

4630 N. Loop 1604 W., Ste. 316 San Antonio, TX 78249 Phone: 210-496-9929

Patier	nt:							
		First Name	Ini	tial	Last		-	
Sex:	\square M	ΠF	□ Single	☐ Married	□ Othe	r		
SSN:	SSN:			Birth Date:		Age: _		
Street	Address	S		_ City:	State:	Zip:		
Home	Phone: _		Cell Phone	Cell Phone:		Preferred: Cell	□ Home	
Emer	gency Co	ontact:		Phone:				
Respo	onsible P	arty:						
Street Address:				City:		Zip:		
Home	Phone: _		Cell Phone:	Cell Phone:		Preferred: Cell	□ Home	
Prima	ry Insurar	ice:						
	•	Name	Po	licy #	Group #	ŧ		
Secondary Insurance: Name Policy # Group #								
Name			Po	Policy #		Ŧ		
In general, the HIPPAA privacy act gives the right (PHI). The individual is also provided the right to alternate means, such as sending correspondence to I wish to be contacted in the following manner (che Telephone Leave Detailed Message at home Y □ N □ Leave Detailed message at work Y □ N □ Leave Detailed Message on cell phone Y □ N □ □ No Restriction Requested			wided the right to request conficerespondence to the individual wing manner (check all that app Written Co Y N Ok to mail: Y N Ok to fax to Y N Ohone Y N	or request confidential communications of the individual's office instead of the individual's office instead of the individual that apply): Written Communication Ok to mail my home Y \(\Bracktorname{N} \) Ok to fax to this number Y \(\Bracktorname{N} \)		or that a communication of PHI be made by		
117	1 .1			OWLEDGEMENT	UDA A NOTICE	. 1	es accessors	
the Ol	FFICE PO	DLICY GUIDELI	n the space provided to indicate NES provided for your review. tes your agreement to follow the	You may request a cop	y of the HIPAA	NOTICE at our f	ront desk if	
(X) Patient / Guardian (if minor) Relationship								
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			PATIENT ACK	NOWLEDGEMENT				
indica	ted above arges wh	e and assign direct ether or not paid	all information listed above is tly to LIMMER DERMATOLO by Insurance. I hereby autho the use of this signature on all in	GY all insurance benefit rize the physician to re	ts. I understand t	that I am financial	ly liable for	
(X)Patient / Guardian (if minor)			Relatio	nship		nte		