

**Johanna Baeuerle, MD**  
**326 North Highland Avenue**  
**Nyack, NY 10960**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Primary Insurance Subscriber: \_\_\_\_\_ Subscriber D.O.B.: \_\_\_\_\_

Insurance Information: Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Social Security #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Emergency Contact Phone: \_\_\_\_\_

Reason for Today's Visit: \_\_\_\_\_ Who Referred you to this office: \_\_\_\_\_

Have you ever been treated or do you currently have any of the following?:

Abnormal Moles	YES	NO	Hip/Knee Replacement	YES	NO
AIDS/HIV Positive	YES	NO	History of Cancer	YES	NO
Alcohol/Substance Abuse	YES	NO	Hives	YES	NO
Allergic to Anesthetic	YES	NO	Intestinal Disease/Ulcer	YES	NO
Arthritis	YES	NO	Intravenous Drug Use	YES	NO
Asthma	YES	NO	Kidney Disease	YES	NO
Bleeding/Clotting Disorder	YES	NO	Melanoma-Family/Self	YES	NO
Diabetes	YES	NO	Neurological Disease	YES	NO
Difficulty Healing Wounds	YES	NO	Overgrown Scars/Keloids	YES	NO
Eczema	YES	NO	Pregnant/Planning	YES	NO
Emotional/Psych	YES	NO	Psoriasis	YES	NO
Hay Fever	YES	NO	Respiratory/Lung Disease	YES	NO
Heart Disease	YES	NO	Skin Cancer-Family/Self	YES	NO
Pacemaker/MVP	YES	NO	Hepatitis/Liver Disease	YES	NO
Tuberculosis	YES	NO	High Blood Pressure	YES	NO
Vaginal Yeast Infection	YES	NO	Venereal Disease	YES	NO

If you answered YES to any of the above, please explain:

LIST ALLERGIES TO MEDICATIONS: \_\_\_\_\_

Family Care Physician: Full Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

LIST MEDICATIONS YOU ARE CURRENTLY TAKING: \_\_\_\_\_

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies (including Medicare), for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I permit a copy of this release to be used in place of the original.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

# FINANCIAL POLICY

Thank you for choosing Johanna Baeuerle, M.D. as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy. Please read and sign. All patients must complete our information and insurance form before seeing the doctor.

All payments are due at time of service. We accept cash or check. If for any reason you do not make a payment the day of service a \$25.00 billing fee will be applied to your account.

**REGARDING INSURANCE:** Your insurance policy is a contract between you and your insurance company. If we do not accept your insurance, payment is due at time of service. Please be aware that some and perhaps all services provided may not be covered under the Medicare Program and/or other medical insurance. All co-pays and deductibles are due prior to treatment. If your insurance company has not paid in full within 45 days, the balance will be automatically billed to you and then it becomes your responsibility to straighten any problems out with your insurance company. In the event that your insurance coverage changes a plan in which we are not participating providers, you are responsible for payment.

**USUAL AND CUSTOMARY RATES:** Our practice is committed to providing the best treatment for our patients and we charge what is usually customary to our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

**REFERRALS:** If your plan requires a referral you must obtain it prior to seeing Dr. Baeuerle. Without the appropriate referral you will be making a voluntary waiver to your right for insurance coverage for that days visit.

**RETURNED CHECK:** For checks returned due to insufficient funds there will be a \$25 surcharge.

**COLLECTIONS:** I understand that in the event that my account is turned over to a collections agency, I will be responsible for all collections fees.

**MINOR PATIENTS:** Minors must be accompanied by a parent or guardian to be seen, unless special arrangements have been made with the office. For minors, the parent or guardian assumes financial responsibility.

**MISSED APPOINTMENTS/NO SHOW POLICY:** Unless canceled at least 24 hours in advance, our policy is to charge \$25 for missed appointments. This fee is to cover cost of medical supplies, employee salaries, and other costs necessary to run a private practice. Please help us serve you better by keeping scheduled appointments. If a patient is a no show three times, they will be discharged from the practice. Medical records will be forwarded once the patient selects a doctor.

**INTEREST:** We reserve the right to charge interest as provided by state law, which is 2.5% per month. If your account is sent to a collection agency you will be responsible for additional fees.

**PRESCRIPTION REFILLS/PRE-CERTIFICATION:** Our office does not refill prescriptions if the doctor has not seen you in 6 months or more. Some medications require pre-certification. If a pharmacy notifies us of that fact, we will request that you, the patient, call your insurance carrier so that they can fax us the appropriate paperwork, which we will complete and return in a timely manner. This will expedite your receiving the medication that was prescribed.

Thank you for understanding our Financial Policy. Please let us know if you have any question or concerns.  
I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

X \_\_\_\_\_

Signature of Patient

X \_\_\_\_\_

Print Patient Name

I authorize my child to be seen and treated in my absence. INITIALS: X \_\_\_\_\_

**Johanna Baeuerle, M.D.  
328 North Highland Ave.  
Nyack, NY 10960  
(845) 358-3300**

**PATIENT AUTHORIZATION TO DISCLOSE INFORMATION TO SPECIFIC INDIVIDUALS**

Date: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize my physician and/or her representative to disclose medical and financial/billing/insurance information to the individual(s) listed below:

**NAME**

**RELATIONSHIP**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**PATIENT NOTES (Not Required):**

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\_\_\_\_\_  
**(Signature of patient)**

\_\_\_\_\_  
**(Date)**

\_\_\_\_\_  
**(Signature of witness)**

\_\_\_\_\_  
**(Date)**