11671 Jollyville Rd. Ste-104
Austin, Tx. 78759
512-345-3599

Ladera Park Dermatology P.A.

Adrienne M. Feasel M.D.
Brooke Stidham, PA-C

PATIENT INFORMATION:

Last Name: _____ First: _____ Middle: _____

Date of Birth: _____ Age: _____ Gender: ◯M ◯F Social Security No: _____

Marital Status: _____ Drivers License #: _____ State _____ Email Address: _____

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

Street Address: _____

City _____ State _____ Zip Code _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone No: _____ Relationship: _____

BILLING INFORMATION (IF BILLS FROM OUR OFFICE SHOULD BE SENT TO SOMEONE OTHER THAN PATIENT)

Last Name: _____ First: _____ Middle: _____

Date of Birth: _____ Gender: M F Social Security No: _____

Marital Status: _____ Drivers License #: _____ State _____ Email Address: _____

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

Street Address: _____

City _____ State _____ Zip Code _____

INSURANCE INFORMATION:

PATIENTS ARE REQUIRED TO PRESENT PROOF OF INSURANCE COVERAGE PRIOR TO SERVICES. OTHERWISE, PATIENT WILL BE RESPONSIBLE FOR FULL PAYMENT OF SERVICES AT THE TIME OF THE VISIT.

Primary Ins. Co: _____

Are you the primary insured? Yes / No *(IF NO FILL OUT THE FOLLOWING FOR PRIMARY INSURED)*

Policy Holder's Name: _____ DOB: _____ Gender: M F

Relationship to Patient: _____ Social Security No: _____

Marital Status: _____ Home Phone: _____ Cell Phone: _____

Street Address: _____

City _____ State _____ Zip Code _____

Are you covered by a secondary insurance? Yes / No

Secondary Ins. Co: _____

Policy Holder's Name: _____ DOB: _____ Gender: M F

Relationship to Patient: _____ Social Security No: _____

Marital Status: _____ Home Phone: _____ Cell Phone: _____

RELEASE OF MEDICAL INFORMATION: I authorize the release of any medical information necessary to process this claim.
ASSIGNMENT OF BENEFITS: I authorize the Insurance company or any third party payor to pay any benefits due directly to this office should they accept assignment on my claim.
PAYMENT POLICY: I agree I am financially responsible for the account even though Insurance may be pending on all or a portion of the charges. We will file insurance, but all co-pays are due at time of service. ***Non-covered services, co-insurance, deductibles and balances remaining after insurance payment will be billed to the patient.***

I understand I may be charged $25.00 for missed appointments if I fail to cancel the appointment at least 24 hours in advance.
I understand there is a $25.00 return check charge.

I agree that a photocopy of this agreement shall be as valid as the original

Date: _____ **Signature** _____