, all insurance benefits for services rendered. Medicare and/or other insurance carriers will only pay for services that it determines to be "reasonable and necessary." If my insurance company determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under my policy with my insurance carrier, they may deny payment for these services and I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

My signature below shows that I understand that all copayments, coinsurance, deductibles, non-par insurance and self pay are due at the time services are rendered. I understand that Dr. Rappaport has the right to charge me \$25 for any returned check and \$25 for any appointments I fail to reschedule (No-Show Appointments)

For HIPAA Compliance, please answer the following questions:

I authorize you to leave appointment messages or send information to me via:

Answering Machine With another person Mail Email

My signature below authorizes Dr. I. Paul Rappaport general consent for evaluation, treatment and the understanding of Dr. I. Paul Rappaport's financial Policies.

Signed: _____ Date: _____

Patient or person authorized to consent signature

If Guardian, state relation: _____

We gladly accept Cash, Checks, MC, VISA, AMEX, DISCOVER. We also offer CARE CREDIT.