

PATIENT REGISTRATION

Name (Last, First, MI) _____

Parent's Name (minors only) _____

Street Address _____

City, State, Zip _____

Phone Numbers: Home _____ Cell _____

Business _____

Birth Date _____ Age _____ Sex M F Marital Status S M D W

Social Security Number _____ - _____ - _____

Primary Care Doctor & Phone Number _____

Name of Emergency Contact _____ Phone # _____

Insurance Card Submitted? Y N Name of Company _____

Where did you hear about us? (Circle one or more)

TV Commercial Newspaper Ad ER Physician Friend Seminar

Authorization to Release Information: I authorize O'Leigh Aesthetic Surgery Center, LLC, to release any information necessary, acquired in the course of my treatment, to process insurance claims.

****Initial here** _____

Authorization to Pay Benefits Directly: I authorize my insurance company to pay O'Leigh Aesthetic Surgery Center, LLC, directly for medical service rendered, and I hereby assign all such policy benefits to O'Leigh Aesthetic Surgery Center, LLC. I understand that I will be responsible for non-covered charges.

****Initial here** _____

Notice of Privacy Practices: I acknowledge that O'Leigh Aesthetic Surgery Center, LLC, has adopted a notice of privacy practices. I also understand that I have an opportunity to view that notice.

****Initial here** _____

Financial Policy: Unless covered by insurance, payment is due, in full, at the time services are rendered.

****Initial here** _____

Smoking Policy: Smoking has been shown to cause numerous complications in surgical patients. Smoking is associated with poor wound healing, tissue loss, failure of surgical procedures, infection, and flap loss. Smoking can result in the need for repeat surgery to correct or treat complications. You must stop smoking for 4 weeks prior to any elective surgical procedure.

****Initial here** _____

****Signature** _____ **Date** _____