**Haleh Bakshandeh MD**
**Board Certified Dermatology and Dermatologic Surgery**

## PERSONAL INFORMATION

Full (legal) Name: _____ □ Male □ Female

Parent/Guardian (if patient is a minor) _____

Date of Birth:_____ SSN#:_____

Home Address: _____ City: _____ State: ____ Zip: _____

Cell Phone #:_____ Home or Work Phone #:_____

Email: _____

Occupation: _____

Emergency contact: _____ Phone #: _____

Primary Care Physician: _____

Who can we thank for referring you? _____

## HEALTH INSURANCE INFORMATION

Insurance Co. Name: _____

Policy #: _____

Subscriber's Name: _____

Group #: _____

## 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, 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:** _____