Renascance DERMATOLOGY

PLEASE UPDATE APPLICABLE INFORMATION

☐ **Name Change** ☐ **Address Change** ☐ **Insurance Change** ☐ **No Change**

Name: _____
Last First M.I.

Mailing Address: _____
City State Zip

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

INSURANCE:

(RESPONSIBLE PARTY FOR INSURANCE)

Name: _____ Date of Birth: _____
Last First M.I.

Address: _____
City State Zip

Primary Insurance Carrier: _____ ID#: _____ GROUP#: _____

Secondary Insurance Carrier: _____ ID#: _____ GROUP#: _____

PLEASE SIGN SO WE MAY HAVE YOUR INSURANCE AUTHORIZATION ON FILE

I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits either to myself or the party who accepts assignment.

IF YOU NEED TO RESCHEDULE OR CANCEL AN APPOINTMENT, PLEASE NOTIFY US AT LEAST 48 HOURS IN ADVANCE, OR YOU MAY BE SUBJECT TO A $25 LATE CANCELLATION FEE FOR STANDARD OFFICE VISITS AND/OR $50 FEE FOR PROCEDURE AND COSMETIC VISITS. IF A FEE IS INCURRED, YOU WILL BE MAILED A STATEMENT REFLECTING THE CHARGE. YOUR SIGNATURE BELOW SIGNIFIES YOUR UNDERSTANDING AND WILLINGNESS TO COMPLY WITH THIS POLICY.

_____ _____

Signature of Patient or Legal Guardian **Date**