The
Dermatology & Cosmetic Care Center

Stanley S. Roland, D.O.
610 North Main Street, Lapeer (810)667-9000
600 N. Main Street, Frankenmuth (866)593-2313
9900 Birch Run Road, Birch Run (866)593-2313
www.stanleysroland-do.com Fax: (810)667-2001

Today's Date: _____ Account #: _____

PATIENT INFORMATION:

Last Name: _____

First Name: _____

Middle Name/Suffix: _____

Previous Last Name: _____

Date of Birth: _____ Male / Female / Other

Social Security #: _____

Home Address: _____

_____

Mobile#: _____

Home #: _____

Work #: _____

Email: _____

Preferred Phone: **Mobile / Home / Work**

Preferred confirmation method/s: **Voice / Text / Email**

EMERGENCY CONTACT INFORMATION:

Name: _____

Relationship to Patient: _____

Phone #: _____

RESPONSIBLE PARTY/GUARANTOR INFORMATION:

Relationship to you: _____

Full Name: _____

Date of Birth: _____

Social Security #: _____

Pharmacy: _____

Pharmacy #: _____

Primary Care Physician: _____

Referred by: _____

Preferred Language: _____

Race: _____ Ethnicity: _____

PRIMARY INSURANCE INFORMATION:

Subscriber: _____

Date of Birth: _____

Subscriber SS#: _____

Relationship of patient to subscriber: _____

SECONDARY INSURANCE INFORMATION:

Subscriber: _____

Date of Birth: _____

Subscriber SS#: _____

Relationship of patient to subscriber: _____

Do we have your permission to:

- Leave a message at: **Home**: Yes/No **Work**: Yes/No **Mobile**: Yes/No
- Discuss your medical condition or financial information with any member of your household? Yes/No
  If yes, whom & relationship: _____

I have received or been offered a copy of the Notice of Privacy Practices from the office of Dr. Stanley Roland.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____ **DATE:** _____

I authorize the release of medical or other information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to Stanley S. Roland, DO PC. I understand that I am financially responsible for **all** charges regardless of my insurance coverage or if my insurance company does not pay for the services provided. I am also responsible for all costs if I do not provide accurate insurance information **at the time** services are provided. Claims will not be submitted if information is provided at a later date. I am also responsible for all charges that the insurance company applies to my deductible and coinsurance and for all amounts that the insurance company states are my copays. It is also my responsibility to obtain any required referrals or treatment authorizations from my insurance company.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____ **DATE:** _____

I understand and agree that, (regardless of my insurance status) **I AM ULTIMATELY RESPONSIBLE** for the balance on my account for any professional services rendered. I have read and filled out all of the information to the best of my ability. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or insurance status as indicated in the above information.

MONTHLY INTEREST CHARGES OF 1.5% (TIME/PRICE DIFFERENTIAL) ARE ASSESSED ON UNPAID BALANCES. ADDITIONAL SERVICE FEES WILL ALSO BE ACCESSED. UNLESS CANCELED 24 HOURS IN ADVANCE, $75.00 WILL BE CHARGED FOR MISSED APPOINTMENTS. ALSO FOR NO SHOW SURGERY APPOINTMENTS A MISSED APPOINTMENT FEE OF $250.00 WILL BE CHARGED.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____ **DATE:** _____