RAPPAPORT DERMATOLOGY

I Paul Rappaport, M.D.
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_____
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 al 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 I. Paul Rappaport, M.D. has the right to charge me $35 for any returned check and $50 for any office appointments and $150 for any procedures 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 I. Paul Rappaport, M.D. general consent for evaluation, treatment and the understanding of I. Paul Rappaport, M.D.'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.