LUPO CENTER PATIENT INFORMATION SHEET

DATE _____ CLAIM CENTER _____
ACCOUNT #_____

PATIENT INFORMATION

PATIENT _____ SEX: M/F
MAILING ADDRESS _____ CITY _____
STATE _____ ZIP _____ E-MAIL ADDRESS*_____
HOME # _____ WORK # _____ CELL # _____
DATE OF BIRTH _____ AGE _____ MARITAL STATUS: M/S/W/D
SOCIAL SECURITY # _____ DRIVER'S LICENSE # _____
EMPLOYER _____ OCCUPATION _____ STUDENT: FULL/PART
REFERRED BY _____

SPOUSE/PARENT INFORMATION

SPOUSE/PARENT _____ SEX: M/F
MAILING ADDRESS _____ CITY _____
STATE _____ ZIP _____ SOCIAL SECURITY # _____
HOME # _____ WORK # _____ CELL # _____
DATE OF BIRTH _____ AGE _____ MARITAL STATUS: M/S/W/D
EMPLOYER _____ OCCUPATION _____ STUDENT: FULL/PART

RESPONSIBLE PARTY

_____ SELF _____ SPOUSE _____ PARENT _____ GUARDIAN _____ OTHER

INSURANCE INFORMATION

PRIMARY INSURANCE _____ PRIVATE _____ PPO

INS. CO. _____
ADDRESS _____
CITY, STATE, ZIP_____
CONTRACT#_____
GROUP #_____
INSURED'S NAME_____
INSURED'S EMPLOYER_____
INSURED'S SS #_____
INSURED'S D.O.B._____

SECONDARY INSURANCE _____ PRIVATE _____ PPO

INS. CO. _____
ADDRESS _____
CITY, STATE, ZIP_____
CONTRACT#_____
GROUP #_____
INSURED'S NAME_____
INSURED'S EMPLOYER_____
INSURED'S SS #_____
INSURED'S D.O.B._____

DOES YOUR MEDICARE COVER PRESCRIPTION DRUGS? YES _____ NO _____

PRIMARY CARE PHYSICIAN (if applicable)

NAME _____ PHONE _____
FULL ADDRESS _____

IN CASE OF EMERGENCY CONTACT

NAME _____ RELATIONSHIP _____
ADDRESS _____ PHONE _____

**By providing your email address, you are giving us permission to send email correspondences to you pertaining to our office's news, updates, specials and events. If at any time you would like to unsubscribe from receiving future emails, we include unsubscribe instructions at the bottom of each email blast. We will never share your email address with others.*

AUTHORIZATION

I. **GENERAL CONSENT TO TREATMENT**:
I AGREE AND CONSENT TO A PHYSICAL EXAMINATION BY THE LUPO CENTER FOR AESTHETIC AND GENERAL DERMATOLOGY, DR. MARY P. LUPO OR ANY OF HER ASSOCIATES. I UNDERSTAND THAT ADDITIONAL DIAGNOSTIC PROCEDURES AND TREATMENT MAY BE RECOMMENDED BY THE PHYSICIAN AND WILL BE DISCUSSED WITH ME BEFORE BEING DONE. I ACKNOWLEDGE THAT THERE ARE NO GUARANTEES, EXPRESSED OR IMPLIED, AS TO THE RESULTS OF ANY PROCEDURES OR MEDICAL TREATMENT.

II. **RELEASE OF INFORMATION**:
I AUTHORIZE PHYSICIANS PROVIDING SERVICES ON BEHALF OF THE PATIENT TO RELEASE ALL BILLING AND MEDICAL INFORMATION (INCLUDING INFORMATION CONCERNING SUBSTANCE ABUSE AND HIV STATUS, IF APPLICABLE) TO PHYSICIANS OR INSTITUTIONS PROVIDING FOLLOW-UP CARE, THE SOCIAL SECURITY ADMINISTRATION, MEDICARE, MEDICAID (OR THEIR VARIOUS INTERMEDIARIES), AND THE INSURANCE COMPANY, EMPLOYER, PERSON ACTING ON BEHALF OF A PREFERRED PROVIDER ARRANGEMENT OR THIRD PARTY NAMED ON THIS PATIENT INFORMATION FORM (OR ANY OF THEIR AGENTS OR REPRESENTATIVES), WHEN SUCH INFORMATION IS REQUESTED FOR PAYMENT, WORKERS' COMPENSATION, UTILIZATION REVIEW, OR COVERAGE DETERMINATION PURPOSES. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING AND DELIVERED TO THIS PHYSICIAN'S OFFICE.

III. **ASSIGNMENT OF INSURANCE OR THIRD PARTY COVERAGE**:
   A. I AUTHORIZE ANY THIRD PARTY PAYOR TO PAY DIRECTLY TO THE PHYSICIAN PROVIDING SERVICES TO THE PATIENT, ALL BENEFITS DUE PAYABLE AS A RESULT OF SERVICES RENDERED.
   B. I AUTHORIZE ASSIGNMENT TO THE PHYSICIAN WHO HAS PROVIDED SERVICES TO THE PATIENT THE INSURED'S RIGHTS TO PENALTIES AND ATTORNEY'S FEES IN THE EVENT THAT THE INSURER FAILS TO TIMELY PAY SUCH BENEFITS IN ACCORDANCE WITH LOUISIANA LAW (LA. R.S. 22:657).

IV. **ACKNOWLEDGEMENT OF RESPONSIBILITY TO PAY FOR SERVICES**:
I ACKNOWLEDGE AND AGREE THAT, EXCEPT AS PROVIDED BY LAW, AND IN CONSIDERATION OF THE SERVICES PROVIDED, I WILL PAY ANY CHARGES WHICH, FOR ANY REASON, ARE NOT PAID BY ANY THIRD PARTY PAYOR UNLESS THERE IS A SPECIFIC WRITTEN AGREEMENT BETWEEN THE PHYSICIAN AND THE PATIENT OR BETWEEN THE PHYSICIAN AND THE PAYOR. I ACKNOWLEDGE THAT THIS FEE IS INCURRED ON OPEN ACCOUNT FOR PROFESSIONAL MEDICAL SERVICES, IN ACCORDANCE WITH R.S. 9:2781. I ACKNOWLEDGE THAT IF I FAIL TO PAY THE BALANCE DUE ON THIS OPEN ACCOUNT WITHIN THIRTY (30) DAYS AFTER WRITTEN DEMAND, AND IN THE EVENT JUDGMENT IS RENDERED AGAINST ME, IN ADDITIONAL TO THE PRINCIPAL BALANCE DUE, I SHALL BE LIABLE FOR REASONABLE ATTORNEY FEES, LEGAL INTEREST FROM DATE OF JUDICIAL DEMAND, UNTIL PAID, PLUS COSTS OF COURT.

V. **MEDICARE PATIENTS**:
I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO THE LUPO CENTER FOR AESTHETIC & GENERAL DERMATOLOGY FOR ANY SERVICES FURNISHED ME BY THE LUPO CENTER FOR AESTHETIC AND GENERAL DERMATOLOGY, DR. MARY P. LUPO OR ANY OF HER ASSOCIATES. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

VI. **I HAVE RECEIVED A PATIENT INFORMATION BROCHURE**.

_____ _____

DATE PATIENT OR GUARDIAN SIGNATURE