PATIENT REGISTRATION FORM

PATIENT INFORMATION: E-MAIL _______________________________

LAST NAME______________________________ FIRST_______________________________ MI_______ SEX: M F

ADDRESS:__________________________________ CITY: _________________________STATE ___ ZIP:__________

DATE OF BIRTH:_________________ MARITAL STATUS: M S D SEP SSN:________________________________

HOME PH:____________________ CELL PH.:__________________ WORK PH:________________________________

EMPLOYER:_________________________ EMPLOYER ADDRESS:____

SPOUSE'S NAME:_______________________ARE YOU BEING SEEN FOR A WORK RELATED INJURY? Y/N

DATE OF MOTOR VEHICLE ACCIDENT:___________________DATE OR ONSET OF INJURY_________________

IF PATIENT IS 18 OR UNDER:
FATHER'S FULL NAME______________________________ HOME PH._______________WORK PH._____________

MOTHER'S FULL NAME_____________________________ HOME PH.________________ WORK. PH.___________

WHO IS FINANCIALLY RESPONSIBLE FOR PAYMENT?
If patient is the responsible party, do not complete this section-**CHECK HERE** □

LAST NAME ____________________________ FIRST______________________________ MIDDLE________________

ADDRESS:____

CITY/STATE:__________________________________ ZIP:________________ HOME PH.:______________________

EMPLOYER:____ WORK PH.:______________________

SSN:____________________________________

INSURANCE INFORMATION: (In addition to listing all insurance plans, please present your insurance cards so that we may obtain a copy.)

PRIMARY INSURANCE:____

CLAIMS MAILING ADDRESS____

CITY/STATE:____ ZIP_____________ PHONE: (   )____________

INSURED'S NAME: _______________________________________ DATE OF BIRTH______________

RELATIONSHIP TO PATIENT:__________________ SEX: M F

INSURED'S ADDRESS:_____________________________________ SCHOOL:________________FULL/PART TIME

EMPLOYER:_________________________________ GROUP NO.____________________ID#____________________

SECONDARY INSURANCE:____

CLAIMS MAILING ADDRESS____

CITY/STATE:____ ZIP_____________ PHONE: (   )____________

INSURED'S NAME: _______________________________________ DATE OF BIRTH______________

RELATIONSHIP TO PATIENT:__________________ SEX: M F

INSURED'S ADDRESS:_____________________________________ SCHOOL:________________FULL/PART TIME

EMPLOYER:_________________________________ GROUP NO.____________________ID#____________________

NEAREST RELATIVE OR FRIEND, NOT LIVING WITH YOU, THAT WE MAY CONTACT IF WE ARE UNABLETO REACH YOU OR IN CASE OF AN EMERGENCY.

NAME:____ PHONE:____________________________________

WHOM MAY WE THANK FOR REFERRING YOU TO DR. MELISSA HOLLIE?
REFERRED BY DOCTOR___________________________ REFERRED BY FRIEND//PATIENT_______________
YELLOW PAGES__, TV.__ NEWSPAPER/MAGAZINES__, RADIO, ____ INTERNET____, OTHER__________.

CONSENT TO TREATMENT:I HEREBY CONSENT TO MEDICAL TREATMENT RENDERED OR PRESCRIBED BY DR. MELISSA HOLLIE.

DATE:____SIGNATURE___________________________________
(If Minor, Parent of Legal Guardian Must Sign)

Aesthetic Medical Associates
of the Central West End
3920 Lindell Blvd., Ste. 105 St. Louis, MO 63108
314-652-8923 office | 314-652-8925 fax

CONSENTS/AUTHORIZATIONS

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND PAY BENEFITS

I hereby authorize the release of any medical information necessary to bill my insurer, and authorize payment or medical/surgical benefits to be made to Aesthetic Medical Associates, L.L.C.

DATE:______________________ SIGNATURE:____________________________________

CONSENT FOR PHOTOGRAPHY

Pre-treatment and post-treatment photographs are recommended to follow your medical care. Pre-treatment and post-treatment photos may be viewed for educational purposes by our physician or patients; or on request, sent to your insurance company. Educational purposes may include: use in physician consults with individual patients or use in physician seminars presented to potential patients or for medical associations.

This consent will be in effect until physician discontinues use of these photographs.

It is our intention to handle all photographs with the highest regard for confidentiality.

DATE:______________________ SIGNATURE:____________________________________

RECEIPT OF PRIVACY NOTICE ACKNOWLEDGEMENT

By my signature below, I acknowledge I received the current Privacy Notice of Aesthetic Medical Associates, L.L.C.

DATE:______________________ SIGNATURE:____________________________________

Aesthetic Medical Associates
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PAYMENT POLICIES

We accept cash, check, Visa, MasterCard, American Express, Discover, and most insurance programs.

If you have insurance, the following apply:

1. It is YOUR responsibility to give us the correct information about your insurance company, and to follow the rules of your insurance company. You must comply with such rules as a valid referral form and pre-certification of testing and surgery, in order for your claims to be paid. We will assist you, but if claims are denied because of your failure for the above, you will be responsible for paying the denied services.
2. You are responsible for paying any deductibles, co-payments or non-covered services.
   a. Work Related Injuries:
      A. If your employer has approved treatment: you will not be charged or billed.
      B. If your employer does not approve treatment and YOU select us for your treatment, you will be billed and charged for the services.
3. If you are involved in a lawsuit that affects the payment of our services, we hold you responsible for payment of our regular fees.
4. We file group insurance claims and by law, must file Medicare claims.
5. Children that are brought to our office under 18 years of age must have Authorization from their parent or legal guardian before being treated by our providers.
6. Certegy check services are used at the time of service for any check written. The transaction will be converted to electronic payment. The check will be returned to the patient along with a receipt. A service fee of $30.00 will be charged to the patient per returned check.
7. A 24-hour notice is requested on cancellations. If a patient does not show up for an appointment it will be considered a no show. No show appointments are documented in the patient's chart. If they become excessive the patient will be billed a fee and/or requested to seek care through another physician.

   In the event of non-payment for charges you have been made responsible, you will become responsible for any legal and/or collection fees.

   I have read all the above terms and assume full responsibility for paying any medical services charges and finance charges according to these terms.

DATE:______________________________________

SIGNED:__________________________________

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Name Birthdate

Chronic Illness Onset Date

Medications Start Date/Finish Date

Allergies/Drug Allergies Side Effects

Family History (Parents,Siblings,Children)

Hospital/Surgery Year

Nutritional Supplements

Tobacco Use Y/N Substance Use Y/N Alcohol Use Y/N