BRUCE A. LUCCAS, M.D.

DAVID A. CALDERWOOD, M.D.

3805B Spring St., Suite 130
Racine, WI 53405
Telephone: (262) 631-8750
Fax: (262) 631-8754

Patient's Last Name | First | M.I.

Address | City | State | Zip

S.S.# | Date of Birth | Home Phone /Cell Phone | Gender

Employer | City, State | Work Number

Spouse's Name | Employer | City, State | Work Number

Whom may we contact in case of emergency? Name_____ Phone Number_____

In general, the HIPAA privacy rule give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

☐ Home Telephone
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with callback number only

☐ Work Telephone
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with callback number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work address
- ☐ O.K. to fax to this number: _____

☐ O.K. to give detailed information to:_____
I would like this authorization to continue to be valid and effective until I revoke it.

INSURANCE INFORMATION

PRIMARY

Insurance Company's Name

Address

Phone | Group No. | I.D.#

SECONDARY

Insurance Company's Name

Address

Phone | Group No. | I.D.#

I hereby instruct and direct that my insurance company pay by check made payable to Bruce A. Luccas, M.D., 3805B Spring Street, Suite 130, Racine, WI 53405 the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. Payment is due within **30 days** of service. A 1.5% per month (18% per anum) late payment fee may be assessed on an unpaid balance remaining after 30 days.

A 24-hour advance notice is required for a cancellation. A cancellation fee may be charged for each missed appointment without a 24-hour notice. After 3 No-Show appointments, termination of medical service by our office will occur after 30 days.

I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any change in my health status or the above information.

SIGNATURE OF PATIENT(must be 18 years of age) | **SIGNATURE OF LEGAL GUARDIAN** | **DATE**