Daniel G. Dupree, M.D.

Please Print

PATIENT INFORMATION

Patient # ____________ Date: __________

WT ____________ B/P ____________

PATIENT INFORMATION			
PATIENT NAME: LAST	FIRST		MIDDLE INITIAL
SEX ☐ MALE ☐ FEMALE	BIRTHDAY __ __/__ __/__ __	S.S. NUMBER __ __ __-__ __ -__ __ __ __	REFERRING DOCTOR NAME

GUARANT OR PATIENT INFORMATION (person responsible for payment)

GUARANT/PATIENT NAME: LAST ______ FIRST ______ MIDDLE INITIAL ______

ADDRESS: ______

CITY: ______ STATE: ______ ZIP: ______

HOME PHONE: (__ __ __) __ __ __- __ __ __ __ WORK PHONE: (__ __ __) __ __ __-__ __ __ __ EXT: __ __ __ __

PATIENT'S CELL PHONE (__ __ __) __ __ __ - __ __ __ __

PRIMARY INSURANCE			
SUBSCRIBER INFORMATION: LAST	FIRST	MIDDLE INITIAL	Patient Relationship to Subsciber (Circle One): 1. Male Self 2. Female Self 3. Male Spouse 4. Female Spouse 5. Male Child 6. Female Child Other:
SEX ☐ MALE ☐ FEMALE	BIRTHDAY __ __/__ __/__ __	S.S. NUMBER __ __ __- __ __ - __ __ __ __	
NAME OF CARRIER:			

EMERGENCY INFORMATION A friend or relative to contact in case of emergency (NOT living with patient)		
NAME:	RELATIONSHIP:	PHONE:
ADDRESS:	CITY, STATE, ZIP:	

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Daniel G. Dupree, M.D., Kristy R. Kennedy, M.D., or Alison Trappey Penton M.D. or any holder of medical information about me to release to the Health Care Finanacing Administration and its agents (Medicare) or Insurance Compaines or Third Parties, any information needed to determine these benefits or the benefits payable for related services.

ASSIGNMENT OF BENEFITS

I request that authorized Medicare or Insurance payments of medical benefits be made to Daniel G. Dupree, M.D., Kristy R. Kennedy, M.D., or Alison Trappey Penton, M.D., or any consulting physician or entity used in connection with this service (to be used only if necessary to file claims).

GUARANTOR RESPONSIBILITY

I understand that I am responsible for payment of any and all charges for medical services rendered by Daniel G. Dupree, M.D., Kristy R. Kennedy, M.D., or Alison Trappey Penton, M.D., and if this assignment is rejected, modified, or not paid within a reasonable time after it has been filed, it will be my responsibility to pay any unpaid charges in full. If it is necessary to collect unpaid fees for services rendered, I agree to pay the charge assessed by the collection service, legal counsel or court.

This authorization and assignment may be revoked by me at any time by a written notice.

I agree that a photocopy of the form may be used in lieu of the original.

______________________________ _______________

Signature of Insured/Patient Date

Daniel G. Dupree, M. D., LTD,
Kristy R. Kennedy, M. D., LLC
Alison Trappey Penton, M. D., LLC

DERMATOLOGY
1245 S. College Road, BUILDING 5
Lafayette, LA 70503

Patient Name:____

Patient Account Number:_____________________________________

I. Privacy Notice Acknowledgment

I acknowledge that I have been given the opportunity to read the Privacy Notice for Dr. Daniel G. Dupree, Dr. Kristy R. Kennedy, and Dr. Alison T. Penton, all of Lafayette, provided in the manuals, located in the lobby of the office. A copy of the notice has been made available to me, for personal use, if requested.

______________________________________ ____________________
Patient's Signature Date

____
Representative Signature / relationship to patient

II. Person(s) or Organization(s) authorized to receive information. Please list name(s).

____

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III. Documentation of Good Faith Effort

A good faith effort has been made to obtain a written acknowledgment of the Privacy Notice made available to the patient, provided in the lobby of our office. An acknowledgment has not been obtained because:

_____ Patient refused to sign the Privacy Notice

_____ Patient was unable to sign because ______________________________

_____ There was a medical emergency. Provider will attempt to obtain acknowledgment as soon as possible.

_____ Other____

______________________________ ____________________
Employee Signature Date

PATIENT COPY AVAILABLE UPON REQUEST

DR. DANIEL G. DUPREE, LTD
KRISTY R. KENNEDY, M. D., LLC
ALISON TRAPPEY PENTON, M. D., LLC

DERMATOLOGY
1245 SOUTH COLLEGE ROAD, BUILDING 5
LAFAYETTE, LA 70503

Dear Patient,

Effective immediately, our office policy will allow 30 days for insurance company payment. Please note: After 30 days, you are responsible for the bill regardless of what the status is of the insurance that has been filed for you. Should any amount be 30 days following the date of service and we have not heard from your insurance company, we ask that the patient contact their insurance company to help speed up payment to prevent your account from becoming delinquent. ALL THREE DOCTORS ACCEPT ALL FORMS OF PAYMENTS. Payment is due at the time of service, in full or co-pay unless prior arrangements have been made. If you have a medical savings account, you should be able get counter checks from your insurance company to pay at the time of service. Thank you for your help and understanding.

Respectfully yours,

Daniel G. Dupree, M. D.

Kristy R. Kennedy, M. D.

Alison Trappey Penton, M. D.

Patient or Parent Signature: ______________________________

Date: ______________________________