Infinity Skin Care & Spa / Infinity Vein Center
Patient Registration Form

Patient Information – 2011 Today's Date:___________________________

Name: ____ Sex ❒M ❒ F
First *Middle* *Last*

Prefer to be called:_____________________________ Title: ❒Mr. ❒Mrs. ❒Ms. ❒Miss ❒Dr.

Date of Birth:_____/_____/_____ Age_______ Employer:_______________________________________
Month *Day* *Year*

Patient's Address:____
Street # *Street Name* *Apt #*

____
City *State* *Zip*

Home Phone:_______________Cell Phone:_______________Work Phone:________________________
Area code *Area Code* *Area Code*

Which phone would you prefer us to call? ❒ Home ❒ Cell ❒ Work

Parent or Responsible Party (if different from patient)

Name: ____ Sex ❒M ❒ F
First *Middle* *Last*

Date of Birth:_____/_____/_____ Age_______ Employer:_______________________________________
Month *Day* *Year*

Address:____
Street # *Street Name* *Apt #*

____
City *State* *Zip*

Home Phone:_______________Cell Phone:_______________Work Phone:________________________
Area code *Area Code* *Area Code*

<u>VEIN PATIENTS ONLY:</u> Insurance Information (Please present insurance card at time of check-in)

Primary Insurance:
Ins. Name ______________________________
Ins. Address ____________________________
Name of Insured _________________________
Date of Birth _____/______/______________
Insured's ID # __________________________
Group # _______________________________
Employer Name _________________________
Relationship of patient to insured ___________

Secondary Insurance:
Ins. Name ______________________________
Ins. Address ____________________________
Name of Insured _________________________
Date of Birth _____/______/______________
Insured's ID # __________________________
Group # _______________________________
Employer Name _________________________
Relationship of patient to insured ___________

How did you hear about us?________________ Pharmacy of Choice ___________________

Do we have your permission to:

	Yes	No
Leave a message on your answering machine at home	❒	❒
Leave a message at your place of employment?	❒	❒
Discuss your treatment with any member or your household?	❒	❒

If yes, whom?______________________ Relationship_________________________________

×____ ____________________
Signature of Patient or Responsible Party *Date*

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Please Sign This Side Of Form At The Time Of Registration

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance application and prescriptions. I also authorize payment of medical benefits to the physician.

×____ ____________________
Signature of patient or responsible party Date

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Care Operations

I understand that as part of my healthcare *Infinity Skin Care and Spa / Infinity Vein Center* originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment
A means of communication among the health care professionals who contribute to my care
A source of information for applying my diagnosis and surgical information to my bill
A means by which a third-party payer can verify that services billed were actually provided

I understand and have been provided with a ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notices prior to signing this consent. I understand that the *Infinity Skin Care and Spa / Infinity Vein Center* reserves the right to change their notice and practices prior to implementation. I understand I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that *Infinity Skin Care and Spa / Infinity Vein Center* is not required to agree to the restriction requested. I understand that I may revoke this consent in writing.

I request the following restrictions to the use or disclosure of my health information:

____
____

Signature of patient or responsible party: ×________________________________ Date:____________

Witness:____Date:____________

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. **Payment is expected from you at the time of service for *your part* of the charges. We accept cash, check, Visa, Mastercard, American Express and Discover for your convenience.** Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the doctor when assigned claim is filed. In the event that your account must be turned over to collections a $10.00 collection fee will be added to your account.

×____________________________________ ______________________
Signature of patient or responsible party Date