

# Raval Facial Aesthetics & ENT, PC

## Personal Information

Date \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Preferred Name \_\_\_\_\_ Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Male  Female  Minor  Single  Married  Domestic Partner

Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

E-mail Address \_\_\_\_\_

How do you prefer to be contacted?  E-mail  Phone  Text Message

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

### Responsible Party

Who is responsible for the account? \_\_\_\_\_

Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Birth Date \_\_\_\_\_ Driver's License # \_\_\_\_\_

Social Security # \_\_\_\_\_ E-mail Address \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

### Primary Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insured's Birth Date \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance Company \_\_\_\_\_

Claims/Insurance Company Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Insured ID # \_\_\_\_\_ Group # \_\_\_\_\_

#### Consent:

I understand that responsibility for payment of medical services in this office for myself and my dependents is mine, due and payable at the time of services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). **Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance.** I also assign all benefits to Name of Provider. I understand that 3.00% fee will be added to any credit card payment collected by the provider's office or its collection agency. I acknowledge that my signature on this document authorizes the submission of claims without obtaining my signature on each and every claim submitted. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996.

Responsible Party's Signature \_\_\_\_\_ Date \_\_\_\_\_