M.A. STAWISKI, M.D.
DERMATOLOGY

PATIENT INFORMATION

Name ______________________________ Date of Birth __________ Sex: M F Mar. Status _____
Last Name First Name M.I.

Address ____
Street address City State Zip +four

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Email: ____

Occupation: ______________ Employment Status: FT PT NONE Student Status: FT PT NONE

RESPONSIBLE PARTY: (If patient is a minor)

Name ______________________ Home Phone ______________ Cell Phone ______________

Address ____
Street address City State Zip +four

PRIMARY IN SURANCE

Subscriber Name: ______________________ Subscriber birthdate ______________

Group# ______________ Insured's ID# ______________ Relation to Subscriber ______________

Employer Name ______________________ City ______________

SECOND INSURANCE

Subscriber Name: ______________________ Subscriber birthdate ______________

Group# ______________ Insured's ID# ______________ Relation to Subscriber ______________

In case of Emergency, who should be notified: ______________________ Phone ______________

Other Family members who are patients ____

Pharmacy of Choice ______________________ Phone ______________

Primary Care Physician ______________________ Did they refer you? ______________

Release of Medical/Financial Information - You must give us permission to talk with others about your medical care or billing information. Unless their name is listed below, we may not speak to them about your care or your bill. Please indicate your emergency contact.

Name	Relationship	Home Phone	Mobile Phone	☐ Medical	☐ Billing	☐ ER contact
Name	Relationship	Home Phone	Mobile Phone	☐ Medical	☐ Billing	☐ ER contact

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Your Privacy:

I have been informed of the Notice of Privacy Practices for M.A. Stawiski, M.D., Dermatology

Signature Date

Financial Policy: Patients who are covered by a private, commercial plans in which our physicians do not participate are required to pay 100% of the bill at the time of service. If covered by a plan with whom we have a contract, applicable co-payments and deductibles will be collected at the time of service, if determinable. You are responsible for paying for 100% of non-covered or cosmetic services. Payment for amounts billed to you are due within 20 daysof receiving a statement. Your signature indicates your willingness to comply with this policy.

Signature Date

Authorization for Payment: I authorize the release of information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I authorize payment of medical benefits directly to the physician.

Signature Date

Special Authorization for Medicare Patients Only:
I request that payment of authorized Medicare benefits be made on my behalf to M.A. Stawiski, M.D., Dermatology for any services furnished me by their providers. I authorize the release of information to the Centers for Medicare and Medicaid Services and its agents in order to determine benefits and payment of the claim. If "other health insurance" Is indicated I authorize releasing of the information to the insurer or agency shown. I permit a copy of this authorization to be used in place of the original. I understand I am responsible for co-insurance and deductible amounts as directed by my Medicare carrier. (M.A. Stawiski, M.D., Dermatology is a participating provider.)

Signature Date

Would you like to be notified by email about cosmetic service or product specials we offer?

email address

How did you hear about us? Doctor Friend Family Member Yellow Pages