

PATIENT REGISTRATION

Name (Last, First, MI) _____

What do you prefer to be called? _____

For minors, please list parent's name(s) _____

Street Address _____

City, State, Zip _____

Phone Numbers: Home _____ Cell _____

Business _____ Email _____

Birth Date _____ Age ____ Social Security Number _____ - _____ - _____

Primary Care Doctor & Phone Number _____

Name of Emergency Contact _____ Phone # _____

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: Health insurance is a contract between you and an insurance company. As such, it is your responsibility to determine if the services provided by O'Leigh Aesthetic Surgery Center, LLC, are covered and to what extent they are covered. By initializing here, you understand that you will be responsible for all non-covered charges. You are authorizing your insurance company to pay O'Leigh Aesthetic Surgery Center, LLC, directly for medical services rendered, and you hereby assign all such policy benefits to O'Leigh Aesthetic Surgery Center, LLC. ****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 medical insurance, payment is due, in full, at the time services are rendered. ****Initial here** _____

Medical Record Release: I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, or other organization or person that has any records or knowledge of my health, to give to O'Leigh Aesthetic Surgery Center, LLC, any such information if so requested.

****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** _____