

**Haleh Bakshandeh M.D. P.A.**  
**Board Certified Dermatology and Dermatologic Surgery**

UPDATE: PERSONAL INFORMATION

Patient's Name: \_\_\_\_\_ Address: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

If patient is a minor

DOB: \_\_\_\_\_ SS# \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_

Cell Phone: (    ) \_\_\_\_\_ Email: \_\_\_\_\_ Do you use it? Y N

Marital Status: Circle:    Single            Married            Divorced            Widowed            Committed

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Physician (PCP): \_\_\_\_\_ PCP Phone: (    ) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

**HEALTH INSURANCE INFORMATION**

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

\_\_\_\_\_

Name of Insured: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Relationship to Patient:  Parent  Spouse  Self  Other \_\_\_\_\_ Relationship to Patient:  Parent  Spouse  Self  Other \_\_\_\_\_

Has Deductible Been Met?  Yes  No                      Has Deductible Been Met?  Yes  No

Who may we thank for referring you? \_\_\_\_\_

PLEASE READ & SIGN BELOW

**OFFICE FINANCIAL POLICY**

PLEASE READ & SIGN BELOW

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in an insurance plan in which we participate. For those patients, applicable co-payments and deductibles will be collected on the day of the office visit. We accept payment in the form of cash, check or credit card.

If your account has a balance not paid by your insurance company, payment will be made using the EASY PAY form. However, if payment cannot be collected (card has expired or has been cancelled), you will be called and told you have a balance and payment is expected within 10 working days. Payments not received within 10 working days will be turned over to a collection agency and you will be responsible for the outstanding balance and the collection agency fees associated with the collection process.

Your signature below signifies your understanding and willingness to comply with this policy.

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

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