Patient Information Form for Dr. Rick Leoni II

Last name: ______________________________ First name: ____________________

Birth Date: _____-______-______ Social Security #: _________-_______-_________

Address: ____

______________________________, LA Zip: _________________________

Phone #'s: home _______________ work _________________ cell ______________

Employer: ____

Nearest Relative for Emergencies: _____________________________________

Address: ____

______________________________, LA Zip: ___________ Phone: ________________

Family or Referring Physician: ____

Insurance: Medicare Medicaid Private Other __________________________

I authorize the payment of benefits to the party that accepts assignment and/or Rick Leoni II, M.D. (dba Leoni 2Med, LLC).

Signature: ____________________________________ Date: ____________________

In consideration of the services rendered to me, the patient, I agree that I am solidarily liable for, and hereby guarantee payment of all charges incurred in my treatment, including any charges not paid, for any reason, by any payer or insurance company. I further agree payment in full is due within 30 days for date of bill or I will be subject to late fees in the amount of 12% per annum, interest and all attorneys' fees and costs incurred in connection with the collection of any charges reflected on the bill.

Signature: ____________________________________ Date: ______________________

Are you allergic to anything, including medicines? ___NO ____YES

List them: ____