## Patient Information

Name ______________________________ Date of Birth: ________________

Address ________________________________________________________

City, State and Zip _______________________________________________

Social Security No ______________________ Male ❑ Female ❑

Home Tel #: ____________________ Mobile Tel #______________________

Emergency Contact __________________________ Relationship ___________

Home #: _____________ Mobile # ______________ Work # ______________

## Payment Agreement

Medicare Patients:
I request that payment of authorized Medicare benefits be made on my behalf for any services furnished by Dr. Michael Shapiro, Dr. Angela Weatherall or the Vanguard Dermatology staff. I authorize any holder of my medical information to release to the Centers of Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

All Patients:
PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED FOR "YOUR PART" OF THE CHARGES INCURRED.
I agree to pay my deductibles, co-payments, and payments at the time services are rendered. We accept cash, checks, and Visa/Mastercard Your signature below indicates that you understand and accept this policy. Furthermore, your signature authorizes your Doctor to release such medical information necessary to process your insurance claims (if any). I herein authorize payment of medical benefits to Vanguard Dermatology when an assigned claim is submitted.

Signature of Patient / Legal Guardian ____________________________________

Date _____________ Patient Relationship to Policy Owner: ❑Self ❑Child ❑Spouse

Should my account fall into arrears greater then 60 days, I authorize that the unpaid balance be charged to my major credit card:
Card #__________________________________ Exp. Date _______________

Name on Card__________________________ Signature______________________

## Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of Vanguard Dermatology's Notice of Private Practices (effective July 1, 2005) detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction (if any) concerning the use of my personal information:

______________________________________________________________________

Signature ____________________________________________ Date __________